EDUCATION AND TRAINING FOR CONSUMER PARTICIPATION IN HEALTH CARE

RESOURCE GUIDE

Prepared by Global Learning Services Pty Ltd for the Consumer Focus Collaboration

A Consumer Focus Collaboration publication
The Commonwealth Department of Health and Aged Care has funded a range of projects to strengthen consumer participation in health through its Consumer Focus Strategy. These projects are overseen by the Consumer Focus Collaboration, which is made up of consumer organisations, professional organisations, Commonwealth, state and territory health departments, and private sector representatives. The Collaboration works to increase effective consumer participation at all levels within the Australian health care system.

Projects funded through the Strategy are intended to promote, integrate and disseminate information and increase consumer involvement in health service planning, delivery, monitoring and evaluation. The Consumer Focus Collaboration publication series documents these projects.

A wide range of organisations participate in the Consumer Focus Collaboration, representing a broad range of views and interests. Consumer Focus Collaboration publications do not attempt to reflect all of the views of the individual organisations and jurisdictions represented on the Collaboration. However they do demonstrate the shared perspective on strategies for building a strong consumer focus for national action on quality and safety.

For information on the availability of the publications, contact the Information Manager, National Resource Centre for Consumer Participation in Health, ph: (03) 9479 3614 or freecall 1800 625 619.

The Consumer Focus Collaboration publication series is available free of charge on this web site: http://nrccph.latrobe.edu.au
FOREWORD

Building a safe, high-quality health care system means that people managing and working in the system need to work together with consumers and the community to achieve sustainable improvements and maintain public confidence in the system.

The Consumer Focus Collaboration publication series provides practical tools to support consumers and health care providers to achieve this goal. These tools have been developed through projects funded by the Commonwealth Department of Health and Aged Care.

The Consumer Focus Collaboration, established in 1997, has played an important role in taking forward work on consumer participation at the national level. The collaboration is a national body with representatives from consumer, professional and private sector organisations, and all health departments. Its aim is to strengthen the focus on consumers in health service planning, delivery, monitoring and evaluation in Australia.

The collaboration is taking the lead in fostering this active partnership between consumers of health care and those who provide that care.

The resource guides, reports and issues papers that make up the publication series have been designed to provide health care consumers, service providers and managers with ideas and information about how to work together in partnerships.

Strengthening the voice of consumers in the health system requires a multi-pronged approach. This publication series reflects the commitment of the Consumer Focus Collaboration to provide strategic resources in a number of areas including education and training, building consumer capacity to participate, building provider capacity to respond to consumer need, and research into aspects of consumer involvement in health services.

Consumer Focus Collaboration
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PART I

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PART 1: INTRODUCTION

1.1 HOW TO USE THE RESOURCE GUIDE

This guide has been designed to assist both consumers and providers who are interested in undertaking some education and training processes that will facilitate consumer participation in the health care system.

It is essentially a guide to what other people have done with some commentary on the processes used and principles that might have underpinned those processes. The aim of the guide is to signpost you to the experiences of others, so that you can choose to look at and adapt to your particular circumstances what others have learnt.

This guide does not provide a cookbook formula on how to undertake education and training for consumer participation. There is no single model to suit all purposes though in Section 2.5 you will find a summary of the basic elements. The case studies and resources in parts 3 and 4 point to a diverse range of successful approaches. The guide will endeavour to point you to successful examples that you can apply to your situation.

The cases in this Resource Guide provide examples of much creative innovation in which consumers and providers have sought to address the challenge of the new environment of health systems. While the cases cited in the Guide could be added to, they offer a typical range of examples of good practice in the implementation of a broad spectrum of education, training, and learning strategies. As far as possible we have used the language of each resource as each resource has a particular approach to consumers, service providers and education.

Through our national consultation we came across a number of excellent initiatives to increase consumer participation that unfortunately did not have documentation that could be shared with others. These were often the less formal strategies. However the resources cited here do provide a good starting point.

Parts 1 and 2

Part 1, which is this section of the Resource Guide, gives an introduction to the concepts of consumer participation and along with part 2 outlines some of the current thinking about education, training and learning. This section introduces the Mindmap for Education, Learning and Training (MELT) model, which provides the conceptual basis for the Resource Guide, and explains some of its most relevant concepts.

This section should be read to gain some ideas on the theory of best practice education. It will lead you into thinking about what sort of education and training might best suit your context. The MELT model is introduced as a way of linking theory and practice.

The theoretical principles are linked to some specific case studies and resources for your information.

Part 3

Part 3 presents a selection of education, training and learning case studies that have been developed in the Australian context. A key feature matrix categorises the cases by their prime education focus (following our MELT model) for ease of reference. It is suggested that you use this matrix to help you choose the resources in part 4 that you are most interested in.
Part 4

Part 4 provides a range of approaches to education, training and learning in the Australian health care context. The resources are presented in the form of one-page summaries. A key feature matrix categorises the resources by their prime education focus (following our MELT model) for ease of reference. It is suggested that you use this matrix to help you choose the resources that you are most interested in.

Part 5

Part 5 describes some of the key strategies for education and training in partnership development. This section is designed for those wishing to embark on a more long term and comprehensive learning pathway. A key feature matrix categorises the resources by their prime education focus (following our MELT model) for ease of reference. It is suggested that you use this matrix to help you choose the resources that you are most interested in.

Part 6

Part 6 contains appendixes with details on other consumer focus projects and the authors.

1.2 BACKGROUND AND ACKNOWLEDGMENTS

Background

This Resource Guide has been prepared to provide examples of effective education and training for health service providers and administrators as a basis for building collaboration and partnership with consumers to improve the health system and to add to the quality of health care outcomes for all stakeholders.

The preparation of the Resource Guide has resulted from a project entitled Education and Training for Consumer Participation funded by the Commonwealth Department of Health and Aged Care as part of the Strategic Plan of the Consumer Focus Collaboration established in 1997. A report on this project provides comment on the broader issues, which underpin the approach adopted for the Resource Guide, and identifies some of the gaps and issues for further work.

The Consumer Focus Collaboration has developed four national goals:
1. to improve the accountability and responsiveness of the health care system to consumers;
2. to facilitate the provision of health information to consumers in appropriate formats;
3. to facilitate active consumer involvement in health system planning, delivery, monitoring and evaluation;
4. to promote education and training that supports active consumer involvement in health service planning, delivery, monitoring and evaluation.

The Education and Training for Consumer Participation project relates particularly to the fourth goal above and was one of a number funded in 1999 by the Commonwealth Government to increase effective and sustainable consumer participation in all levels of health service provision. We would encourage you to access these projects, as their work is complementary in many ways. A list of these projects is included in Appendix 1 within Part 6.
The National Resource Centre for Consumer Participation in Health has also been established to promote partnerships between consumers and other stakeholders. It will act as a clearinghouse, collecting information on consumer feedback and participation methodologies and widely disseminating this information to consumers and health service providers. The Centre will also offer expertise to client users and critically analyse new methods and models of consumer participation.

As part of this role, the Centre will be a central point for the development and dissemination of further innovations in the education and training strategies that support the learning of consumers and service providers. The contact details for the Centre are

The Director, National Resource Centre for Consumer Participation in Health
ph: 03 9479 3529, fax: 03 9479 5977,
web site: http://nrccph.latrobe.edu.au

Acknowledgments
Production of this Resource Guide involved extensive consultations with consumers, health administrators and health providers in order to identify examples of good practice and issues and gaps which need to be addressed. Their generous assistance is acknowledged and appreciated. Without them the stories that unfold in this guide would not have been possible. It is hoped that the sharing of these stories will encourage others along the road of education and training for consumer participation in health care.

Given that little education and training currently exists for health care professionals and administrators about consumer participation in health care, there is a unique opportunity to establish some best practice education interventions. It is hoped that this Resource Guide will be a dynamic product that is regularly updated as consumers and health service providers together forge new and effective ways of working together.

1.3 THE CONTEXT: CONSUMER PARTICIPATION IN HEALTH CARE

Consumer participation in health care
The World Health Organization’s 1978 Declaration of Alma-Ata set out a vision for primary health care, which stated that:

The people have the right and duty to participate individually and collectively in the planning and implementation of their health care...

Primary health care ... requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate (clause IV and clause VII(5)).

In the 1986 Ottawa Charter on Health Promotion from the World Health Organization, consumer empowerment in health care was seen as a central element of achieving improved health and well being in a society. The Charter also saw the promotion of health as something that went well beyond individual health care treatment. It involved cooperation and the skills and experience of many different people:

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by government, by health and other social and economic sectors, by non-governmental and voluntary agencies, by local authorities, by industry and
by the media. People in all walks of life are involved as individuals, families and communities (WHO 1986).

The means of achieving health set out in the Ottawa Charter were reiterated in the recent Jakarta Declaration on Health Promotion in the 21st century, with health promotion being described as ‘a process of enabling people to increase control over and to improve their health’. The declaration goes on to say:

Health promotion is carried out by and with people, not on or to people. It improves both the ability of individuals to take action, and the capacity of groups, organisations or communities to influence the determinants of health.

Improving the capacity of communities for health promotion requires practical education, leadership training, and access to resources. Empowering individual’s demands more consistent, reliable access to the decision-making process and the skills and knowledge essential to effect change (WHO 1997).

These international declarations provide a broad conceptual framework in which many other developments in health care can be placed. They provide high-level recognition of:

• The importance of partnership, not just at the individual consumer/provider level but to the degree of consumer participation in the system as a whole;
• The need for practical skills development and education to empower consumers and communities to participate in their health care at a systemic level;
• The importance of the active cooperation of health professionals and managers in facilitating consumer empowerment across the health system; and
• The needs of health professionals and managers for skills development and training to work with consumers to achieve the full potential of partnership and consumer participation in gaining better health for all citizens.

The growth of partnership concepts in health care

The past few decades have seen a gradual shift in health care from a paternalistic approach, where ‘the health professional knew best’ and there was little consultation with the person upon whom the services were to be performed (PIR 1995; CHF 1999, chapter 8). These changes are part of a broader social shift within our society, which ‘acknowledges the fundamental democratic rights of all citizens to be involved in issues that affect them’ (CHF 1999, p5). In the health care arena, this is perhaps most epitomised by the legal principle of consumer self-determination in health care.

Many of these democratic developments in health care have centred on the concept of partnership in individual consumer/health care provider relationships. However, the establishment of individual partnerships has had an impact on the broader policy discussion in health care decision-making. Partnerships are recognised as useful and desirable for both consumers and health professionals at the systemic level.

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1 For a discussion of this issue, see PIR Final Report: p25, paragraphs 2.59–2.61. While the Northern Territory legislation referred to in this passage was overturned by the Commonwealth Parliament in 1996, the remainder of the law remains as described.
Consumer involvement in systemic decision-making

There has also been growing recognition of the need for public participation in health system decision-making in Australia over the past decade. For example, in 1993 the National Health Strategy looked at the need for improved public participation in health system decision-making and a public process of debate concerning the priorities of the health system (NHS 1993).

More recently, the Task Force on Quality in Australian Health Care in 1996 drew a direct link between the developments in individual care and systemic change.

There is a broad social change in the direction of a more active consumer role in health care. Individuals expect decision making to be more of a partnership between provider and consumer. At a broader system level the expectation is that consumers will participate in quality definition, monitoring and feedback (AHMAC 1996, p30).

In her 1997 report on models of consumer participation in Australian hospitals Mary Draper uses the term ‘working partnership’ to describe this sort of relationship and indicates the continuing importance of education and training to achieve this:

... consumer participation is about participating, it is an active working relationship, it is ongoing and dynamic and it can take place in a range of ways.

It is about clinicians and consumers becoming aware of each other’s perspectives; about changes in service delivery, about good working relationships in which issues can be resolved, about sharing problems and finding lateral solutions, about developing better communication and respect for each other. It is a process of mutual adjustment. It is a ‘powerful tool for change’... but it is a process, which requires commitment, appropriate skills and time to develop trust in the process (Draper 1997, p75).

In 1997, the Commonwealth and state and territory health departments agreed to take part in a two-year Consumer Focus Collaboration to progress the task force recommendations and other Australian research highlighting the key elements of consumer participation in health care. The Collaboration includes individuals with specific expertise on consumer issues, and representatives from consumer organisations, medical professional groups and other key industry bodies along with officers from each health department. As the Collaboration’s Strategic Plan indicates, the ‘vision’ was for

a health care system focussing primarily on the needs of potential and actual users of health services in order to achieve optimal and effective health care in Australia ... (which) would also provide frameworks and opportunities for consumers of health care services to participate collaboratively with health organisations and service providers in planning, delivery, monitoring and evaluation at all levels, in a dynamic and responsive way.

It is within this national and international context of cooperation and progress towards partnership that the Resource Guide has been developed.
Consumer participation education and training: assumptions and principles

As material for inclusion in the guide was reviewed, the following assumptions and principles emerged. These are not presented as an exhaustive or a prescriptive list. Every learning situation needs to be approached as a unique opportunity, however the following points do provide a beginning point for consumers and service providers.

Basic assumptions:

1. Effective and efficient health care requires consumer participation in the planning, service delivery, monitoring, quality improvement and evaluation of health services.
2. Consumer participation in health services benefits the services, their administrators and service providers as well as consumers.
3. For consumer participation to be effective, all participants in the process need to respect the different skills and expertise of the other participants.
4. Effective participation is facilitated by the development of mutual trust, respect, integrity and goodwill between participants.
5. Effective participation can be enhanced through many different forms of learning, including education, training and other less formal ‘learning processes’.
6. Consumers, providers and administrators of health services can all benefit from learning about the planning, delivery, monitoring and evaluation of health services.
7. Consumers, providers and administrators of health services can all benefit from learning the skills necessary for effective participation in collaborative work on the planning, delivery, monitoring and evaluation of health services.

Basic principles:

A. Participation in any mechanism for the planning, delivery, monitoring and evaluation of health services is, of itself, a learning experience, consistent with the concept of life-long learning.
B. Effective education, training and other learning on consumer participation openly acknowledges the fears and power imbalances in the relationships between consumers, providers and administrators of health services and work towards changing this culture towards a more collaborative one.
C. Any education, training and other learning processes relating to effective participation in the planning, delivery, monitoring and evaluation of health services recognises that consumers, providers and administrators of health services usually have limited time available for these activities.
D. Effective education, training and other learning on consumer participation recognises the diverse learning needs of participants and that different people learn in different ways, and seek to positively accommodate this diversity.
E. Effective education, training and other learning on consumer participation recognises and addresses affirmatively the economic, physical and social barriers which can arise from poverty, disability, illness, other caring responsibilities and geographical location.

F. Effective education, training and other learning on consumer participation needs to be an element in mainstream education about citizenship and in all health professional and administrator training and education, at the undergraduate, postgraduate and continuing medical education levels.
PART 2

APPROACHES TO EDUCATION, TRAINING AND LEARNING

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PART 2: APPROACHES TO EDUCATION, TRAINING AND LEARNING

Education, training and learning—just what do these words mean; how do they relate to each other? For some of us the word ‘education’ reminds us of a dictatorial teacher who left us feeling stupid and scared to learn; others think of an enthusiastic, inspiring guide and mentor who brought learning to life. Equally the word ‘training’ can bring flashbacks of regimented learning and of a ‘black and white’, ‘one-way only’ of doing things; or it can recall the thrill of mastery following careful, well-designed instruction. Such reactions remind us that we come to education and training situations with very mixed baggage.

This section will unpack some of this baggage by outlining some of the current thinking about what makes effective education and training. It will explore ideas about adults as learners, about how people learn, and present some of the key approaches used in designing learning opportunities. Reading through this section may trigger your interest in some of these concepts; therefore you will find references to more detailed reading throughout. You will also find links to examples of Australian projects that show the theories in action.

The section also introduces you to the Mindmap for Education Learning and Training (MELT) model. It shows the many facets of successful education and training for increasing and sustaining consumer participation in health. The model acknowledges that collaborative learning is challenging and relatively new to our health care system by showing how we can work across the model to create culture change. The section also covers issues of power—a reality that all of us as stakeholders need to consider. Learning is a dynamic process that is affected by both individual and cultural factors, and in which there are no pat answers. We invite you to read on and assess what may be of value to you in your setting.

2.1 SOME PRINCIPLES AND THEORIES FOR LEARNING

About adult ‘learning’

Although learning can be a noun, a thing, we more often understand learning as a verb, as something we ‘do’. And this is why we have focused on the concept of learning throughout this Resource Guide. Learning is a dynamic and active concept. The notion of learning puts the learner in the foreground. There may be a teacher and a set program but equally there may be a sole learner reflecting on activities, or reading, and learning from this. The learning may arise from a group of peers discussing a shared experience (eg ward round or case conference) or it may take the form of an ‘a-ha’ experience (ie a sudden insight often emerging out of context).

Learning is a lifelong activity, one that is equally important for an adolescent or an aged person. In our complex society, where information is changing constantly and rapidly, we can no longer be taught everything we need to know, rather we must develop the ability to ‘learn how to learn’ (Candy 1991). This means recognising that learning may occur from formal education experiences (where we are taught or instructed) from non-formal education (where we may ‘learn-on-the-job’ for example) and from informal learning (where we learn through the experiences of everyday life).
The principles of adult learning have also been summarized by Knowles (1990) who states that adults are motivated to learn by what

- is perceived as relevant
- builds on previous experience
- actively involves them and is participatory
- is problem focused
- enables them to take responsibility for their learning
- can be applied in practice immediately
- involves a cycle of action and reflection
- is based on mutual respect and trust

See examples:

| C09 | Training for health professionals, especially medical practitioners | p61 |

The Kolb learning cycle

The learning cycle has been used to explain the basic process of how an adult learns. David Kolb (1984), for example, suggested that people learn in four ways:

- through immediate concrete experience (an affective way)
- through observation and reflection (a perceptual way)
- through using abstract concepts (a thinking way)
- through active experimentation (a behavioural way)

Although many of us have a preferred way to learn, to be most effective a learner needs to develop the skills of all four ways of learning, and to utilise the full cycle of the learning process. Given appropriate support we can, and should, extend our skills in all areas.

Figure 2: Kolb's learning cycle
Multiple intelligences

Another important shift over the last decades is that we no longer think of IQ as the measure of the ability to learn, instead we see that people have multiple intelligences (Gardner 1999). These intelligences have been described as verbal/linguistic, musical/rhythmic, mathematical/logical, visual/spatial, emotional, body/kinaesthetic, interpersonal and intrapersonal intelligence. When we consider our multiple intelligences and our learning cycle strengths, it is clear that learning experiences must be diverse and dynamic to support the range of consumers as learners.

See example:

- C10 Lemon Tree project—a multi-level learning model bringing mental health consumers and service providers together p66

Learning styles

Most of us have learning style preferences (Kolb’s Learning Style Inventory is one way of assessing learning style preferences; see Kolb & Fry 1975). For example, some of us talk about ‘learning from experience’, which often means we prefer to use a concrete experience and to reflect on that. These people usually enjoy debriefing and mentor-based learning. Others talk of ‘trial-and-error’ showing their preference for active experimentation, for example by joining a committee having been prepared ahead by a course giving them a range of strategies to try in the new situation. Learning preference may also affect how people like to have a training course delivered. Some people have a preference for visual material and value diagrams, flow-charts and the like, others prefer listening to auditory material, whereas another group like the kinaesthetic experience of ‘doing’, perhaps in scenarios or role-plays (Mills 1992). Some people prefer formal learning (in classes) others highly value informal learning (Boud et al 1993). For effective learning, we must consider all.

It should be remembered that learning is not just a rational (head-only) activity—it involves our emotions, our values, our culture and our understanding of our society. It is affected by the language we have available to us and by the people around us. It has been said that we learn with our head, our heart and our hands.

See examples:

- C06 Advocacy for change: educating mental health consumers and carers to make a difference at many levels p49
- R15 The Little Purple Book of Community Rep-ing North West Suburbs Health and Social Welfare Council p100

The context of learning

Of course, there is no such thing as a generic, one-size-fits-all, adult learner. All of us have learnt how to learn in a particular context. Thus, when considering best practice for any education and training for consumers, health professionals or administrators, it is important to consider both the context in which they learn and the evidence for what might be effective learning practices.

Some of us will have backgrounds compatible with the traditional education system; others will find the knowledge and processes of that system quite alien. (See for example the work on women’s ways of knowing (Belenky et al 1986) and adult education with indigenous Australians (Byrnes 1993).) As we plan to work with any group
of learners it is crucial that we first consider any particular learning issues that may be applicable to that group.

Prior learning experiences for consumers will be as diverse as the consumers themselves.

See example:

R31 The Right to Have a Say: a kit of tools for consumer participation Intellectuual Disability Rights Service p119

Health professionals on the other hand are trained in a particular way and a particular culture has developed around that training, perhaps most marked in the medical profession. They are trained in their basic disciplines through undergraduate courses at University. Varying amounts of clinical practice is incorporated into such undergraduate training.

See example:

C09 Training for health professionals, especially medical practitioners p61

Further postgraduate training may then occur. For example, medical practitioners then undergo further hospital-based training once they begin their mandatory pre-registration hospital practice of one to two years. They then undergo vocational training in the specialty of their choice under the auspices of the appropriate Medical College. Once vocationally trained and registered to practice, health professionals are usually required to show evidence of continuing education and quality assurance activities in order to maintain their professional status.

Health administrators may weave a more diverse pathway along their careers. Some are specifically trained in health administration; some are health professionals by background; others come from different sectors entirely. Their prior learning is therefore likely to be more diverse. When considering education and training for any group in any subject area, it is important to find ways of including that subject area into the normal pathways of education for that person or group of people.

**Facilitating learning through education**

Although any group of learners will have diverse preferences and backgrounds, there are some common things that have been found to be effective in the facilitation of learning. Indeed the term facilitation illustrates the move away from the didactic one-way transfer of information to a more interactive exchange. The five principles of facilitation of effective learning are (Brookfield 1986):

• willing and voluntary participation;
• mutual respect between teacher and learner;
• a spirit of collaboration;
• the opportunity for action and reflection; and
• the encouragement of self-direction and critical reflection.

In an effective learning environment, all participants (teachers and learners) are able to learn from each other. Rather than being seen as ‘empty vessels to be filled’ (with the right information), adults value learning environments in which there is an exchange of information, a sharing of perspectives and collective focus on an area of mutual interest. This form of education/learning is known as ‘dialogic’ (Freire 1972). Taking a further step some learning environments are designed to challenge people’s world-views and encourage ‘transformative’ or ‘socially critical’ learning (Arnold et al
These approaches are central to the improvement of health services through more effective involvement of consumers. No one group has **the** answer to the issues we face and it is only through mutual learning and exchange that sustainable, viable and equitable solutions will be found.

See example:

| C03 | Consumer tutors for medical students | p42 |

2.2 **THE EVIDENCE FOR EDUCATION AND TRAINING IN CONSUMER PARTICIPATION**

More and more people are interested in evaluating the evidence that is available, before deciding to act in a particular way. Health professionals in particular will need to be convinced by the evidence if they are to consider changing the way they practise at the moment. Professionals will need to know that any change of professional behaviour is supported by evidence. Increasingly people are also concerned that any education and training interventions are also best practice in their approach and supported by evidence (Campbell & Johnson 1999).

Unlike most service providers, consumers will not need evidence that their participation will improve service delivery and design. They are only too aware of needed system improvements, but instead they will want to know that the training will help them develop a constructive interaction with service providers. Consumers will need to see that the training enables them to be more than a token representative and they will want evidence that they are able to be part of the whole service delivery team. Consumers will seek training that acknowledges the skills they bring and extends and challenges them.

Benefits of training and education range from the personal to the professional. At the personal end, participants report increased skills in handling sensitive issues, in interpersonal communication and in their understanding of the whole health system, for example. Professionally, some consumers may gain skills for employment whilst some service providers may develop new career paths. All participants, be they service providers or consumers, will want to see that the training they are offered provides practical and constructive ways for differing stakeholders to collaborate to improve health service delivery.

**The evidence for consumer participation in health care**

One of the questions frequently asked by health professionals in this project’s consultations when challenged with the concept of consumer participation in health care was ‘What does the evidence say?’ The papers published in recent medical journals, as outlined in part 3 of this Resource Guide as a case study, provide some important answers to that question.

For many years, consumer participation has been seen as a democratic ideal and therefore has been assessed for its process more than its outcomes. As demonstrated in a recent article, although the outcomes of consumer participation may include community and individual empowerment, consumer participation also enables a health system to be administratively effective and politically efficient (White 2000).

Section 1.3 of this guide, The context: consumer participation in health care, also outlines some of the evidence and trends. Any education and training for health professionals must be backed up by convincing evidence. As scientists, health professionals must also be challenged to continue to gather and refine that evidence as part of their clinical practice.
The evidence for education and training strategies for consumers

Unlike most service providers, consumers will not need evidence that their participation will improve service delivery and design. It is usually consumers’ commitment to system improvements that motivates their involvement. Instead consumers will want to know that the training will help them develop a constructive interaction with service providers. Consumers will need to see that the training enables them to be more than a token representative and they will want evidence that they are able to be part of the whole service delivery team. Consumers will seek training that acknowledges the skills they bring and extends and challenges them.

There is evidence that the design, location and management of training for consumers may impact on the effectiveness of the training. A recent British study (ibid) found that it was preferable that the preparatory training for community representatives be undertaken by a group outside the health system as this ensured that the training was not unduly influenced, even inadvertently, by the health system.

The best practices in education described in the preceding sections are relevant to education and training for both consumers and health professionals. However education for health professionals has additional dimensions that are discussed in the following section.

The evidence for education and training strategies for health professionals

The undergraduate education of health professionals including the medical profession is now espousing the theories of learner-centred education and lifelong learning (Spencer & Jordan 1999). Medical courses in the United Kingdom and Australia are now equipping young doctors with adult learning skills to prepare them for the lifelong learning that is essential to future competent practice. Medical teachers are now acting as facilitators of learning rather than traditional expert didactic teachers (Cantillon & Jones 1999). Problem based learning, self-directed learning and guided discovery learning are all features of undergraduate education.

Problem based learning has been one of the most significant initiatives in professional education and is recognised by the World Health Organization as important in the future challenges to health care. This form of learning involves the learner identifying issues raised by specific problems and from this developing an understanding of basic principles and concepts. It is usually centered around a small group that is guided by a tutor.

Postgraduate vocational training, particularly in the medical profession through the Medical Colleges, is largely apprentice or mentor style learning. The old adage of ‘see one, do one, teach one’ still holds true in many of the specialty training programs. Some examples of College activities include the Royal Australian College of General Practitioners’ Training Program, which has led the reform of medical education in this sector as illustrated by its extensive RACGP curriculum (RACGP 1999). The Royal Australasian College of Surgeons, while it does not follow a defined curriculum, does assess its candidates in communication skills every six months by means of a mentor rating form.
Continuing education for health professionals has become of growing importance. Governments and professions alike have recognised the growing accountability to consumers to deliver effective and efficient healthcare. There is now an increasing emphasis on the maintenance of professional standards and quality assurance (Cantillon & Jones 1999). Systematic literature review has begun to identify the most effective continuing education interventions. Best practice includes education activities directly linked to clinical practice, and usually incorporates a number of interventions such as interactive education events and outreach activities. Peer review and group learning is effective as is decision support software for use within the patient consultation. Clinical audit, unsolicited feedback activities, consensus statements and unsolicited printed material are less effective. Didactic lectures are least effective.

The question of what motivates doctors to change has been asked and some models proposed that need further testing (Armstrong, Reyburn & Jones 1996). Postulated models include:

- the accumulation model, which maintains that when evidence exceeds a threshold behaviour change is triggered;
- the conflict model, where behaviour is changed by a critical event; and
- the continuity model, where doctors constantly update their practice and are sensitive to outside influence.

It is clear that if behaviour change is expected by medical and other health professionals in forming partnerships with consumers in health care, then best practice educational practices together with evidence-based content must be used to support that behaviour change. These issues will need to be considered carefully by those responsible for the design of any such training. The medical professions are in a time of change as they move towards partnerships of care with the consumer. It is by understanding and acknowledging the health professionals’ prior experience in education, that we are best placed as consumers to maximise this learning partnership.

See examples:

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<td>R18</td>
<td>RACGP Training Program Curriculum Royal Australian College of General Practitioners</td>
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**POWER: A BARRIER TO LEARNING IN HEALTH SETTINGS**

Most learning projects will at some point of time confront barriers that may impede the project’s success. Both consumers and service providers often face a lack of time and resources to undertake the learning, they may find institutional apathy and even over-enthusiasm may sabotage a project. However one of the most persistent barriers to a productive learning exchange in the health setting arises from the issue of power.

The health system is in a time of transition. We no longer look to any one group to provide the answer but rather individuals and different discipline groups are working together to provide an integrated and flexible response in health care. But we find that the language and many of the perceptions from the older models stay with us and affect both our current understandings and actions. It important that each of the stakeholder groups who are about to engage in a learning exchange directly confront and think through the issue of power before they engage in a learning exchange. The following section is offered as a basis for such reflection.
Definitions of power
There are many definitions of power. Power has been seen as an attribute held by some and not by others—for example as a personal characteristic of an individual, ‘he is a powerful person’. Others see power as a hierarchical attribute, related to a person’s profession or role—for example ‘the Chief Executive Officer holds all the power’. Other definitions of power point to the use of opposite pairs to that create a power difference—male/female, black/white, teacher/learner. Here we find that in each pair one is typically seen as ‘naturally’ superior, when in fact each side of the pair depends on the existence of the other in order to exist. For example, it is not possible to understand yourself as a male without the existence of the other group, female. Concepts of class, race, gender and capitalism have also been linked to power. We can therefore see that power has individual, group and societal dimensions.

Most understandings of power reject the simplistic notion of an active person with power and a passive ‘victim’ controlled by that power. Power is a much more dynamic concept. It is more useful to see power as a process that involves our perceptions, language, social practices and cultural norms (this post-structural/postmodern understanding of power comes from the work of Michael Foucault; see Danaher G et al 2000 for a readable explanation of Foucault’s ideas). Power has both individual and collective aspects; although we individually experience ‘power’ relationships we understand them through the tools we have from our culture and time (For a full exploration of theories of power, see Wearing B 1996 Gender: the pain and the pleasure of difference, Addison Wellesley Longman, pp71–91).

Perceptions and language
In order to cope with a complex world we all slip into our own cultural shorthand in order to describe and understand our experience. For example, when I enter a meeting I bring with me my taken-for-granted assumptions about all of the other groups of people in that room. I see various people as different or ‘other’ to me. I will have certain language available to me to describe these ‘others’ and that language becomes part of the power interplay. For example there is a difference when someone is introduced as an AIDS sufferer, an AIDS victim, and AIDS survivor or a person living with AIDS. If the person chooses to introduce themselves with one of these titles there will be one effect, however if someone else imposes one of the labels there may be a very different dynamic created. We need to consider the impact of the power to name.

However any person who has experienced such ‘power to name’ will quickly tell us how simplistic that idea is in reality. Just ask a doctor who has recommended a particular treatment regime and found that the person has not followed instructions—is this ‘non-compliance’, ‘lack of understanding’ or ‘different life choices’? In fact it may be all three. Equally a person who re-names their own experience can gain greatly as is evidenced in the many health consumer groups who resist the professional naming, for example an epileptic, and re-position themselves as a person living with epilepsy.

The issue of power through language is apparent in a number of the resources in this guide. Most courses have exercises on jargon, acronyms and the like. The use of an ‘in’ language may be deliberate but more often it is another form of shorthand that is used without reflecting on the impact that this may have on effective communication and learning. It is essential that all education overtly analyse the issue of power and language early in their learning experience.

Social practices and cultural norms
Using the above example of ‘non-compliance’, another aspect of power becomes apparent. When we ask ‘which of the three labels will be the one most readily understood across the health system’, there is no doubt that the professional label will have the greatest impact. It will be spoken of as a ‘diagnosis’, it is will be recorded in files and it will change the relationship between the consumer and many others in the
health system. It may even have ramifications in other institutions, for example through legal implications. A ‘non-compliant patient’ is therefore created by the system as well as the individuals within that system.

Further, every institution has ways of working that form a particular culture and this often becomes a taken-for-granted aspect of life. When someone new enters that culture they can see dynamics that have become invisible to those used to that culture. Thus when a new committee member questions a particular practice or doesn’t conform to certain norms, for example, they can be seen as challenging the system. And indeed they may be doing so, or they may also be bringing a new awareness to a rigid system, or they may just be confused. Depending on what role they hold, their behaviour may be understood differently.

Many of the resources have sections on effective meeting procedures. These are not just essential for new members but for all committee members. No matter who we are we probably have assumptions about practices that we should review and reflect on. An open and interactive committee procedure enables the talents and perspectives of all participants to be harnessed.

Power issues will always be present in human interactions but when we conceptualise power as an individual or a group attribute we can go no further. Power is not something in limited supply—‘they took away our power’. We do not need to guard our power as if it is something we own. Rather when we need to see power as a complex process—one of meaning making that operates at both an individual and collective level. Our focus then turns to dialogue, exchange of meaning and an openness to learn from another’s perspective to which we have not previously had access. We enter a learning exchange looking not just at our differences but seeking the boundaries that unite us.

This is not to say the process is easy—people find it easier to stay in their taken-for-granted world, particularly if staying with that worldview is of benefit. The challenge for those facilitating learning is to provide a safe environment for each group of stakeholders to explore and analyse their own worldviews and to acknowledge the power dimensions at an individual and cultural level. Only then will people be ready to work with others in a true learning dialogue and exchange.

See example:

C03 Consumer tutors for medical students p42

2.3 EDUCATIONAL OBJECTIVES

An important trend in much current educational development for adults has been to broaden the focus of education beyond the traditional preoccupation with knowledge and skill. This is necessary so that individuals can adapt throughout life to a changing, complex, and interdependent world.

This broadening of the scope of education is reflected in the report of the UNESCO Commission on Education for the 21st Century (the Delors Report) in which a concept of four pillars for education was proposed.

These pillars are:
• learning to know;
• learning to do;
• learning to understand others; and
• learning to be.
The concept of learning to be is directed at the personal fulfillment of an individual, which is a lifelong process of personal development.

**The MELT mind map**

The notion of four pillars of education is relevant to the Mindmap for Education, Learning and Training (MELT) (see figure 3) model of strategies for education, training, and learning developed by this consultancy and set out in figure 3. The range of strategies given in the MELT model can build in each of the four pillars of education identified by UNESCO.

- Learning to know in the information and knowledge components.
- Learning to do in the skill components.
- Learning to understand others in the use of team learning strategies such as action learning, and other strategies that foster reflective interaction and better understanding of other people.
- Learning to be through enhanced informal self-directed learning and other activities that build personal fulfillment, including leadership development.

There is no ideal starting point in the model—each learning environment will need to be assessed, and the most appropriate starting point determined. However there is a progression of complexity from the simple strategies on the left through to the more challenging and broad-based changes to the right. In summary, the model emphasises the need for education that:

- meets orientation and information needs;
- meets skill needs such as those needed for communication, listening, problem solving, and partnership skills;
- is directed at attitudes, values and cultural change, fostering dialogue and partnership and building organisations and communities responsive to changing conditions; and
- leads to systemic change so that partnership becomes a natural process.

An effective education and training program will offer consumers the opportunity to learn in one or more of these areas. A number of programs were found that focus on the first two components (Orientation/Information and Skill Needs) of the MELT but very few were overtly working towards big picture cultural change.

In parts 3 and 4, a key feature matrix categorises the resources by their prime education focus (following our MELT model) for ease of reference.
Figure 3 MELT (Mindmap for Education, Learning and Training) model
### 2.4 SOME STRATEGIES AND APPROACHES TO LEARNING

Having outlined some of the principles for effective learning, bearing in mind the evidence and context for learning for health providers and administrators, it is important now to examine some strategies or approaches to learning for consumer participation. The resources set out in parts 3 and 4 show a range of approaches to education, training, and learning to foster effective consumer and provider collaboration in health care. These approaches are illustrated in the MELT model given in figure 3.

It will be seen that education, training, and learning strategies involve a progress from approaches which meet orientation and information needs, through those which meet skill needs such as those needed for communication, listening, problem solving, and partnership skills, to those which are directed at attitudes, values and cultural change, fostering dialogue and partnership and building organisations that are responsive to changing conditions, and on to those which lead to systemic change so that partnership becomes a natural process.

All of these objectives can be necessary components in education, training, and learning strategies to build effective consumer and provider collaboration. It is a matter of determining what the particular needs and priorities are in your situation.

Examples are given in the resources of effective strategies that address each of these areas of need:

- **Orientation and information needs.** A diverse range of strategies has been adopted including special orientation programs, courses, discussion groups, newsletters, workshops and forums.

  See examples:

<table>
<thead>
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<th>R01</th>
<th>Consumer Representatives Handbook Australian Consumers’ Council</th>
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<td>R06</td>
<td>Workshop for Consumer Liaison Officers and Consumers Working with Divisions of General Practice Consumers Health Forum</td>
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<td>R10</td>
<td>Working with Community Councils: A Training package for Health Service Managers Far West Area Health Services, NSW Health</td>
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<td>R11</td>
<td>Handbook for District Health Forums Department of Health, Tasmania</td>
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<td>R15</td>
<td>The Little Purple Book of Community Rep-ing North West Suburbs Health and Social Welfare Council</td>
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<tr>
<td>R17</td>
<td>Evaluation Report on the Primary Health Care Bundaberg Pilot Study Pharmaceutical Society of Australia, Queensland Branch</td>
<td>p102</td>
</tr>
<tr>
<td>R21</td>
<td>Health Council Orientation package Rural Health Support Unit, NSW Health</td>
<td>p108</td>
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</table>

- **Skill needs.** Similar methods to those adopted in meeting orientation and information needs are common with methods such as courses, seminars, and workshops often used. However, a major trend is the growing use of informal self-directed learning and team learning through strategies such as action learning.
• Values and cultural change. These may include ambitious change programs aimed at fostering values and systems that underpin and support collaboration and partnership. Community development strategies, learning communities and Learning Cities, learning organisations, and Healthy Cities strategies have been used to address these objectives.

See examples:

<table>
<thead>
<tr>
<th>Example</th>
<th>Description</th>
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<tr>
<td>C08</td>
<td>Training during development of Health Advisory Councils</td>
</tr>
<tr>
<td>R16</td>
<td>Community Consultation and Participation Resource Kit for Area Health Service Managers and Project Leaders</td>
</tr>
</tbody>
</table>

While all the methods outlined above can have a place in strategies to build consumer and provider collaboration, a key feature of the present environment of health care systems is the growing importance of learning strategies. It is probable that this trend will continue in the future.

Learning strategies may include:

- action to increase the effectiveness of informal, self-directed learning;
- team and group learning, with strategies such as action learning where individuals learn from each other;
- strategies to build entire organisations or communities as learning organisations/communities. These strategies usually address the three levels of individual, team, and organisational learning.

**Experiential and action learning**

People learn from their experiences in many situations. Experiential learning can be made more effective if individuals are aware of their habits and preferences as learners, and if explicit strategies are adopted to increase the effectiveness of learning. One such strategy is action learning where individuals learn from each other in teams or sets and where reflective processes are built into the work of the set.

Action learning involves deliberate, conscious effort to review and reflect on the action of an individual, a team, or an organization. In action learning a team addresses a practical problem in a self-managed team, although a facilitator often assists the team. Action learning strategies can be adopted to increase the effectiveness of experiential learning for participants. In the health sector it can be used to address real problems and issues.
Informal learning

Informal learning occurs all the time at work, in the home, and in the community. Often learning occurs in an unconscious manner as tacit learning. However, a number of barriers to informal learning exist which need to be addressed to increase the effectiveness of this critical mode of learning.

Experiential and Action Learning in part 5 of this guide provides guidance on ways of making informal learning more effective through addressing the identified barriers. Examples are given of strategies such as using mentors, conducting workshops, and keeping diaries or notebooks, which can be useful. This paper could be discussed in a workshop leading to individuals devising their own self-development plans. This profile was included in a recent national report on the implications of lifelong learning for vocational education and training in Australia and could also be used in a workshop discussion.

Information Technologies

Australia has become an information society in which modern information and communication technologies underpin many economic, social, and cultural activities. Information technology is having a growing role in education and training, and there is little doubt that this role will increase further in the future.

Australia is also about to enter the era of digital television broadcasting from January 2001, with digital television offering new opportunities for ongoing learning in interactive modes. It is therefore highly desirable that planning for education, training, and learning for consumer and provider collaboration take account of the opportunities to extend learning that these technologies offer. These opportunities include:

• using the Internet to obtain information;
• computer-based training;
• using email to link consumer and provider networks to allow ongoing dialogue and exchange of ideas; and
• videoconferencing and other distance education methods, which have particular value for people in remote locations.

Interactive digital television broadcasting will extend the opportunities that technology offers.

It is important that the so-called ‘digital divide’ in society does not impede access by consumer representatives to these opportunities. Where this barrier exists, information and skills programs on basic computer skills may be required. The very popular programs offered by the BBC in England, with programs such as Computers Don’t Bite and
Webwise illustrate an effective approach. It is likely that similar programs will become more widely available in Australia.

Building networks of consumers and providers through technologies such as email and videoconferencing illustrates how ideas can be enriched, and ongoing dialogue established, through the use of technology. Joint planning by consumer and provider representatives can have substantial value in finding ways to harness technology to extend learning opportunities.

See the following resources:
Consumers' Health Forum of Australia at http://www.chf.org.au

**Partnership process**

If education and training is directed at building collaboration and partnership among consumers and providers, this should be guided by a clear sense of what is involved in building partnership. Good partnerships don’t just happen.

Understanding the partnership process is one of the foundations for education and training directed at building collaboration and effective partnership. Section 5.2 of this guide provides information on barriers to partnership and on strategies that can assist partnerships to grow and develop in quality. International experience in partnership development is cited to illustrate the qualities of effective partnerships that progress through a number of stages of development. Principles and guidelines for high quality partnerships are given together with a planning guide developed for British Learning Cities that provides a matrix for planning and monitoring progress.

See examples:

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<td>Consumer tutors for medical students</td>
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<tr>
<td>R13</td>
<td>Health Councils Report of the Community Consultations and Recommendations Mid Western Area Health Service, NSW Health</td>
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**Team and group learning**

Modern learning strategies make increasing use of team and group learning. Enhancing team learning is one of the building blocks of a learning organisation. The features of a learning organisation have been well described by Senge (Senge 1992).

While effective team learning depends on informal self-directed learning to a significant extent, a number of strategies have been developed to foster good team learning. Examples of action learning are provided in both parts 3 and 4. Action learning is a process through which participants learn with and from each other as they work on practical problems in real conditions.

There are many ways in which action learning methods could be used in the health sector with consumers and providers collaborating to address real problems. An action learning dimension could be added to the use of task forces or working groups investigating real issues. In these cases, the three phases of an action learning approach (action/reflection/understanding) should be built into the work program.
Organisational and community learning

The most ambitious forms of learning strategies are directed at learning in the organisation overall. While these strategies usually incorporate informal self-directed learning (sometimes called personal mastery) and team or group learning, they progress learning to a third level through addressing the learning needs of the whole organisation, system, or community. Partnership becomes a key dimension in such development.

These strategies are usually concerned with cultural change and the fostering of values and attitudes that support collaboration and partnership. Developing values such as trust, which underpin the accumulation of social capital, is central to these strategies.

Examples of these strategies include learning organisations, learning communities, and Learning Cities. The Healthy Cities program initiated by World Health Organization has many of the attributes of a Learning City. A Healthy Cities program can adopt Learning Cities strategies to achieve its health objectives while also contributing to broader social, economic, and civic purposes. The example of Healthy Cities Illawarra, provided in part 3 of this guide illustrates this approach. In the Illawarra example, consumer and provider collaboration occurs in the range of task forces established to address major health problems such as aged care and AIDS. A key aspect of the Illawarra development has been the active fostering of a shared vision and values such as trust to underpin this vision.

Learning organisation strategies are also relevant to the health sector and can provide for consumer and provider collaboration, and the development of a shared vision. These strategies can build on existing foundations, such as quality programs, and some Australian hospitals are developing a number of the attributes of learning organisations. Section 5.3 of this guide discusses the concept of learning organisations and the strategies that have been used to build these organisations.

2.5 MAKING A START

Designing and evaluating formal learning activities

Good formal learning opportunities do not happen by accident—they arise from careful planning and analysis. In the first stage it is important to clearly define what the learning needs are of the people involved. This is called a training needs analysis or a needs assessment. It usually involves an analysis of the situation the learners to be involved with, determining the skills, knowledge and attitude relevant to that situation, as well as looking at profile of the learning group, seeking out their prior experiences and educational and socio-cultural backgrounds. Finally a training needs analysis consider the resources and expertise available to the group (Arnold et al 1991 provide a community-based example of needs assessment; Tovey 1997 gives a more competency/skill base approach).
The next step is to determine the most appropriate educational strategy for the situation. Decisions at this point include the type of approach (for example a workshop or a short course), the best location, the facilitators and the number of sessions. Each session can then be designed with an overall aim and a list of learning objectives that can then be matched with the most effective learning experiences. You now have a learning plan or ‘curriculum’. Many will find a learning plan very similar to the project plan that is often undertaken at the first stage of a new project.

Evaluation is the final core feature of effective formal education. When working from adult learning principles we cannot wait until the end of a course to assess how the learners are responding to the course. This means that we undertake process evaluation (checking the effectiveness of each session), as well as impact evaluation (gaining feedback at the end of a course) and outcome evaluation (looking for the long-term effect of the learning experience) (Degeling & Hall 1990; Kirkpatrick 1998).
Most of the resources in this guide were not developed for specialised situations, for example for work with people who come from culturally and linguistically and other equity groups. Therefore it will be crucial that at all stages of education program planning attention is given to the particular characteristics of your learning group. In some cases resources will be able to be adapted but in other cases it may be necessary to trial a radically different approach. In this case we would urge you to share your outcomes with others in the health system, as above all none of us need to re-invent the wheel.

**The education, training, and learning continuum**

Figure 3, the MELT model, also reminds us that education, training, and learning is a never-ending continuum of activities linked to ongoing lifelong learning. While a careful progression of activities is necessary so that all participants feel comfortable, effective education and learning strategies have a clear sense of goals and objectives, and a vision of what is to be achieved. ‘Having stars to steer by’ is a necessary part of this journey.

This means that effective education, training, and learning is usually underpinned by a careful assessment of needs, planning, and ongoing monitoring of progress and outcomes. The planning process in itself can provide many opportunities for consumer and provider collaboration.

Examples of collaboration in planning and monitoring are given in part 4 of this guide, the resources. They are examples of good practice in addressing the full spectrum of education, training, and learning needs in a well planned and systematic manner. Several have been expanded in the case studies in part 3 of this guide.
PART 3

CASE STUDIES

The case studies in this Resource Guide provide examples of much creative innovation in which consumers and providers have sought, through education and training, to address the challenge of the new environment of health systems. As far as possible we have used the language of each resource as each resource has a particular approach to consumers, service providers and education. As you read the case studies, look for ideas and practices which may apply in your own situation.
3.1 CASE STUDIES

Orientation and information needs. A diverse range of strategies has been adopted including special orientation programs, courses, discussion groups, newsletters, workshops and forums.

Skill needs. Similar methods to those adopted in meeting orientation and information needs are common with methods such as courses, seminars, and workshops often used. However, a major trend is the growing use of informal self-directed learning and team learning through strategies such as action learning.

Values and attitude change. Strategies are typically based on mutual and continuous learning and may include ambitious change programs aimed at fostering values and systems that underpin and support collaboration and partnership.

Systemic change and partnership. Community development strategies, learning communities and Learning Cities, learning organisations, and Healthy Cities strategies have been used to address these objectives.
## 3.2 CROSS-REFERENCING CASE STUDIES

The MELT model which has underpinned development of the Resource Guide for the Education and Training for Consumer Participation in Health Care project contains four groupings of activities on the continuum from Involvement to Partnership. The groupings are referenced in the following table.

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<td>Peer Support: a central part of informal learning</td>
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Introduction

The development of consumer participation policy, program implementation processes (illustrated by the workbook Bringing in the Voice of the Consumers: A Practical Guide to Consumer Participation) and actual service delivery examples within the Adelaide Women’s and Children’s Hospital (WCH) have been the result of almost a decade’s effort. A large number of staff and consumers at the hospital at all levels of management and service delivery have been involved.

The second edition of the practical guide to consumer participation was released in September 1999.

The second edition of the guide has been underpinned by hospital-wide policy regarding consumer participation (see current draft attached) and is closely linked with the hospital’s Quality Evaluation and Quality Improvement Program (EQiP).

What has been achieved?

One of the more tangible outcomes of the Women’s and Children’s Hospital’s efforts so far has been the development of the workbook Bringing in the Voice of the Consumers: A Practical Guide to Consumer Participation. This workbook’s introductory section covers topics such as:

- where consumer participation fits in with other structures within the organisation
- models of change management
- philosophical and ethical perspectives
- detailed exploration of degrees of consumer participation with examples
- examples of consumer participation successes

The other three sections contain guides to:

- The development of a team approach
- The techniques and tools necessary for consumer participation

HIGHLIGHTS

- The dynamics of cultural change as a gradual process over time.
- Commitment is required at all levels to change objectives.
- The need exists for strategies to address the patchy process of cultural change.
- Flexible strategies are needed to address different sub-cultures in a large organisation or community.

FOR REFLECTION

- How could the patchy process of cultural change be addressed to achieve a more holistic and comprehensive change process?

KEY WORDS

Cultural change, values, learning organisation.
• Actual resources to use such as worksheets, checklists, example letters, plans for running focus groups, responses to roadblocks and commonly held staff reservations about consumer participation.

The content of the second edition has been built from the experiences of staff with their activities in fostering consumer participation in various areas of the hospital and so has a high degree of face validity. In addition the experiences have fed into the development and revision of the hospital’s policy in an iterative fashion.

Implementation

The hospital recognises that the degree of uptake of these initiatives varies in a qualitative sense. This variation reflects variation in philosophical commitment to the principles of consumer participation.

The guide describes levels of consumer participation starting from the ‘information giving’ stage where staff develop policy and procedures without input from consumers and then inform them of the outcomes, expecting agreement.

The spectrum proceeds through ‘information seeking’ (surveys focusing on information rather than opinions or views, etc) to ‘consultation’ where views and opinions are integrated into decision making, to ‘partnership’ where decisions are made jointly by consumers and staff and eventually to ‘management delegated to consumers’.

At the lower end of the spectrum all departments and divisions gather some form of consumer feedback either through the use of suggestion boards and boxes or by conducting consumer satisfaction surveys as part of their requirements under EQuIP (probably ‘information gathering’).

However, there are several examples of true consumer-provider partnerships and where they have developed they have been highly successful.

The Cystic Fibrosis Home-based care program has been driven by consumers and their families. The program has attempted to make the medical interventions necessary for the management of children with cystic fibrosis as non-intrusive as possible, through shifting the site of delivery of many of the services to the home. There are established and continuing processes for consumer input into all levels of the program. See next section for more detail on this program.

Another example is the Multiple Admission/Long Stay project that has attempted to address the problems faced by patients with frequent appointments and/or admissions and long inpatient stays. The project was initiated after a series of focus groups with such consumers, and has resulted in the development of a package of ‘Frequent Flyer’ type benefits which it is hoped will streamline services for these consumers and offset some of the higher costs they experience as a result of their frequent or long visits to the hospital. The resultant ‘Frequent Flyer’ package (which is currently undergoing a consumer-naming competition) was modeled on a similar program at the Princess Margaret Hospital in Perth. Another project which is currently underway is care management. This is a wide ranging program with several desired outcomes, including the redesign of discharge processes, and better integration with community based and outpatient services.

Cystic Fibrosis Home-Based care program

This program has been developed over the last 18 months at the Adelaide Women’s and Children’s Hospital. Several home-based acute care trials have been developed in other metropolitan hospitals in South Australia and the WCH wanted to undertake such a project. Young people with cystic fibrosis (CF) and their families were a logical choice as they had frequent admissions that had a major impact on the quality of life of these young people and their families.
The project in its 12 month planning phase had an extensive process of consultation with consumers and their families through a series of forums.

There was a need to gain absolute commitment (ie philosophical, financial, personnel and other resources) from divisional management to ensure that expectations that were raised during these consultations were able to be met.

There was also a need to ensure that consumers actually wanted the ‘initiative’ and that they were committed to the changes. The underlying driver behind the project has been the perceived opportunity to improve the quality of life for young people with CF and their families without compromising health outcomes of a more biomedical nature.

There were several technical planning groups for the project as well as a consumer based advisory group whose deliberations and decisions fed into and were integral to the other more technical planning groups.

At each stage of development of the clinical procedures, consumers were consulted to ensure that what was being planned would work ‘at home’ in a pragmatic sense. The project formally commenced by enrolling patients in September 1999 and is being evaluated using quality of life indicators.

There are now established several consumer advisory groups that continue to feed into coordination of the project. All of these groups have established rules of conduct and are benefiting from the trust that has been established over the past 18 months. This trust has been developed as the hospital staff has demonstrated a willingness to respond to issues raised during the consultation process.

**Plans for the future**

Development of the WCH’s guide has been a significant achievement and staff responsible for the program are now examining ways of further facilitating uptake of the consumer participation policy and the guide.

A series of training sessions are planned for senior staff from interested divisions which will focus on practical skills. These will address planning consultation strategies such as focus groups, the skills needed to conduct these, as well as the skills needed to bring about changes in attitude amongst staff. While the training sessions are open to all staff, support for the program will be sought through each of the division’s Quality Management facilitators. These staff members are responsible for overseeing the divisions’ reporting through the EQuIP program and so there is a personnel linkage between the consumer participation program and each of the division’s Quality Management processes.

**Summary**

The Adelaide Women’s and Children’s Hospital’s consumer participation program illustrates several points:

- Change is a **gradual** process involving effort over an extended period of time.
- Commitment at upper management level is **necessary** for any policy to be developed and implemented in a meaningful way.
- However commitment at upper management level is **not sufficient** and a ‘top down’ approach will not succeed. Commitment needs to be fostered at all levels of management and service delivery; this is based on attitude change.
- There needs to be **commitment from consumers** as well regarding improved collaboration between services and themselves. This commitment often is based on an expectation that health service providers will themselves be committed and be able to deliver better collaborative programs.
• Uptake within larger organisations may be patchy, at least in the early stages.
• The use of initial successful examples as ‘showcases’ and the use of opinion leaders in changing peer attitudes is vital to comprehensive policy implementation within the organisation.
• The process skills of different sections within the organisation are variable and any program needs to include strategies for addressing the learning needs of the different sections within the organisation.

The WCH’s second edition of Bringing in the Voice of the Consumers: A Practical Guide to Consumer Participation is a good example of a living document that summarizes policy and theoretical ground. In addition it provides detailed step by step guidelines for actually implementing a Consumer Participation program within a health care institution that would be readily generalisable within the Australian health care context.
APPENDIX

WOMEN’S AND CHILDREN’S HOSPITAL

SECTION: Quality
POLICY TITLE: Consumer Participation

Aim

The WCH acknowledges the value of consumer participation in contributing to improved quality, informed decisions, social justice and sound management. This acknowledgment is encapsulated in our vision and values (Commonwealth Department of Human Services and Health 1995, p4). The aim of this policy is thus to ensure that our commitment to working in partnership with the community is demonstrated through active and supported consumer and community participation at all levels of health care planning and evaluation undertaken by the WCH.

Principles

1. The WCH will provide opportunities, information, resources and support for consumers, including those with special needs, to have input into policy development, priority setting, planning, delivery and evaluation of health services, including the delivery of individual patient/client care.
2. The aim of the WCH is to operate in ‘partnership’ with consumers and the communities we serve. At an individual patient level, this means that decisions are made by staff and consumers jointly and consensually, and that every effort is made to establish processes for this to happen. At the broader level of service planning, it means that communities of interest will be consulted about their health care needs and will participate in planning processes undertaken by the WCH.
3. Consumers will be provided with opportunities to determine and influence methods of participation appropriate to their needs and circumstances.
4. A range of consumer participation methods appropriate to different situations will be used.
5. Consumers will be given feedback on the outcomes of their input and of decisions made.
6. Consumer participation will be conducted ethically. (See below and refer to Policy on Ethical Guidelines for Consumer Feedback.)
7. Consumer participation strategies will be culturally relevant, and will aim to seek the participation all consumers, including those groups who are most disadvantaged in terms of health outcomes, to ensure that services are accessible and relevant to their needs.
8. Consumer participation activities will be evaluated and documented, with feedback provided to participating consumers and other interested parties.
9. Consumers will be reimbursed any expenses incurred as a result of their assisting the WCH.

Degrees and methods of consumer participation

The WCH recognises that there are different types of consumer participation (ranging from providing information through to consumers directly deciding on service design and managing health care) which can occur at all levels of the organisation. In addition, consumer participation can be both ongoing, or established as a discrete activity for a specific purpose. Examples of different types of community and consumer participation across different levels in the organisation are provided in Table 1.
<table>
<thead>
<tr>
<th>Degree of Participation (high to low)</th>
<th>Explanation</th>
<th>Individual Staff Member Level</th>
<th>Unit Level</th>
<th>Divisional or Organisational Level</th>
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</thead>
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<tr>
<td><strong>Consumer control</strong></td>
<td>Consumers/ community make decisions.</td>
<td>Self-management of care plan.</td>
<td>Consumers decide how to spend refurbishment budget for unit waiting area.</td>
<td>A service program is designed and managed by consumers.</td>
</tr>
<tr>
<td><strong>Partnership</strong></td>
<td>Decisions are made jointly by consumers and staff.</td>
<td>Partnership in Care, Joint development of care pathway. Shared Care Program where GPs are the consumer as well as women.</td>
<td>Joint planning session involving staff and consumers.</td>
<td>Involving consumers in an ongoing committee, management or advocacy group. A consumer/staff steering committee for a new program is set up.</td>
</tr>
<tr>
<td><strong>Consultation</strong></td>
<td>Consumer views are sought and incorporated into decision making.</td>
<td>Parents are consulted about their preferences for their child's care.</td>
<td>Women are consulted about a plan to set up a multi-cultural clinic. Regular focus groups or informal meetings, eg a coffee break meeting.</td>
<td>Community organisations are consulted about a proposed change in services.</td>
</tr>
<tr>
<td><strong>Information Seeking</strong></td>
<td>Staff seek information (as opposed to opinions) from consumers.</td>
<td>A woman is asked about her clinical history. Gathering informal individual feedback from consumers.</td>
<td>A survey of consumer patterns of visiting times. Regular surveys, eg written, telephone, interview. Compliments and suggestions boards and boxes.</td>
<td>GPs are surveyed about their use of discharge summaries.</td>
</tr>
<tr>
<td><strong>Information Giving</strong></td>
<td>Information is provided to consumers.</td>
<td>A family is given information about risks of treatment. Responding to consumer complaints and taking preventive action.</td>
<td>A brochure on a disease is given to patients attending a medical clinic.</td>
<td>Seminars are held to inform consumers about recent advances in clinical care.</td>
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</table>
Ethical considerations

The following ethical issues are to be addressed when planning consumer participation:

• it is the consumer’s choice whether or not to participate
• a consumer’s choice to participate or not is to be respected, and is not to affect the delivery of care and services to them in any way
• the identity of consumers, and the information they provide, are to be handled in accordance with the WCH policy on confidentiality of information
• consumer participation activities which are more consultative in nature will be undertaken with integrity and the views and opinions of consumers will actively inform decision making
• feedback on the findings and outcomes of consumer participation strategies is to be provided to them


Responsibilities

The Chief Executive Officer (CEO) is responsible for ensuring that performance objectives negotiated between the CEO and divisions are informed by consumer input and include plans for consumer participation activities.

The Assistant CEO Strategic Development and Nursing is responsible for ensuring that the culture and strategies for ongoing organisation-wide consumer participation are developed and implemented by ensuring:

• that organisation-wide planning and service improvement activities incorporate targeted consumer participation strategies, and the outcomes of same are used to inform decision-making.
• that appropriate staff education programs that explore the various methods of consumer participation are incorporated into the strategic plans of the Centre for Continuing Education.
• that processes are in place whereby staff may access the support of a consultancy service to assist them in undertaking consumer participation programs.
• consumer participation achievements and outcomes are promulgated.
• that the values of consumer participation are built into a framework for job and person specifications.
• consumer participation is built into annual performance management and staff recognition processes including reference to consumer participation efforts and achievements.
• a process exists whereby consumers and community groups are supported to participate.
• resources are identified to support consumer participation and to assist in the analysis and documentation of consumer input and its outcomes.

Divisional Chiefs are responsible for ensuring that the ongoing culture of consumer participation is embraced within their division by:

• divisional planning and service improvement activities incorporating consumer participation strategies, and the outcomes of same are used to inform decision-making.
• divisions identifying resources to support a model of consumer participation within their division.
• consumer participation value statements being included in individual job and person specifications.
• recruitment and performance management of individual staff members includes reference to their involvement in consumer participation activities.
• staff being supported to pursue consumer participation.
• staff being provided with opportunities to learn how to use models of consumer participation.
• the division recognising that consumers at times need support (including financial support) to undertake these processes.

Unit/Department Heads are responsible for ensuring that staff embrace the culture of consumer participation by ensuring:
• that at least one method of ongoing consumer participation at the level of ‘consultation’ is undertaken by the unit/department, and that the method(s) used, and outcomes, are documented in a unit Evaluation and Quality Improvement Program (EQuIP) Quarterly Summary, or where appropriate, in the unit’s Australian Health and Community Service Standards (AHCSS) report.
• that unit/department planning and service improvement activities incorporate specific consumer participation strategies, and the outcomes of same are used to inform decision-making; the method(s) used, and outcomes, are to be documented in the unit EQuIP Quarterly Summary, or where appropriate, in the unit’s AHCSS report.
• staff training and development needs are incorporated in unit/department education plans.

It is anticipated that units will use a range of methods across the various degrees of participation.

Individual staff are responsible for working in partnership with their consumers. This means valuing the participation of consumers in their care by recognising that people know themselves and their child best and are the constants in their own or their child’s life. It also means jointly determining the patient’s or client’s needs and goals, negotiating care requirements between the patient, client, caregiver(s) and staff, and mutually establishing, monitoring and evaluating a plan of care.

Policy integration
This policy integrates with the following policies:
• Consumer Rights and Responsibilities
• Ethical Guidelines for Consumer Feedback
• Quality Management
• Health Promotion

This policy also integrates with EQuIP and AHCSS, particularly the following standards and criteria:

EQuIP
Criterion 2.1.10: The organisation’s strategic and operational plans are integrated, responsive to the needs of its community and developed cooperatively by management, staff, the community, and other relevant health service providers and authorities.

Criterion 2.2.4: The governing body facilitates consumer involvement through policies, procedures education and support.
Criterion 6.1.5: Mechanisms are implemented to facilitate consumer participation in improving organisation performance.

AHCSS
Standard 2.1: The service’s planning processes involve all stakeholders and use needs assessment of its community of interest to identify desired outcomes, set goals, and plan activities.

Standard 6.3: There is a wide culture of consumer and community participation supported by its philosophy, management committee, organisational structures and provision of resources.

SOURCE

Women’s and Children’s Hospital, 72 King William Rd, North Adelaide, SA, 5006, ph:(08) 8204 7000, web site: http://www.wch.sa.gov.au
EFFECTIVELY COMBINING INFORMAL AND FORMAL LEARNING FOR BOTH CONSUMERS AND SERVICE PROVIDERS

Directors Education Program, Loxton Hospital Complex, South Australia

HIGHLIGHTS

- A combination of different stakeholders learning together and maximising both formal and informal opportunities.

FOR REFLECTION

- Are there opportunities in your situation to enhance the formal learning with some informal processes.

KEY WORDS

Informal learning, dialogue, collaborative learning.

It is often the process as much as the actual education itself that creates an effective learning situation. In the following example provided by Julie Wilksch, Member of the Health Consumers of Rural and Remote Australia, it is clear that the negotiated process and the informal learning exchange over a meal together were key factors in the success of this board of consumers and service providers.

'The diverse members of Board of Directors of health units bring many skills and attributes and much knowledge which when combined have the potential to bring about dynamic leadership to a health unit. Both consumers and professionals have skills to be further developed. Our Board was committed to quality assurance and total quality management therefore it followed that we should have in place a structured education program which met the needs and expectations of its members. The following process ensured that training was tailored to meet the specific priorities of the group, and through involvement in the process all Directors had ownership of and a commitment to the education strategies.

At the start of each year one session was dedicated to a needs analysis to ascertain the personal as well as the collective training needs of the group. All consumer representatives, medical and executive staff who attended Board meetings were encouraged to be involved in the needs analysis. The technique used was a face-to-face one where each member wrote down his/her own education needs; individuals then joined to form a small group to share needs. The process continued to larger groups compiling needs. Once the whole group training needs were established and agreed upon, priorities were set by the total group and an annual training plan drawn up. Any member who had a need not accommodated in the collective plan was given the opportunity to have this need met on an individual/small group basis.

The timing of the education/information sessions was also determined by the members. The majority of ours were held prior to a normal Board meeting. We then would have a light meal together before the official Board. This would enable further informal learning and exchange to take place and was an important way for staff and consumers to continue their mutual learning. Attendance at Board education segments was purely voluntary but as our members “owned” the program we always had a very high rate of commitment.

Through this planned approach to education members were not only more informed and confident, but negotiation, communication and participation at Board meetings was heightened. The Board of Directors took a leadership role in education and provided a model for other staff to rectify and develop their own educational and professional development program essential to the provision of effective health care services.'

SOURCE

Loxton Hospital Complex, Drabsch St, Loxton, SA, 5333, ph: (08) 8204 7000.
Introduction

This case study is based on an interview with Professor Cathy Owen of the Department of Psychological Medicine, Canberra Clinical School, University of Sydney, and tells the story of the development of this pilot project. It is an example of education and training for consumers for their role as members of a teaching team in an undergraduate medical course. It is also an example of a partnership initiative between a consumer group and a provider group. It is an interesting example of both involving consumers in the health system as well as modelling a partnership experience between consumer and trainee doctor early in the doctor’s career path.

The beginnings

The idea for this pilot proposal came from Professor Owen observing patients with joint disease being trained to teach joint examination to medical students at the Sydney North Clinical School. This program legitimised the consumer experience of illness at the point of assessment and treatment and gave medical students the benefit of learning about that experience directly from the consumer.

Professor Owen approached the consumer network in Canberra about the concept of trialing the use of mental health consumers in the formal course training of medical students in how to assess mental health patients. The Department of Psychological Medicine and the ACT Consumer Resource Network embarked upon a cooperative project. The pharmaceutical company Pfizer Pty Ltd provided some funding support.

A Steering Committee was formed to oversight the development of the project. It consisted of five mental health consumers and Professor Owen. The committee undertook:

- the recruitment process for the tutors;
- the development of a training program for consumer tutors; and
- the development of the teaching course and manual for students.
Members of the committee shared the responsibility for producing the material for both training programs based on a core outline suggested by Professor Owen. Some members of the committee had had teaching experience and some had not.

Expressions of interest were sought for the tutor positions through consumer newsletters. Selection criteria were predetermined by the Steering Committee. The only mandatory criterion was that the applicants be mental health consumers. The work arrangements were the same as for other tutors at the university with the same processes of appointment applying. Nine expressions of interest were received, although one was later withdrawn due to illness. Eight consumers were recruited for training, four of them having been members of the Steering Committee.

The training of prospective tutors

The prospective tutors received six weekly, one-and-a-half hour sessions of training. Professor Owen acted as the trainer using the course material that had been prepared by the Steering Committee. Tutors were paid to attend training at normal Sydney University rates at the level of casual tutor rates for non-honours graduates. The six sessions consisted of:

- orientation to students—this session informed the tutors about the stage of training of the students and the problem based learning approach that is being used throughout the undergraduate course. It also informed them about the prior and concurrent learning activities of the students.
- working in small groups—the dynamics of teaching with activities and small group behaviour was explored.
- giving effective feedback—the general principles of feedback were explored using a learning to drive role-play.
- review of the student training package—two sessions were devoted to walking through the training manual for students.
- trouble shooting and problem solving and tutor assessment—this sessions looked at potential difficulties and potential solutions. All tutors then completed an assessment process of a 12-question pen and paper test, which examined course process and content. All tutors passed the assessment.

A graduation ceremony was held with certificates and presentations by the Dean of the Clinical School and later the ACT Minister for Health.

Tutors provided written evaluation of each session. Participants expressed that they were nervous and unsure at the beginning of the training, but at the end expressed an assurance of their own capabilities.

The medical student training

Six medical students were allocated for this segment of training. It was decided that the students would be divided into two groups of three, each group having two teaching tutors with two backup tutors that could be called on if needed. The tutors self selected for who was ready for the teaching role. The back up tutors were not called on during the training period.

Six sessions were originally planned but during the course of the training a seventh was designed in response to student need. The sessions were:

- establishing the context of the patient interview.
- mental state examination.
- opening the interview and conducting sensitive examination of a patient’s past and family history.
• dealing with lifestyle issues and recent events.
• dealing with depression and self-harm. This was the session that was added and an example of art therapy was used.
• talking diagnosis and therapy.
• how to bring it all together.

At the end of each session, a feedback sheet was completed by both student and tutor commenting on process, content and personal development.

**Evaluation**

The project is yet to be formally written up, but the following data has been collected to inform the overall assessment of the project:

• feedback sheets from both training courses;
• pre- and post-assessment tool on attitudes of students working with consumers with a control group at Sydney Western Clinical School; and
• results of the examination of observed clinical interviews of this cohort of students.

Some comments by Professor Owen on the usefulness of the project included:

• The initial concern for the welfare of the consumers working as tutors was unfounded and demonstrated a rather paternalistic view on her part initially.
• The time and intervention required by Professor Owen to devote to the tutors was not as much as expected.
• The relation between student and tutor that developed was invaluable as students began to feel comfortable to share concerns with their tutors regarding dealing with patients.
• The experience and knowledge that the tutors brought was seen as legitimate and valued by students.
• Other teaching staff in the unit, who had known some of tutors as patients, were surprised and impressed.
• Consumer tutors provided a better caring role of patients used from the ward in interview training.
• Some other provider disciplines, for example nursing, have shown interest in using this approach at other sites, but there has been no local interest.

**Where to from here?**

The project and materials that have been developed as a joint venture between consumers and providers are available to be used as resources for other providers at a cost. For example:

• Australian Federal Police are using the resources in teaching police how to deal with mental health patients;
• nurses and other health providers are showing an interest in the project and materials; and
• future publication and presentation should open up more possibilities.

**SOURCE**

Further information can be obtained from Professor Cathy Owen, Department of Psychological Medicine, The Canberra Hospital, Woden, ACT, 2606, ph: (02) 6244 2222.
Sometimes peer learning happens because no other support for education is available, in other cases peer learning is integrated as part of a wider plan of education. For both consumers and service providers, there are a range of opportunities for peer support and reciprocal formal and informal learning.

- **Briefings**: through phone, computer or person-to-person contact consumers or staff can be given the opportunity to work through consultation issues prior to meetings or forums. In the ideal situation there will be a paid consumer/staff member available for this learning support (see for example the Consumers’ Health Forum, ACT Health Care Consumers Association). The key factor is a support person who has wide experience and the ability to share this experience in a constructive way with the newer representative.

- **Debriefings**: the second crucial aspect of peer learning is the opportunity to talk through the experience of consumer participation as soon as possible after the experience. Here the consumer or staff member needs the opportunity to work through both their thoughts and feelings about that experience. (See The Kit—A Guide to the Advocacy We Choose To Do for more information on briefing and debriefing, pp77–80. See C06 for the full reference.)

Personal, professional and political learnings are part of the briefing/debriefing process. Personal responses to the experience often demand immediate debriefing in order to deal with issues that may have been triggered, however even in a relatively uneventful session, learning will be consolidated effectively if debriefing is available as soon as possible.

**Mentor system**

Effective peer learning occurs when there is an adequate structure supporting that learning. The Health Consumers of Rural and Remote Australia stress the need for a mentor for the mentors, and the need for consumers to meet together in person at least once a year so that support relationships can be strengthened by direct contact. There needs to be resources available to help peer supporters work through their briefing and debriefing role in an effective manner. Some of the resources in this resource guide could be adapted for use in peer learning (for example, Appendix 5 on learning from a critical incident in the Orientation and Job Manual for the Staff-Consumer Communication Program (1996) or Appendix 2 on ‘Listening Partnerships’ in the same document).
A STURDY FRAMEWORK FOR CONSUMER PARTICIPATION

Health Care Consumers’ Association ACT

HIGHLIGHTS

• A local initiative driven by health consumers.
• Demonstrates the importance of maintaining support networks to build on the provision initial information and training.

FOR REFLECTION

• What types of ongoing support services are most likely to be of assistance to health consumers in your own situation?

KEY WORDS

Mentoring, networks, partnership, power.

Introduction

This case study outlines the work of a local health consumer organisation in supporting consumers to participate in health planning and policy decision-making processes. Health Care Consumers’ Association of the ACT (HCCA) is a broad-based health consumer organisation that provides a voice for health consumers on local health issues. The Consumer Representative Project enhances HCCA’s capacity to identify consumers that can contribute a consumer perspective to the work of government and professional committees. It provides policy support, network resources and training opportunities. The ACT Department of Health funded the project.

Key features

• The Consumer Representative Project aims to develop and resource a consumer network in the ACT to provide a consumer perspective to health planning.
• The project addresses the power imbalance between consumers, planners and health providers in contributing to the planning of health services.
• It addresses imbalances in the following areas:
  — Access to information about planned changes,
  — Resources available to contribute (information, time, costs), and
  — Infrastructure that supports and encourages this involvement.
• The project is a focal point for information about consumer representation and consumer representatives in the ACT. Expertise and information about the needs of consumer representatives in relation to training and support are gathered through the project.
• The project worker actively involves consumers in the work of the project to facilitate learning opportunities, provide training or enhance capacity to promote the consumer perspective (mentoring).
• Through formal training and other informal opportunities, the project aims to be a forum for information exchange and support for health consumers in the ACT.

Background to the project

This work builds on Health Care Consumers’ Association ACT contribution to planning activities over a twenty year period. HCCA had worked with health services in an ad
hoc fashion to achieve responsive, respectful, accessible and affordable services. It has always advocated for direct consumer involvement in health decision making and lobbying.

HCCA identified key areas that would increase the ability of consumers to contribute effectively. HCCA could see that effective consumer participation could only take place within an infrastructure that supported it. The following areas were identified as key elements to further development:

- opportunities to develop skills for consumers wanting to participate.
- understanding the local and federal context for representation.
- networking opportunities to discuss issues of concern and share experiences.
- debriefing and support mechanisms.
- policy support.

More specifically, the HCCA:

- maintains a database of prospective and active consumer representatives;
- provides policy support and network resources for consumer nominees to participate effectively on committees;
- conducts training programs on consumer representation;
- develops and encourages mentoring relationships for emerging representatives; and
- conducts forums with prospective and active consumer representatives on issues identified by HCCA and through the project.

**Education and training**

Support for consumer representatives is based on comprehensive training in the skills and knowledge needed to be able to participate effectively. Training takes an adult education approach and is developed with the support of consumers. These training needs are placed in the broader context of the local health system and the needs of health consumers in the ACT.

A two-day training program is available to consumers, which is supplemented by a seminar program. A kit of training materials has been developed which is a resource of training activities developed over a two-year period. The material in the kit can be adapted and used to suit the needs of particular groups and covers the following:

- understanding the role and responsibilities of a consumer representative;
- the context for consumer representation at the state and federal levels. The political environment and the nature of policy development;
- the role of HCCA in providing a voice for health consumers in the ACT (aims and strategic goals);
- committee processes, for example protocols, model rules, and the role of the chairperson;
- the opportunities for participation in decision-making forums of the ACT government and major health providers; and
- ways to participate in HCCA and other ACT community sector organisation activities, to provide an effective voice in health service delivery.

The training aims to develop confidence in representing a consumer perspective, develop negotiation skills as a consumer advocate and increase the ability of consumers to develop and maintain a personal network that supports the consumer representative role.
Seminar program
In order for consumer representatives to bring a consumer perspective, a broad range of consumer views need to be canvassed. The project aims to provide varied opportunities for representatives to meet, gain information about particular health issues and current initiatives and to share ideas with other consumers. The seminar program supports the training and offers topics of interest to consumer networks and a focus on consumer representation issues. These seminars are held once a month and also provide a forum for representatives to discuss issues of ongoing concern with other representatives.

Support/ debriefing activities
The project officer is available for telephone or face to face debriefing for consumer representatives. Support meetings are a regular part of the project and are held as required. These meetings with two or three consumers and the project officer are held to explore and discuss particular issues about processes or content, that arise from the work with health providers and planners.

Mentoring
A more experienced representative shares his or her knowledge and experience with someone new. These are informal arrangements based on the needs of health consumers who are new to consumer representation.

The health consumer representative movement in the ACT has been developed through peer education; support, validation and encouragement of experienced consumers with other consumers. Mentoring acknowledges the role of consumers in building consumer networks and is a vital aspect of consumer networking activities supported by the project.

Information exchange
Where training provides the skills to participate, forums for exchange of information provide the means for developing a shared understanding of the issues that are important to consumers as a group. Structured forums where information can be shared fosters the understanding of complex health issues facing consumers. Topics for these forums come from the project, HCCA members and consumer representatives. A newsletter is produced four times a year and a website is proposed as a further means for health consumers to gain information and have input into current committee work.

Good practice
This is a local initiative driven by health consumers. The project work is developing a strong and effective consumer network that can bring a confident consumer perspective to health planning.

The activities of the project are a vital step in strengthening the health consumer networks and building confidence and trust with health providers. It has developed a solid base for further partnership work between consumers, providers and government.

SOURCE
Further information can be obtained from the Project Officer, Health Care Consumers' Association ACT, GPO Box 1659, Canberra, ACT, 2601, ph: (02) 6290 1660, fax: (02) 6290 1662, email: hccapru@dynamite.com.au
ADVOCACY FOR CHANGE: EDUCATING MENTAL HEALTH CONSUMERS AND CARERS TO MAKE A DIFFERENCE AT MANY LEVELS

Mental Health & Special Programs Branch, Commonwealth Department of Health and Aged Care

HIGHLIGHTS

- A comprehensive resource for enhancing consumer advocacy.
- Demonstrates the importance of linking consumer-focused skill development strategies with broader strategies for systemic change.
- Illustrates how to accommodate to a variety of learning styles.

FOR REFLECTION

- How can this comprehensive resource, developed for use in the mental health area but with wider application, be taken advantage of in your situation?

KEY WORDS

Advocacy, attitudes

The Kit—A Guide to the Advocacy We Choose To Do is the product of the national Community Development Project conducted over 12 months in 1997 and 1998, as an initiative of the National Mental Health Strategy. The project goal was ‘to enhance advocacy activity through increasing knowledge and strengthening skills with the health community sector’ (pv). Beyond The Kit itself, the project has been complemented by more system wide change through the development of the resources, through a ‘leadership strategy’ and via a ‘dissemination/ information strategy’.

Contents

This is a large and complex resource, comprising a 275-page loose-leaf kit and a 114-page complementary Knowledge and Attitudes booklet. The authors stress that it can be used in a range of ways—by individuals and by groups. It has been designed with exercises and strategies to appeal to the diversity of learning styles, is written in plain English, and includes a bibliography and index.

The introduction provides background and context to the materials and to the history of the Community Development Project.

A separate booklet discusses knowledge and attitudes that have an impact on the experiences of carers and consumers today. There are nine knowledge and attitude areas; within each, different viewpoints may be presented and discussed. Some areas provide background to the history of consumer and carer movements in Australia, the United Kingdom and the United States of America; some provide information about the challenges of undertaking advocacy, based on consumers’ and carers’ experiences; some take account of external influences such as the higher education system and the broader community.
A series of skills and strategies which can be selected, mixed, matched and adapted. The skills, strategies and related tools are numbered and grouped into five clusters to assist with their practical application:

- advocacy and the individual;
- getting organised;
- some specific exercises;
- advocacy and the organisation; and
- getting strategic.

Each skill and strategy has both practical and motivational information including a brief background, some concrete ideas, and often a tool like sample forms, tables and diagrams, actions to try, reminders and questions for you to consider.

A glossary of key words which are particularly useful or which have been used in a specific way in the kit. Some of the words are jargon, discriminatory or used in one state of Australia but not another. Their inclusion in the glossary does not imply that they are ‘preferred’ or that they should be used; it simply provides an explanation for the word.

**The Knowledge and Attitudes booklet**

This 114-page ‘booklet’ covers the following topics:

- consumer and carer movements
- undertaking advocacy
- forms of consumer and carer participation
- challenges of advocacy
- maintaining personal effort in advocacy
- engaging networks and organisations
- mental health system
- broader community.

Although some sections focus particularly on mental health issues, much of the booklet contains transferable information. The booklet provides an essential background for individual/collective exploration of the politics, philosophies and practices that may/will impact on most consumer representative in the mental health sector.

**Skills, strategies and tools**

Useful details in the manual sections include:

- advocacy and the individual
  - assertiveness, problem solving, personal organisation, communication skills, family involvement.
- getting organised
  - briefing, debriefing, barriers, finding information, managing change, evaluation.
- specific activities
  - education, telling stories, workshops, conferences, report writing, being a layperson among experts.
• advocacy and organisation
  — group development, team development, leadership, business and promotion, organisation and business planning.

• getting strategic
  — creating networks, fundraising, lobbying, media.

**Highlights and challenges**

• size
  — this kit covers a lot of territory and is best seen as a training ‘resource’. Although the authors stress it can be used in many ways, its sheer size and range of issues may be daunting to an individual consumer using it for self-directed learning.

• consumer focus
  — the frustrations and challenges for consumer advocates at all levels are delineated. Examples are drawn from a range of contexts in an inclusive way. Although there is some information on service providers and the roles of professionals, this is not a strong focus.

• mental health focus
  — although The Kit has been developed specifically for use in the mental health area, many of the strategies and tools could be used in other sectors. This may require a specific context analysis especially regarding knowledge and attitudes relevant to the sector.

**SOURCE**


At the time of writing, new copies of the kit are not available, although plans for a further print run are in hand. For details of agencies with a copy or for an update on the expected date of availability contact Ms Katy Robinson, Mental Health & Special Programs Branch, Commonwealth Department of Health and Aged Care, ph: (02) 6289 7313, email: katy.robinson@health.gov.au
The Healthy Cities Illawarra (HCI) project illustrates a strategy to develop a collaborative framework to address the health issues of the Illawarra region of New South Wales over a period of more than a decade. Both consumers and providers have been involved in this collaborative effort, along with other stakeholders. A key feature of the Healthy Cities movement is the links forged between health and other sectors that bear on health outcomes such as welfare and the environment.

The Healthy Cities movement is an international development initiated by the World Health Organization (WHO) which grew out of the 1986 Ottawa Conference on health promotion. There are now some 2000 Healthy Cities, Communities, Towns, and Villages throughout the world which exchange information and ideas. Illawarra, Noarlunga (SA), and Canberra were the initial three Australian projects inaugurated in 1987 with special project funding.

Healthy Cities Illawarra is of interest in illustrating the development of a partnership arrangement over a period of more than ten years. The experience of HCI over this period illustrates the various phases of partnership development which are discussed in Section 5.2 of this guide. These phases of development, and the strategies adopted to progress collaboration and partnership are discussed below.

Origins

The HCI project was inaugurated in 1987 following the 1986 WHO Ottawa Conference on health promotion which led to the Ottawa Charter for Health Promotion with its strong emphasis on collaboration for health promotion. Healthy Cities were intended to implement the charter at a local level.

Following the Ottawa Conference, the Australian Community Health Association with funding from the Commonwealth Department of Community Services and Health sponsored a three-year Healthy Cities project. Illawarra, Noarlunga, and Canberra were successful in obtaining funds for these pilot projects.
Start-up phase: coming together
The initial planning phase of the project brought a key group of stakeholders together to plan for the project. An initial planning group from the University of Wollongong and the Illawarra Area Health Service convened a public meeting to which they invited some 100 community groups, business, unions, churches, local government, and government agencies. It was recognised that active involvement of a wide spectrum of groups with an interest was essential and that coordination of effort should be a key aim.

There were two key developments in the initial start-up phase:
• a management structure was developed; and
• a shared vision was forged which was reflected in the charter for Healthy Cities Illawarra.

The management structure developed for HCI initially involved a Reference Committee and a smaller Management Committee with representatives from the three local government areas in Illawarra, the Area Health Service, Wollongong University, the Department of Education, and the community.

The present Management Committee now meets monthly and now includes the Director of the Public Health Unit as well as the Directors of Community Health and Health Promotion (as observers), local government representatives, representatives of the Department of School Education, Wollongong University, and community representatives. A project manager gives executive support. The active involvement of local government is a feature of both Healthy Cities and Learning Cities.

Vision and charter
A critical aspect of gaining support and commitment to the objectives of Healthy Cities Illawarra was to build a shared vision. This was reflected in the charter adopted for HCI.

The charter was developed from the Ottawa Charter for Health Promotion and was developed into a vision that incorporated four beacons as guiding principles:
• The Ottawa Charter
  — Build healthy public policy
  — Support community action
  — Develop personal skills
  — Create supportive environments
  — Re-orientate services towards community need
• Forging a shared vision
• Human relationships
  — Developing shared feelings and trust as essential values to underpin and support collaboration and partnership
• The environment
  — Improving the environment through collaborative effort.

The charter adopted for HCI is attached to this guide.

The development phase: moving forward
Following the start-up phase of partnership development, HCI adopted strategies to progress collaboration in addressing the objectives of the adopted charter. A key aspect of this phase of development was the establishment of a number of task forces.
to address important issues bearing on health in the Illawarra region. Task force activity included the following:

- **aged task force**
  - This included representatives from 22 organisations with an interest in issues pertinent to elderly people. This task force has operated for some years and has performed a strong advocacy and lobbying role in various areas of need including nursing home provision, disabled access, podiatry services etc. The task force helped to initiate the Wollongong University of the Third Age.

- **AIDS task force**
  - This task force is also widely representative of interested parties. It now employs a project officer with funding from the NSW Health Department. The task force has been active in promoting public awareness of AIDS issues including activities in schools.

In addition to task force activity, HCI has been active in working with disadvantaged communities. This work has included a number of projects undertaken in the Berkeley, Bellambi, and Cringilla village communities. This work has involved a number of Aboriginal communities and has linked to the promotion of the multicultural character of Wollongong and its region.

The activities undertaken in this development phase of partnership development illustrate the importance of ‘getting runs on the board’ in progressing partnerships from an initial start-up. Some partnerships never make this transition.

**Mature partnership phase: sustaining momentum**

Healthy Cities Illawarra after 12 years of operation has progressed to a mature phase where a partnership culture has been embedded in the community and the vision of HCI is widely shared in the community. This is the reflective phase of mature partnership where the main pay-off occurs. The key issue is now to sustain the momentum.

An important reflective activity of this phase of development was the writing of the history of HCI over the decade 1987 to 1997. This history, Healthy Cities Illawarra: Ten Years On, provides a rich source of information on the experience of HCI over this decade.

It outlines lessons for other communities wishing to develop as Healthy Cities. A set of 12 steps are identified as a guide to other communities.

The mature phase of partnership has also been featured by developing and extending links with other Healthy Cities in Australia and overseas. Helping others starting out is one of the principles derived from the experience of HCI over a decade. There are now five new Healthy Cities in New South Wales: Albury-Wodonga, Temora, Port Macquarie, Blue Mountains, and Hawkesbury Windsor.

The network building which is a feature of the mature phase of partnerships includes extending international links. With its strong interest in environment issues, HCI was one of the initiators of the Global Ecohealth Network (http://www.vianet.net.au/eco-heal).

**Comment**

The HCI experience over 12 years demonstrates good practice in building and sustaining collaboration and partnership. Critical features include careful planning and management, active community involvement and participation by all stakeholders, the fostering of a shared vision and values, and collaboration in practical activities directed at key health issues. A good deal of incidental learning has occurred as the partnership has matured and derived lessons from its experience.
Healthy Cities have much in common with the Learning Cities movement which is also found around the world and which is currently the subject of a special study by the Organisation for Economic Cooperation and Development (OECD).

Both movements foster collaboration and partnership and inculcate the values, such as trust and respect for others, which underpin effective collaboration.

The Healthy Cities movement illustrates how collaboration and partnership between consumers and providers can be built into broader collaborative frameworks which enable a wide range of health and other issues to be addressed. The Healthy Cities model can be applied in a community of any size, including towns and villages.

SOURCE

Healthy Cities Illawarra, 63 Auburn St, Wollongong, NSW, 2500, ph: (02) 4226 5000.
APPENDIX

HEALTHY CITIES ILLAWARRA CHARTER

1. Every individual has an equal right to his or her optimum level of health.
2. Health is the responsibility of everyone in the community.
3. We therefore commit ourselves to action at a local level to improve the health of the people of Illawarra by:
   • working together on a cooperative basis
   • supporting community action
   • developing personal skills and worth
   • ensuring effective health advocacy
   • encouraging health promotion and community care
   • protecting and enhancing the physical environment
   • recognising the right of the individual to work and contribute
   • developing local policy and actions to establish a social, economic, and physical environment conducive to health

Aims

• To involve government agencies and non-government organisations in the development of Healthy Public Policy and actions by acting as a catalyst for change.
• To increase community awareness at every level of the many factors which affect health and the necessary elements of a Healthy City.
• To achieve wide community involvement through intersectoral collaboration and Community participation recognising the special needs of those most disadvantaged.
• To act as a community advocate and facilitate supportive community action.
• To assist in the reorientation of services towards community need.
• To facilitate the creation of a social, economic and physical environment in the Illawarra which is supportive to health.
• To develop links and a mutually supportive relationship with participating Healthy Cities and new and intending Healthy Cities.
Far West Area Health Services, New South Wales Health

HIGHLIGHTS

- Demonstrates the value of clearly stated objectives both in the development and evaluation of education and training activities.
- When well utilised, additional short-term resources can be used to effect lasting change.
- Evaluation requires a variety of techniques and can deliver valuable lessons, both during and after a project.

FOR REFLECTION

- How was evaluation built into the project from the beginning?

KEY WORDS

Rural, action learning, evaluation, needs assessment.

Introduction

In 1997, the NSW Health Department decided to establish Health Councils in each Area Health Service. The purpose of these Councils was to establish a means of communication between Area Health Services and their communities. Because of its size, the Far West Area Health Service (FWAHS) took an approach of establishing 13 separate Health Advisory Councils in each subregion rather than just one large Health Council for the whole area.

A Rural Health Support, Education and Training (RHSET) grant was obtained from the Commonwealth Government Department of Human Services and Health to fund education and training of health service managers (and consumers) that would be needed to support the formation of these new councils.

The report entitled Working with CommunityCouncils: a training package for Health Service Managers (Far West Area Health Services, NSW Health 1997) written by Diane Beard, the Health Advisory Council Coordinator for the Far West Area Health Service, tells an important story of how these Councils were established and what education and training supported their development, both for consumers involved and for the health service managers charged with the responsibility of their formation and development. This report also provides an evaluation of the training of the managers and therefore provides some valuable insight to those who might wish to embark on similar processes.

Concurrently the Rural Health Support Unit of NSW Health produced a Health Council Orientation Package (1997) targeting the training needs of consumers participating in the newly established Councils throughout NSW. The use of this more generic resource within the specific training designed for the FWAHS Health Advisory Councils is also described.

Setting objectives

In a best practice sense, the first task in any project, including an education and training project, is to set objectives and performance indicators for the project. This was done at the beginning of this project and therefore provided an important basis for evaluating the effectiveness of the project. The objectives were to:
• increase the capacity of the remote health service managers to work effectively with community consultative committees and Health Councils;
• improve the capacity of remote health services to identify and respond to community analysis of local health needs and priorities;
• enhance the interface between the traditional operational management role of remote health service and community councils as the forum for communities to negotiate the range, mix and direction of their local health services;
• install a uniform set of community development and consultative skills at the local health service management level for far western NSW communities; and
• develop a transportable training package for other managers of health services in rural and remote settings.

Looking at these outcomes for the project, they were clearly directed at the higher levels of Kirkpatrick’s hierarchy of levels of evaluation (Hutchison 1999), i.e. the results or impact on society, the behaviour change in the workplace and the learning of specific skills and knowledge (in descending order of complexity). There is some evaluation of the reaction or satisfaction with the training, which is the lowest level of evaluation.

The process

The method for the project included the following activities:
• formation of a steering committee;
• appointment of a coordinator;
• undertaking a needs assessment of both health service managers and consumers;
• developing a separate training package for health service managers;
• implementing the health service manager training package through a workshop and resources;
• additional training of health service managers according to further needs assessment, including supervised project work;
• individual support to health service managers in their new role;
• developing an orientation training package for Health Advisory Council members, including incorporating relevant material from Health Council Orientation Package;
• evaluation of the project against set objectives.

Each of these steps will be described.

Steering committee

The formation of a steering committee to oversight a project such as this where the education and training is supporting a system-wide change to health care delivery seemed most appropriate. It is, however, noticeable that the steering committee did not include consumer or community representation but consisted only of health bureaucrats.

A future project along similar lines might benefit from more comprehensive representation at this level.

Coordinator

The role of this coordinator was quite extensive. The incumbent was responsible for the development and implementation of the training package but also for the considerable level of individual support needed by the health service manager partici-
pants. It is clear that where considerable behaviour change is being asked in the work-
place, then a system of coaching or mentoring becomes essential. One of the prin-
ciples of adult learning is that learning involves a cycle of action and reflection
(Spencer & Jordan 1999).

It is always useful if that reflection can occur with a mentor or coach where large shifts
in behaviour are occurring.

**Needs assessment**

Undertaking a needs assessment of the learners is a first step in any educational inter-
vention design. It is important step in engaging the adult learner and enabling them
to take responsibility for learning (ibid). It is also important at this point to scan the
literature and gain some knowledge on what has worked elsewhere, as was done in
this case. Particularly at the beginning of a learning pathway in a new or unfamiliar
field the learner may not know what they need to know (Cantillon & Jones 1999).

**Training package for health service providers**

The package designed for health administrators, provided them with a workshop
addressing many of the issues and concerns they had about a change of role as well
as providing them with some skills training in areas generating community interest
and culturally appropriate consultation. Managers were also provided with a resource
pack, some before the workshop and some during it. It contained some very practical
tools eg proforma letters as well as an implementation manual for the formation of the
new Health Advisory Councils. An important feature of the workshop was to gauge
further training needs, thus allowing the learning cycle to continue.

**Additional training: community consultation training**

Community consultation training was identified as the most important further training
need. A series of workshops were designed using external expert consultants. Where
Health Advisory Councils already existed, then some members of these councils were
also included, thus joining both managers and consumers in the same training task.
A supervised work project formed an ongoing part of this stage of training which was
clearly task based learning, employing the principles of adult learning (Spencer &
Jordan loc cit). It was probably one of the most important steps in this learning project.

**Individual support**

The individual support of the Health Service Managers was clearly important in
enabling them to effect change. This support was largely provided by the coordinator,
a difficult task given the distances involved. It was mentioned in the evaluation that
further use of distance technology would have to be considered in any such project in
the future. It was clear through this phase of the project that additional supports for
generating community interest in the Health Councils was important, and a clear
marketing approach was developed and implemented.

**Orientation training package for Health Advisory Councils**

The Health Service Managers were given responsibility for developing the training for
the Health Advisory Councils (HACs). In some cases, joint education of health admin-
istrators and consumers in community consultation had occurred. At the initial meet-
ing of the HACs, some basic information was provided to the councils as part of the
orientation. Further training needs were explored. The Health Council Orientation
Package was provided to each health service manager to be used and adapted as
needed. The package was in self-contained modular form, with detailed instruction for
the trainer.
Evaluation
As mentioned previously this project was carefully evaluated. The objectives that were clearly stated with defined performance indicators are reported on in the evaluation. The results make interesting reading and demonstrate that some change has occurred at the more complex level, namely, the results or impact on society, the behaviour change in the workplace and the learning of specific skills and knowledge (in descending order of complexity). The majority of managers (83 per cent) were more comfortable and confident to work with councils. Councils were involved in setting health priorities through strategic planning and population health planning. Consistent and uniform training was being delivered to health service managers and the councils, and community consultation was occurring. The evaluation of the reaction or satisfaction with the training, which is the lowest level of evaluation, also showed a high level of satisfaction.

Observations
Perhaps one of the most interesting parts of this report is the description of the observations on what was a change management exercise and a reflection on the level of support that is needed for people during that process. A resource manual developed by the Department of Community and Health Services in Tasmania (1997) outlines the five key successful elements of change as leadership, planning, communication participation and staff support. It is clear from some of the qualitative data in this analysis that all these elements were important in the training and education processes. The Steering Committee provided critical leadership. The planning with definite objectives and needs assessment was central to success. Communication was a central theme of the training content and the outflowing projects and action plans. Participation by all the service managers was critical as was the support for the process, which increased over time.

Some important ongoing issues were raised including the difficulties of time and geography, the expanded role of the health service manager with potential conflicts in role, the increasing credibility and trust in the community, the importance of understanding primary health care principles, the empowerment of community development, the importance of recognising diversity, the centrality of good communication and the need to maintain and not lose the considerable gains made.

Conclusion
This report provides a good description of best practice education and training for health administrators and could be used in other circumstances as a blue-print for how to best support health administrators through a process that involved increased consumer participation in health care. It is an example of action learning. The process for increased consumer participation in health care had already been politically predetermined by the formation of the Health Advisory Councils. It was clear however that the health administrators benefited greatly by the education and support provided to them in the process of establishing the councils. It would be interesting to similarly evaluate the orientation training of the Health Councils.

Sources
Far West Area Health Services, NSW Health 1997, Working with Community Councils: a training package for Health Service Managers, Rural Health Support Training Program 96/97 RH Grant 423.
Further information is available from Ms Marg O’Malley, Population Health Unit, Far West Area Health Service, PO Box 457, Broken Hill, NSW, 2880, ph: (08) 8080 1218, email: momalleyfwhs@doh.health.nsw.gov.au
TRAINING FOR HEALTH PROFESSIONALS, 
ESPECIALLY MEDICAL PRACTITIONERS

Journal articles on consumer participation

HIGHLIGHTS

• Scans recent refereed medical journals for current thinking on consumer participation.
• In editorials and articles traditional attitudes to doctor/patient relationships and the role of the consumer are being challenged.
• The implications of a partnership approach to health care are wide-ranging—at all levels from the individual to the health care system, partnership affects decision-making, evaluation, research, education and training, information-sharing, etc.

FOR REFLECTION

• How can the views of health professionals and others, as published in refereed journals, be used to good effect in education and training programs?

KEY WORDS

Partnership, paternalism, enabling, quality.

Introduction

It is clear that for the medical profession and probably for other health professions as well, refereed medical journals form a very important source of learning in their discipline. This is particularly so for continuing medical education, but also for initial undergraduate and vocational training.

Recent issues of both the British Medical Journal (BMJ) (1999, 319) and Medical Journal of Australia (MJA) (2000, 172(1)) have highlighted the theme of consumer participation in health care. As highly regarded peer reviewed journals they are clearly laying the agenda before the profession and informing them of the current research and debate that is occurring.

The 18 September 1999 issue of the BMJ contained a number of editorials which considered the paternalism of the medical profession, the involvement of consumers in clinical research at the design end and the conflicts that may be involved in a shared decision-making model in publicly funded health systems. It also contains some articles about original research in education and training for doctors in consumer participation at the individual patient and doctor level. Other articles focus on what features of general practice might lead to enabling of patients as well as some challenges about providing good quality health information to patients.

The 3 January 2000 issue of the MJA tackles the difficult area of determining patient attitudes to commonly promoted medical interventions and what might influence their choice around decision-making. An editorial article is provided by a leading Australian consumer advocate in this debate and sets an example and perhaps a precedent for a partnership in academic discussion even at the hallowed level of peer refereed journals. Debate on integrated health records again sees another well known consumer advocate responding to a model being proposed by a group of health academics.
Journal articles from these two issues will now be considered with an emphasis on how they might further educate the medical profession about consumer participation in health care.

**British Medical Journal**

In this issue of the British Medical Journal (BMJ), consumer participation in the individual doctor-patient encounter is the emphasis. The article on involving consumers in research does however consider consumer participation at the broader health system level. The articles on education and training also focus at the individual doctor patient level.

It is clearly important to begin developing competencies and attitudinal change at this individual doctor patient level, as this is the world and experience level of most clinicians and patients. Adult education needs to start where people are. Without consumer participation attitude and skill changes at the individual clinical encounter level, it is unlikely that consumer participation will occur at the system wide level. It would therefore seem important that these articles are taken seriously and initiate further learning and research.

**Paternalism or partnership?**

This editorial (BMJ, 1999, 319, pp719–720) sets the tone for the whole issue, challenging the benevolent paternalism that has long been the normal attitude of physician to patient. The unhealthy dependency that this generates is challenged with a vision for creating meaningful partnerships between doctors and their patients. The concept that the consumer is also an expert, but in different areas from the doctor, is clearly outlined. Some of the barriers to forming such partnerships are raised including the threatened stance of the profession and the lack of knowledge about patient readiness or willingness to take on new responsibilities in a partnership role. It is clear, as outlined in subsequent articles, that some of the evidence is now suggesting that such partnership development requires longer consultations in general practice, greater continuity of carer general practitioner, better quality evidence based information for patients, and more communication skills training for doctors.

**Involving patients in clinical research**

This editorial (ibid, pp724–5) challenges the way patients have been objects of research in the past, rather than partners in it. It suggests that patients may be better equipped to ask the right research questions that are most likely to affect health outcomes that are meaningful to them. Funding consumer participation as well as the academic culture have been barriers in the past, but this is changing. A number of examples of change are given, including the United States Department of Army congressionally directed medical research now requiring that consumers be partners in the research grants at the development and implementation stages. This editorial forms an important challenge to the medical academic world of the future about its need to partner with consumers.

**Shared decision-making in a publicly funded health care system**

This editorial (ibid, pp725–6) sets a clear scenario of potential conflict between the patient and doctor that could arise in the publicly funded health system where the individual choice of the informed consumer may not be aligned with the most cost effective choice being propagated in the form of clinical guidelines by the doctor. The consumer needs to also be informed of the cost of choices even in the public system, so that they can share the responsibility for cost effective decisions. It is clear that while governments might be more concerned about cost, the individual patient and doctor may have a different view. It is suggested that a clear distinction must always be made between clinical best practice guidelines and system guidelines that also take into account the cost agenda. This editorial raises a critical area in health decision-making.
for both the clinician and the consumer. It is likely to be an area that will test future consumer participation in health care.

Quality at general practice consultations: cross-sectional survey
This is a fascinating piece of original research (Howie J, ibid, pp738–43), which looks at enablement of the consumer as a quality outcome of a GP consultation. It demonstrates that the three features of general practice that consistently allow a patient to feel ‘enabled’ (an outcome that has been shown to be important in predicting improved health outcomes) are longer consultations, continuity of care with the same general practitioner and smaller practices. These findings may well be critical in the way we continue to develop general practice and develop incentives for increasing the quality of care. Learning how the system encourages or discourages consumer participation is important for both professional and consumer.

Framework for teaching and learning informed shared decision-making
This article (Towle A, Godolphin W, ibid, pp766–771) proposes a set of competencies for the practice of shared decision-making by the patient and doctor. It sets the need to attain these competencies against a background where there are now legal trends to require a high standard of informed consent.

It is accepted that there are challenges in informed shared decision-making, namely lack of time in the clinical encounter, doctor’s skills and attitudes and patient’s inexprience or unwillingness to participate in clinical decision-making. A list of competencies is described for both the doctor and the patient. It is suggested that this competency framework could then be further used in teaching, learning, clinical practice and research.

This article receives some interesting feedback commentary, suggesting the framework of competencies is too simple and not yet rigorously tested. It is also suggested that shared decision-making implies a partnership developed over time between doctor and patient and that so often the system does not allow this to occur.

Towards a feasible model for shared decision-making: focus group study with general practice registrars
This study (Elwyn G et al, ibid, pp753–6) demonstrates that GP Registrars in the United Kingdom are not being trained in the skills required to involve patients in decision-making. The attitudes of these doctors in training to involving patients in decision-making were also highly variable from a ‘doctor knows best’ attitude to enlightened self-interest ie ‘lessening the doctors load.’ The article highlights how sharing decision-making means sharing responsibility as well as sharing uncertainty. It sees shared decision-making as the middle ground between paternalism and informed consent.

Elwyn refers to his own framework for stages and competencies in health care decisions and also draws on Towle’s (loc cit) framework of competencies. These must both be seen as useful in the future teaching of doctors for consumer participation.

Helping patients access high quality health information
This article (Shepperd et al, ibid, pp764–6) provides some information on the better international sources of high quality health care. It is clear that patients need this sort of information to be better equipped to participate in decision-making about their health care. The amount of information is escalating in most media especially the Internet and patients and physicians alike need to be able to critically evaluate information. Doctors must take an increasing role in directing their patients to appropriate information sources.
The articles in this issue are interesting in that they combine the findings of health academics with comment from highly regarded consumer advocates in Australia. It is important to see this partnership debate occurring at this academic level.

Allies or enemies? Evidence based medicine and consumer choice
This editorial (MJA, 2000, 172 (1), pp5–6) raises the fundamental question of who should decide best practice in health care for the community? It is clear that at the moment evidence based medicine (EBM) is largely determined by the profession with outcomes focussing on mortality and disease morbidity. The outcomes of the EBM road may not be the outcomes that the consumers see as most important for their health care. It is clear that the values, skills and knowledge of both consumer and health professional are needed to move the debate forward, and this article does just that. The gold standard of randomised controlled trials in the hierarchy of evidence may not in itself be enough to provide comprehensive information to support decision-making for the consumer.

It critically reviews the article by Fitzgerald and Phillipov (pp9–12) in the same issue, highlighting that their findings should come as no surprise, given the different values and concerns of patient and doctor. Some concern is expressed about the methodology of this research and the way information was framed when presented to patients. Meaningful communication must be objective.

This editorial is an excellent example of a consumer participation in the academic literature, an important source of knowledge for the medical profession.

Patient attitudes to commonly promoted medical interventions
This article (ibid) describes three best practice guidelines that have been developed from randomised controlled trials and tests their usage with a sample of patients in a hospital outpatient’s clinic. The results seem to indicate that there is a discrepancy between patients and doctors in the perceived benefits of these three common best practice medical interventions. Patients seemed more concerned about the context in which the intervention occurred or the risks associated with the procedure than the likelihood of a successful outcome. This was especially the case in the preventative intervention, which was hormone replacement therapy. There was a negative attitude by patients to starting an intervention in an asymptomatic patient. This article therefore questions whether involving patients in the decision-making will lead to better health outcomes on the whole, in fact it may do the reverse. As outlined in the editorial mentioned above perhaps increased decision-making by patients about preferred health outcomes may at the hub of the debate.

Integrated electronic health records and patient privacy: possible benefits but real dangers
This article (Carter, ibid, pp28–30) provides some interesting comment on the work of Mount et al (pp25–7) also published in this issue. It provides another example of a high profile consumer advocate debating the premises on which health academics base their research and propose system changes. Carter highlights the ‘newspeak’ that has entered into the integrated health record discussion, which assumes that such a record would provide a consumer focus to health care. She questions that the real focus may be on the government ability to collect integrated financial health care data.

The systems being proposed which include a centralised database will mean that health policy makers and funders as well as researchers would have access to data that they do not at the moment. This level of access raises concern over rights to use the data and privacy. This is not just paranoia as there have been plenty of examples of things actually going wrong which are mentioned in the article. The alternative direction that may be worth developing is improving secure electronic exchange of
information between parties that need to know. Local and regional solutions rather than one global solution to health information management is the course advocated.

This article is a good example of involving the consumer in the academic debate about what is a critical area of health system reform.

**Conclusion**

While it is acknowledged that this collection of articles does not necessarily exclusively consider education and training for health professionals for consumer participation in the system of health care planning, delivery, monitoring and evaluation, it does begin to introduce the profession to the concepts of consumer participation at the various levels of health care. Some of the articles also focus on the attitudinal and skills training that is needed by both the provider and the consumer.

These articles could form a good selection for private reading of the individual practitioner or for use in a structured education intervention.
THE LEMON TREE PROJECT: A MULTI-LEVEL LEARNING MODEL BRINGING MENTAL HEALTH CONSUMERS AND SERVICE PROVIDERS TOGETHER

Victorian Mental Illness Awareness Council

HIGHLIGHTS
- The Lemon Tree model provides a comprehensive approach to the many levels of learning needed for sustainable change
- Includes specially developed approaches that encourage deep dialogue
- Able to be adapted to non mental health settings
- Accommodates a range of learning styles

FOR REFLECTION
- What types of learning have we tried in our setting?
- Do our ‘leaves’ have support of a ‘trunk’ and ‘roots’? (read on for further explanation!)

KEY WORDS
Dialogue, system change, feedback, cultural change.

The 135-page report on the Lemon Tree Learning Project articulates a model which promotes participative approaches to learning. It foregrounds the issue of the different perspectives and understandings of experience of consumers and service providers, and acknowledges the power relationships. The project aimed for system and individual change and focused strongly on the process of learning.

Funded in 1995 by the National Mental Health Strategy, the Lemon Tree Learning Project describes the ‘complex and subtle relationships between consumers-as-educators and services-as-learners’ (p9). The report provides a mixture of theory, practical examples and tips from personal experience which combine to be a rich resource, however as the model is a multi-leveled and integrated, it is necessary to read through the whole report to gain maximum benefit.

The Lemon Tree model

This model (p26) proposes that:
- training for consumer participation can be broken down into:
  a) ‘root’ learning where the training is nourishing an infrastructure to support consumer participation;
  b) ‘branch’ learning where the training is adding to or modifying existing knowledge, skills and attitudes developed around consumer participation; or
  c) ‘leaf’ learning where the training is providing information about consumer participation where little or no infrastructure to support it exists.
- training for effective consumer participation needs to be premised on a theory of effective consumer participation—this project utilized the ‘U & I’ model as the trunk of learning.
training for consumer participation needs to take account of three sites in which participation takes place—decision-making sites, consumer-only sites and decision free/exchange sites.

consumers should be involved throughout the training of service providers for consumer participation—examples given are the Consumer Facilitation Model and a board game ‘Lemon Looning’.

consumers participation provides a service to the organisation therefore it follows that consumers should be paid.

consumer learning for effective participation largely should be led by the relevant consumer groups.

training for effective consumer participation, for both consumers and staff, should model collaborative roles and relationships and should not inadvertently be an occasion for further abuse, disempowerment and energy drain.

Definitions of learning used in the project

Leaf learning
According to the Lemon Tree model, leaves are one-off learning situations, such as guest speakers, talks etc, which are not integrated with real, ongoing consumer participation within services. They are not consumer driven, not grounded in the local context and are least likely to produce positive change.

• ‘Leaves’ are peripheral, tokenistic adornments to service provider agendas.
• ‘Leaves’ allow service providers to talk about, rather than involve, consumers.
• ‘Leaves’ are easily dismissed and do not require any change of practice from participants (p35).

Branch learning
Where there is some form of infrastructure around consumer participation it is possible to grow on ‘branch’ level training. Five major forms of branch work are described:

• Consumer consultant training course
  — Consumer consultants or staff-consumer consultants are paid workers with consumer perspective and experience employed by mental health services in the context of quality assurance. Content of the course includes understanding the roles the concept of the consumer perspective, conducting workshops, public speaking, skills in policy reading and reportage committee work and communicating with poetry and song writing. Processes for learning included stories, reading, quizzes, consumer-to-consumer teaching and some ‘expert’ presenters.

• Content based workshops
  — For example an activist workshop that utilised an experienced grassroots activist who provided practical campaign strategies.

• Resourcing specific consumer groups
  — For example, an incorporation workshop where a community sector consultant provided an evening workshop on becoming an incorporated association.

• Consumer facilitation courses
  — This model has been designed to utilise the consumer perspective and experience without exploiting the emotional reserves of the consumers involved. It is an active learning exchange. Consumers are trained to specifically maintain and develop their consumer perspective and to use their own consumer experience to draw attention to the way that language is used, biases developed and maintained and the like. They are then able to facilitate learning groups with service
providers, drawing out the politics and engaging in what the authors call ‘an unusual subversion.’ Process is central to this practice and debriefing of facilitators is as crucial as the initial training.

- Deep dialogue
  - In the Lemon Tree project, two facilitators (one female, one male) worked with four staff members and four consumers in four six-weekly meetings of one-and-a-quarter hours each. The learning exchange emerged from the less structured (agendaless) opportunity provided for people to speak together in a way that they came to know each other as more than ‘just another nurse/consumer.’ The principle of deep dialogue is to provide the grounds for culture change.

**Root learning**

This process is necessary where there has been little infrastructure to support consumer participation. The Lemon Tree project describes incremental developments from small regular meetings to documenting needs through to gaining funding for staff-consumer consultants. Root learning is needed both within an organisation and with other allied organisations. ‘Root work learning is crucial. It is about developing the trust and the relationships within which “consumer perspective” is glimpsed or experienced as real and valuable’ (p84).

**The Trunk of Learning**

The Lemon Tree project draws on the earlier project ‘Understanding and Involvement’ (1992–1996). The principles common to both projects are elaborated:

1. A quality assurance/improvement framework.
2. Not just consumer feedback, but also staff-consumer communication.
3. Comprehensive and systematic change.
4. Robust and built in consumer participation process.
5. An emphasis on culture change.
6. Multiple feedback and communications mechanisms.
7. Three crucial conceptual sites for participation—decision-making sites, consumer-only sites, decision-free exchange sites.
8. The missing fourth site—support and organisational resource structure for staff.
9. Involvement of all levels of relevant organisations.
10. Centered on acute unit and other high-risk settings.
11. Consumers as staff.
12. Consumer support structures.
13. Consumer driven and staff collaborative.

**Examples of other education strategies**

**Lemon Looning board game**

This board game is designed to be played by up to six players and led by two paid consumers. The aim of the game is for all players to reach the ‘Path to Well-being’, however as they attempt to play a range of events and obstacles are experienced. The game gives players the opportunity to discuss the range of meaning and perspectives behind different squares and cards in the game. Bold or subtle differences between the perspectives of consumers and those of service providers emerge. Consumer facilitators are trained in using the game.
Story telling as parables of practice

Stories of personal experience can provide a birds-eye view of some of the contemporary health care practices, however there is a danger that stories can be seen as 'entertainment' only. This project shows how stories can be used in large or small groups as effective learning opportunities rather than one-off party tricks.

SOURCE


Copies are available for $12 (1997 price) from the Victorian Mental Illness Awareness Council (VMIAC), 23 Weston St, Brunswick, VIC, 3056, ph: (03) 9387 8317.
These three volumes, plus the supplementary Orientation and Job Manual, are the result of a three-year project undertaken by the Victorian Mental Illness Awareness Council, funded by the Victorian Health Promotion Foundation. The project was located primarily at the Royal Park (now Royal Melbourne) Hospital, although experiences examined arose from a range of acute psychiatric hospitals. Although this is not a training or education kit, it provides a valuable description, analysis and position on the challenges of system change when the mutual learning of consumers and service providers is facilitated.

In the first year, the Understanding and Involvement (U & I) project sought the views of over 60 consumers, staff and others regarding possible process and methods by which to build in consumer evaluation. In the second year, a staff input survey regarding the questions they would like to put to consumers generated more than 1,400 questions. To overcome emerging barriers, the project team successfully ‘initiated the use of ex-consumers as consultants to catalyse a range of activities designed to both seek consumers feedback and engage with staff in discussion of this feedback and its implications for practice’ (1996b, p2). A wide range of activities were developed, all aiming to increase ‘deep dialogue’ and resultant improved service delivery, with both organisational and culture change emerging.

**Volume 1: A Project’s Beginning**

This 88-page report documents ‘the beginnings of a dialogue about what might be methods or mechanisms for seeking consumers’ evaluative feedback’ (1996b, p1). It explores the culture of service delivery and the context of the project, through a series of discussion papers. Both the voices of consumers and staff are effectively integrated throughout the document.

- Part one: About this Study, explains the project principles, ethics, methodology and design.
- Part two: Responses to ‘Understanding Anytime’, relates the project to prior work.
• Part three: ‘Mechanisms’ for consumer evaluation, provides detailed explanations of:
  — community ward meetings;
  — complaints procedures;
  — interpersonal information, sensitive conversations between consumers and staff;
  — end-of-stay reviews;
  — spot surveys;
  — personal care plans;
  — involvement of former patients; and
  — advocates.
• Part four: Cultural Context of Consumer Evaluation, utilises consumer and staff stories to explore the culture and dynamics of the care setting.

**Volume 2: A Project Unfolds**

In this 232-page volume, the story of the U & I project is continued. This volume documents a range of issues that needed to be addressed as the consumer feedback methods were trialed. Major topics include the further development of:

• quality assurance;
• using monthly bulletins as intervention;
• spot surveys (ethics and consent);
• consumer consultants group (development and issues);
• ward meetings (second round);
• end-of-stay reviews (analysis and improvement);
• consumers case stories of using services and change);
• group discussion (trial results);
• suggestion box (successes and limitations);
• consumer involvement in treatment plans (a dialogue approach);
• sensitive interpersonal/conversational exchange (looking for language that heals and strengthens rather than shames);
• complaints procedures (trial methods and results);
• approaches to advocacy);
• consumers as part of management structures (challenges and potential); and
• consumer input to staff training (trial methods and results).

**Volume 3: A Project Concludes**

The 200-page book that concludes the U & I project documents the comprehensive model for building in consumer evaluation within psychiatric acute care services. As with each of the other volumes there is an effective mixture of direct quotes from consumers and staff, examples of project material and description and analysis of the project process.

The sections of this volume include:

• discussion of moving from consumer feedback to communication about that input;
• shaping the model and seeking funding;
• putting the theory to the test;
• the culture of acute psychiatric hospital practice;
• an elaboration of the multilevel model; and
• implications of the project, reflection and future prospects.

**Good practice**

• Practice and theory are both explained in an accessible manner.
• The politics of organisational and individual learning and change are apparent.
• The integration of personal responses and stories enable immediate learning for the reader as well as adding strong impact and reality.
• Both staff and consumer challenges are included.
• Wide range of presentation methods—ranging from actual proforma examples, process description to further reading and theory.
• Narrative style enables the whole of the project experience to be clear, however it is left to the reader to determine which are the transferable issues for other sectors.
• Has the potential for self-directed learning by the reader and/or providing sections that could be used as material for training courses for consumers and/or staff.

One of the strengths of the U & I reports is that they combine practice, theory, individual experience, personal responses, system responses and project narrative and process description in a creative way. However this is also one of the limitations. To gain maximum value from this project, it is necessary to first immerse oneself in the multiple realities presented by the project team. It is necessary to read the ‘story’ from start to finish. Only then is it possible to step back and harvest the learnings that may be relevant to other health service settings. As the project is written in a clear style, it is not hard to read from volumes one to three but as there are many sensitive and often confronting issues throughout the project, time will be the key factor.

**SOURCE**


Copies of these volumes are available for $15 (each, 1997 price) from the Victorian Mental Illness Awareness Council, 23 Weston Street, Brunswick, VIC, 3156, ph: (03) 9387 8317.
The Junction Youth Health Service, Australian Capital Territory

**HIGHLIGHTS**

- Commitment to the principle of client-driven decision-making.
- A multidisciplinary, team-based approach to the provision of health care services.
- Shows how education and training can be built in to everyday activities in an informal, yet deliberate way.

**FOR REFLECTION**

- In a situation where formal education and training activities are likely to dampen enthusiasm, how can knowledge, skills and attitudes be developed in less formal ways?

**KEY WORDS**

Empowerment, self-determination, informal learning, multidisciplinary.

The Junction Youth Health Service has a high and successful level of consumer participation in all levels of the health service and yet there has been no formal education to support consumer participation in the service. The service’s success comes from a deeply-held philosophy that consumers have a key role in service development at all levels, and that central part of the service is to use informal strategies to increase consumers’ skill, knowledge and attitudes to maximise this involvement.

The following excerpts, taken from The Junction Youth Health Service—Evaluation (1999) and The Junction policy documents, explain the service and illustrate the philosophy and practices that underpin their approach.

**Service description**

The Junction is a youth health service targeting homeless and otherwise at risk young people. The Junction project commenced in January 1998 and the pilot is due for completion on 31 December 1999. During this time it was proposed to design, develop, deliver and evaluate a flexible multidisciplinary [brokerage] approach to the provision of health and support services, for young people in the ACT. The pilot is funded through the ACT Department of Health and Community Care and auspiced by the Youth Coalition of the ACT.

The Junction is committed to ensuring activities are consistent with the Ottawa Charter and Jakarta Declarations on health promotion and a social justice agenda for young people. They have developed an extensive service philosophy, much of which focuses on consumer participation. (Other issues of philosophy include: access and equity, equality of rights, cooperation and advocacy.)
Staff have developed an agreed way of working; this is particularly important as staff from a number of agencies provide service through The Junction. The most relevant sections of the document are selected below.

<table>
<thead>
<tr>
<th>Service philosophy</th>
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<tbody>
<tr>
<td>Consultation</td>
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<tr>
<td>Young people have the right to be involved in decisions, which effect them personally, communally, socially, environmentally and politically. Responsibility for the effectiveness of consultative processes rests with those in decision-making positions. For The Junction, this means strategies and processes need to be developed to encourage feedback from young people, and to involve young people in service and project evaluation, a consumer forum, and to resource two young people on The Junction Steering Committee. Additionally, The Junction is committed to the principles of client driven practice, and will actively strive to be directed and driven by the thoughts, opinions, needs and experiences of the target group, and young people using the service.</td>
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<tr>
<th>Empowerment</th>
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<tr>
<td>Young people often experience disempowerment through a range of social processes, which operate in opposition to the concept of social justice. The Junction is committed to facilitating the empowerment, agency and self-determination of young people.</td>
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In the evaluation, the following comments were made about the orientation of staff to a reoriented consumer-centred approach

**Agreed Ways of Working**

The Junction Youth Health Service is unusual in that it exists as an environment in which health and support professionals from a range of services are able to work together in accessing homeless or otherwise marginalised or at risk young people. This document outlines the spirit in which we will work with young people using The Junction. Having an Agreed Way of Working will hopefully assist us in developing a culture which is consistent and empowering for young people and workers!!! ...

- In regards to Choice—The Junction Youth Health Service is concerned with enabling young people to make informed choices and decisions about their lives. Broadening a young persons range of options, and the possible consequences of those options is fundamental to the notion and practice of young people gaining more personal power. The Junction Youth Health Service respects the right of young people to make choices about who they work with.

- In regards to Control—Young people must feel and be in control of any processes they are a part of at The Junction. Our job to provide information, explore options, express concerns, provide services, resources and referrals, but ultimately, it is the young person who is in control of the process. Our actions as workers are guided by a desire to act as a resource and support for young people in negotiating issues, problems, structures and services in their lives. Regardless of what we as workers think or feel is the most appropriate option or choice, our role is to resource young people to make their own informed decisions.

- In regards to Respect—The diversity of skills and experience of workers participating in The Junction is a great strength. Respect and acknowledgment of the differing but equally important roles of each worker is an essential aspect of providing coordinated, wholistic and effective health services and supports to young people using The Junction. Activities at The Junction are underpinned by a profound respect for the young people using the service, and respect for the choices and decisions that young people make about their lives.

**Key Features for Staff of the Service Approach**

... people commented on being involved from the very beginning and working together to establish the service. Some team members commented on team building and others spoke about the importance of team meeting time, particularly in a co-location service. Participants discussed the culture of the service and spoke about a very positive atmosphere and a culture of ongoing checking with each other. It should be noted that all participants highlighted the informal nature of many of the processes that took place, which somehow just continued to happen.

... Workers said that agreed ways of working gave clarity to how different roles could work together. An example of this was cited during consultation. The different roles of doctors and support workers in regards to confidentiality was highlighted. After unpacking the issues involved, both medical and support workers were surprised at how easy it was to actually come to an agreement about how to work. The common theme, which it was felt made this possible, was ‘what the young person wanted.’ (emphasis added)
The young people are given a Client Information Kit when they first attend. This kit gives them information on all services and the ways that they as consumers can be involved. The following excerpts from the Rights and Responsibilities document show the orientation of the service.

### The Junction: Rights and Responsibilities

#### Participation

<table>
<thead>
<tr>
<th>RIGHT</th>
<th>RESPONSIBILITY</th>
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<tbody>
<tr>
<td>You have the right to participate in decisions about your life</td>
<td>You are responsible for your own decisions</td>
</tr>
<tr>
<td>While at The Junction you will be encouraged to make your own decisions and be supported to follow them through. The workers are here to assist you but not to pressure you to go in a particular direction.</td>
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<table>
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<tr>
<th>RIGHT</th>
<th>RESPONSIBILITY</th>
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</thead>
<tbody>
<tr>
<td>You have a right to a say in how the service is run</td>
<td>Improving the service is everyone’s responsibility and your contribution is valued</td>
</tr>
<tr>
<td>The Junction has a way for you to make suggestions and be involved in the running of the service. The workers will encourage you to get involved and to share your ideas about how to improve The Junction.</td>
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</tbody>
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<tr>
<th>RIGHT</th>
<th>RESPONSIBILITY</th>
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</thead>
<tbody>
<tr>
<td>You have a right to make a complaint if you are not happy with something that has happened here</td>
<td>Everyone involved has the responsibility to seek a fair resolution to a complaint</td>
</tr>
<tr>
<td>The Junction will deal with all complaints fairly and quickly. Making a complaint will not be held against you now or in the future. The workers will explain how to make a complaint and how you can use an advocate to help you if you wish.</td>
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Although The Junction does have two young people on the Steering Committee, they primarily involve the young people in service development through opportunistic, informal strategies. Again the evaluation report highlighted the effective consultation and participation involved.

#### Consultation strategies

Young people at The Junction have a number of opportunities to have input into how The Junction operates and to provide feedback on the services they receive ... Young people are encouraged to have a say. There is a blackboard in the foyer, the arts space and materials can be used to provide creative feedback, workers provide the opportunity for feedback after group activities and there are the more formal processes, such as focus groups, needs assessments, complaints forms, advisory committee participation and client feedback forms.

One essential aspect of participation was that the young people themselves were able to recognise that their feedback made a difference.
For Steering Committee representatives there is a standard but informal process of briefing, debriefing and re-briefing. For example: Pre-meeting preparation includes an informal chat (with well-planned essential points thought out ahead by staff member) explaining meeting processes, usual practices, what to expect, the personalities and roles of who attends and what their agenda is, valuing the young persons role and emphasising they can make a difference ‘you are the expert!’

The Consumer Reference Groups, which are held whenever a group of young people are interested and available, utilise a process of learning through modelling. The workers, not the young people, are trained to maximise all opportunities to increase young person’s skill in participating, modelling how to handle group dynamics and to validate all input from young people.

Because the key first step in staff education was to develop agreed ways of working with young people, skilling up young people was seen as core business. Staff adapt to the young people’s framework, rather than expecting the young person to adapt to staff system. Staff focus on creating a culture of rights and a robust philosophy for work with young people—this is your service, you can lead with ideas. This philosophy is adopted across the whole service through a coordinator who models a similar philosophy with the staff by working with her staff in a congruent consultative way.

**SOURCE**

Further information can be obtained from the Coordinator, The Junction Youth Health Service, ph: (02) 6247 5567.

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**Young people’s responses**

- We made the suggestion box.
- We got Joscelyn to work more hours because we said she was a good doctor and more people needed her.
- We were on the reference group (steering committee).
- Food, decorations, music, data system.
- We have a say.
- We informally approved of the last staff member being employed.

**Informal education strategies**

The staff support the development of the young people’s skills and confidence in all aspects of their service so that there is no need to select out any specific skills for improved consumer participation. These are the same skills that young people require in all aspects of their life. Staff have an opportunistic approach to education—whenever young people are open to a discussion either individually or in a group, staff are trained to maximise this educational opening.
This case study provides a British example of partnership development using a network model so that the members of the network share ideas and experience and offer support to each other in bringing about cultural change from a traditional provider dominated approach to one focussed on consumer needs. This transformation also empowered nursing staff and other staff involved in this development. A key feature is the role that the Division of Nursing in King’s College, London played in this project in partnership with the Centre for Mental Health Services Development.

The project arose as a result of growing concern by both consumers and staff alike about the quality of acute in-patient mental health care. There had been growing interest among policy makers, consumers, administrators, and senior clinicians in the prospect of establishing community mental health services as alternatives to hospital care. In addition, there was growing evidence of drug and alcohol abuse and a general increase in violence which had been putting great stress on nursing staff in particular who were feeling increasingly demoralised and disempowered. The former system was clearly breaking down with evidence of decreasing quality, a lack of clarity about the purpose of admission to a hospital, concerns about staff skills, and with growing community dissatisfaction.

It was decided therefore to develop a community mental health system as an alternative to the former failed approach. The new approach would be based on partnership principles, collaboration, and empowerment.

The aims of the new Mental Health Network were to support practical, evidence-based care in mental health acute in-patient settings, and to change the former culture of in-patient care to a more user-focussed model. A key objective is to engage consumers and staff at all levels in identifying priorities for change, as well as to contribute to the development, evaluation and dissemination of best practice. In this way the development of the Network aimed to empower and support nursing staff (and other staff involved), in providing modern in-patient care while also mobilising community resources so that consumers were active partners in this systemic change. The Network also aimed to raise the profile and status in the community of good quality in-patient care.
The approach adopted with the active involvement of all stakeholders in all phases of development meant that implementation of the new approach became an exercise in experiential learning. A number of activities were built into the implementation process to enhance the educational value of this experience for all partners.

Mental Health Trusts throughout England and Scotland were invited to join the Network in the autumn of 1998. Twenty Trusts joined in the first wave of membership giving the Network a coverage from Aberdeen in Scotland to Cornwall. This membership brought in 73 development wards with 1,600 nurses. The 1,626 beds represented about 11 per cent of the short stay beds for adults. This meant that the Network was large enough to make an impact on the culture of acute in-patient care.

A two-year development process was inaugurated for the Network and the first Network conference was held in London in January 1999 with all member Trusts represented. The conference brought together nursing staff, consumers, managers, and psychiatrists. It was clear from the conference that there was a consensus across the Network on the seriousness of the problems and the need for change.

There are a number of elements to the Network. These include: change management support, Network conferences, opportunities for senior nursing staff to develop skills in change management and evaluation support through an action research approach. Action research is similar to action learning (which is discussed in part 5 of this guide) but extends the investigation aspect of selected activities. However, it still involves learning through undertaking practical activities with research findings being an outcome.

There is a formal launch for the Network in each Trust area so that the full range of stakeholders are involved and become participants in the process of diagnosing concerns and devising priorities for change.

This process of consultation and discussion has led to the emergence of a number of common themes and issues. These include: the need for a more meaningful day for in-patients in terms of both social and recreational opportunities, as well as more therapeutic treatment options; the need for more empowerment in the provision of this service; and the need for closer integration between community teams and in-patient units in order to improve procedures for patients. In these ways the development of the Network is contributing to improved quality of service for patients and greater satisfaction for the staff involved in this service. The shift of power from bureaucratic processes to more consultative and democratic arrangements is a key aspect of the changes.

Care is being taken to obtain quality feedback from stakeholders. Nursing staff members are asked to complete confidential questionnaires as are current in-patients. The information collected is fed back in a confidential format to each Trust to provide further quality information to assist in steering the change process.

Following the activities of the start-up phase, each of the Trusts in the Network decides on a change project. These projects are usually based on information obtained from the local launch and from the staff and patient questionnaires. In progressing these partnerships beyond the ‘coming together’ phase, the projects serve a similar function to the task forces which were used in Healthy Cities Illawarra development (CO7 case study).

The Network aims to support staff in trying out new ideas in improving the quality of service. While the Network has only been in operation for a short period, it is already clear that both staff and consumers have similar ideas about what a service should provide.

The Centre for Mental Health Services Development has been a key player in this development and has been supporting strategic change in mental health services for
eight years. The philosophy of the centre is built around an acceptance that successful change requires engagement of both staff and consumers, as well as that of senior managers and senior clinicians. Hence partnership strategies are essential in bringing about change.

The Centre is currently setting up a web site on its work and holds open conferences every six months directed at developing best practice in acute in-patient care.

The Network strategy adopted in this case can be seen as building a learning community. The members of the Network interact and share ideas and experience through the regular conferences and through informal ongoing contacts. All members of the Network benefit through sharing ideas and experience so that a pool of successful strategies is built up.

This case study shows that the members of a learning community do not need to be located in the same area to form such a community. Modern technologies such as email, videoconferencing, and teleconferencing are making the development of such communities of practice increasingly feasible. With advances in modern information and communication technologies it is likely that virtual learning communities will become increasingly common. A key requirement is leadership to bring stakeholders together in this process of developing a shared vision and commitment to improved quality of service.

SOURCE

Further information can be obtained from Ms Liz Kurtz, Practice Development Administrator and Ms Penny West, Project Manager of the Practice Development Network. Both can be contacted on ph: +44 171 633 0241.
The examples in this Resource Guide provide examples of much creative innovation in which consumers and providers have sought, through education and training, to address the challenge of the new environment of health systems. We hope that this Resource Guide will be a dynamic product that is regularly up-dated as consumers and health service providers together forge new and effective ways of working together.
4.1 **THE RESOURCES**

While the examples cited in the guide could be added to, they offer a typical range of examples of good practice in the implementation of a broad spectrum of education, training, and learning strategies. As far as possible we have used the language of each resource as each resource has a particular approach to consumers, service providers and education. Examples are given in the resources of effective strategies that address each of these areas of need:

- **Orientation and information needs.** A diverse range of strategies has been adopted including special orientation programs, courses, discussion groups, newsletters, workshops and forums.

- **Skill needs.** Similar methods to those adopted in meeting orientation and information needs are common with methods such as courses, seminars, and workshops often used. However, a major trend is the growing use of informal self-directed learning and team learning through strategies such as action learning.

- **Values and attitude change.** Strategies are typically based on mutual and continuous learning and may include ambitious change programs aimed at fostering values and systems that underpin and support collaboration and partnership.

- **Systemic change and partnership.** Community development strategies, learning communities and Learning Cities, learning organisations, and Healthy Cities strategies have been used to address these objectives.

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**Education and Training for Consumer & Provider Collaboration in Health Services**

![Diagram of Education and Training for Consumer & Provider Collaboration in Health Services]

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4.2 CROSS-REFERENCING THE RESOURCES

The MELT model which has underpinned development of the Resource Guide for the Education and Training for Consumer Participation in Health Care project contains four groupings of activities on the continuum from Involvement to Partnership. The groupings are referenced in the following table.

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<td>Resource ID</td>
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<td>Community Consultation and Participation Resource Kit for Area Health Service Managers and Project Leaders</td>
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<td>Consumer Feedback and Staff-Consumer Communication, Consumer Participation Program: Orientation and Job Manual Staff-consumer consultants in mental health services</td>
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<td>Developing Effective Consumer Participation in Mental Health Services: the Report of the Lemon Tree Learning Project</td>
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<td>Rural Health Training Unit, South Australia</td>
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<td>The Preparing the Ground for Healthy Communities Manual</td>
<td>Rural Health Training Unit, South Australia</td>
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<td>R30</td>
<td>Working together to improve health: a team handbook</td>
<td>University of Queensland Primary Health Care Reference Centre</td>
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<td>R31</td>
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<td>A Guide to Participation by Older Victorians</td>
<td>Aged Care Branch, Department of Human Services, Victoria</td>
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<td>R38</td>
<td>Bringing in the Voice of the Consumer: A Practical Guide to Consumer Participation</td>
<td>Adelaide Women’s and Children’s Hospital</td>
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CONSUMER REPRESENTATIVES HANDBOOK

Australian Consumers’ Council

Key features

- A generic handbook for community and consumer representatives in any circumstance. It does not just target health.
- Considers the responsibilities and rights of consumer representatives as well as the likely barriers that might be encountered.
- Provides some basic information and skills training in meeting procedures.

Overview

This handbook is divided into three parts:

- a look at consumer representation and some of the issues likely to be encountered;
- some specific skills training on participating in a meeting, including a self-assessment section; and
- resource materials on consumer rights, committee functioning, and related topics.

Good practice

- Provides basic information easily set out and readable.
- The section on self-assessment of performance as a consumer representative is very useful.

SOURCE


This handbook is available from Secretariat, Australian Consumers’ Council, Federal Bureau of Consumer Affairs, GPO Box 9839, Canberra, ACT 2601, ph: (02) 6273 3515.
PRIORITIES IN HEALTH: ENCOURAGING THE DEBATE

Hospital and Health Services Association of South Australia

Key features

- A project report of a South Australian activity where community and consumer debate on health spending was initiated by providing an information kit and conducting a series of focus group discussions.
- Funded by South Australian Health Commission and managed by the Hospital and Health Services Association of South Australia on behalf of a consortium of health organisations.
- An example of participative learning.

Overview

- An example of participative learning based on community debate following provision of information to the group.
- The Hospital and Health Services Association of South Australia produced the kit of information.
- Focus groups were drawn from community networks.
- Issues debated include health/illness concepts, the health system, and factors affecting health priority setting.
- Evaluation indicated the kit was well received as a source of information, and assisted participants in the debate process.
- A sample of the kit information is provided in the report.

Good practice

- Example of how consumer representatives can be informed and prepared for engagement with participative debate processes.
- The process was evaluated.

SOURCE

Hospital and Health Services Association of South Australia 1995, Priorities in Health: encouraging the debate.

This report was produced by Anne Barrey of the Hospital and Health Services Association of South Australia, ph: (08) 8364 3808.
CONSUMER REPRESENTATIVES SKILLS TRAINING (PILOT PROGRAM)

Consumer Health Advocacy

Key features
- A report of a pilot program undertaken by Consumer Health Advocacy in Queensland, providing a model for development elsewhere.
- Researches the training needs of the consumer and community representatives.
- A two-day program designed for consumers.
- Draws on other training material in its development.

Overview
Designed to be delivered at a workshop and contains the following material:
- The Role of the Consumer Representatives; builds on the experiences of the consumer, introduces concepts of levels of consumer participation and also provides information on the Queensland Health System;
- Communication Skills; provides some basic information on processes;
- Committee dynamics; looks at group dynamics as well as input to meeting procedure;
- Negotiation and Conflict Resolution; provides some skills training in this area; and
- Course Evaluation; results are reported including the participants comments.

Good practice
- Program was developed as a result of an educational needs analysis of potential users.
- An evaluation was incorporated into the course
- The workshop also identified ongoing training needs of the group

SOURCE
Consumer Health Advocacy 1996, Consumer Representatives Skills Training (pilot program), Queensland.
This program was produced by Irene Opper from Consumer Health Advocacy, which is no longer funded.
A copy of this program was obtained from Health Improvement Branch, New South Wales Health, Locked Mail Bag 961, North Sydney, NSW, 2059, ph: (02) 9391 9399.
WORKING WITH CONSUMERS: A GUIDE FOR DIVISIONS OF GENERAL PRACTICE

Consumers' Health Forum of Australia

Key features
The guide describes the many ways in which Divisions of General Practice can work more closely with consumers. It gives a rationale for working with consumers, addresses the question ‘who are consumers?’ and gives practical advice ranging from how to communicate with consumers to how to work together to how to evaluate the effectiveness of consultation.

Overview
The need for the guide became apparent when Divisions of General Practice asked the Consumers’ Health Forum for easily accessible advice on how to work more effectively with consumers. Consumers’ Health Forum General Practice project staff reported that the two most commonly asked questions were, ‘How do I involve consumers?’ and ‘Where do I find consumers?’ These and other questions, such as ‘Why work with consumers?’ are addressed in the guide.

The guide is directed at Division Executive Directors, Community/Consumer Liaison Officers, Project Managers and Management Committees. It is written so as to be useful to Divisions which have only just begun to involve consumers as well as to those which are interested in involving consumers in activities that are more integral to divisional functioning, such as strategic planning, evaluation and management.

Good practice
• Through the use of rhetorical questions, case studies and illustrations the guide presents its messages very clearly.
• It is evident that the client group has been closely consulted.
• A feedback proforma is included.

SOURCE
Consumers’ Health Forum of Australia, PO Box 52, Lyons, ACT, 2606, ph: (02) 6281 0811.
THE AUSTRALIAN HEALTH CONSUMER
Consumers’ Health Forum of Australia

Key features
This journal, published three times a year by the Consumers’ Health Forum provides an overview of news and activities relating to consumer health issues. It also contains a number of informative articles concerning a range of current health topics to assist consumers.

Overview
The journal covers a wide range of health issues taking place in Australia, with particular orientation towards consumers.

It is designed to assist consumers to develop knowledge and understandings of government policies, health initiatives, and to present discussions of medical advancements and procedures.

It is written in a clear and concise style, in a ‘user friendly’ manner.

Good practice
The information presented in this journal makes it an invaluable resource for all health consumers.

SOURCE
Consumers’ Health Forum of Australia, PO Box 52, Lyons, ACT, 2606, ph: (02) 6281 0811.
WORKSHOP FOR CONSUMER LIAISON OFFICERS AND CONSUMERS WORKING WITH DIVISIONS OF GENERAL PRACTICE

Consumers’ Health Forum of Australia

Key features

- The workshop was to enable consumers and Consumer Liaison Officers (CLOs) to share experiences and learn from and examine the successes and failures of consumers and Divisions of General Practice working with each other.
- An example of a workshop enhancing the knowledge base of consumers and CLOs and to facilitate group learning.

Overview

The workshop, facilitated by an experienced consumer representative, covered the following:

- brief introduction and information sharing from participants about the activities in Divisions of General Practice;
- identification of key issues explored by small group activities. The key issues included the general practice culture, structures and processes for consumer liaison, consumer issues and support for CLOs;
- information on future directions in general practice, including outcome based funding, accreditation and state based organisations;
- information on evaluation followed by small group work on the application of the learning on the ‘evaluation trail’; and
- support needs of CLOs and consumers with potential solutions were identified and explored through small group work.

Good practice

- An example of a workshop as a training method, bringing consumers and consumer advocates together to define joint needs and explore some solutions.
- A means to impart important knowledge and information to the group.
- As it was attended only by the consumers working with Divisions of General Practice and not general practitioners, the group learning was limited to only one side of the partnership.
- This meant that the second objective of the workshop, to examine the successes and failures of consumers and divisions of general practice working with each other, was more difficult to achieve.

SOURCE


Consumers’ Health Forum of Australia, PO Box 52, Lyons, ACT, 2606, ph: (02) 6281 0811.
Department of Community and Health Services, Tasmania

Key features
• An example of a resource manual for Health Department staff which includes some information on community/consumer consultation of change management.
• It provides an example of how community consultation can be included in other mainstream training programs for health staff.

Overview
• Provides a practical approach to managing change in an organisation.
• Describes a theoretical framework for considering change and the five key elements of leadership, planning, communication, participation and staff support.
• Introduces concepts around the nature of change and the types of change that might be expected.
• Attachments to the manual outline project management pathways, stakeholder analysis, risk management, problem solving and communication strategy.
• The sections on communication and stakeholder analysis relate most to training for consumer participation.

Good practice
• Provides an example of how the concepts of consumer participation can be taught within a broader framework of change management.
• Highlights the overlap between many of the good practices of change management and of consumer participation.
• Provides a range of simple tools and checklists that can be easily used in the workplace.

SOURCE
This handbook is available from Ms Helene Delaney, Department of Community and Health Services, GPO Box 125B, Hobart, TAS, 7001, ph: (03) 6233 3247.
LEARNING TOGETHER: EDUCATION AND TRAINING PARTNERSHIPS IN MENTAL HEALTH

Deakin Human Services Australia

Key features

• This report provides guidelines, information and resources for all associated with the field of mental health. It is particularly relevant and pertinent to the teaching of mental health educators, the training plans of workplace trainers, and the day-to-day practice of practitioners in all mental health services.

• The project was commissioned to advise on future directions for education and training in the field of mental health. The key issue was of the need for change, with the emphasis on the needs and rights of consumers and carers.

Overview

• The report outlines the over-arching principles developed during a series of workshops; it also contains a number of chapters consisting of input from consumers, carers, and representatives of the five most relevant disciplines, mental health, occupational therapy, psychiatry, psychology, and social work.

• It is a resource which will assist in the future planning of mental health education, training, consumer/carer partnerships, workforce supply and service delivery structure.

• It also contains a number of appendices ranging through a national audit of mental health, a curriculum for a fellowship in psychiatry, the future roles and training of mental health staff, and a bibliography and list of resources.

Good practice

The following is given as a statement of principle:

The relationships between consumers and service providers and carers and service providers, should be the primary focus in practice and research in mental health. Consumers and carers are therefore major players in the education, training, and development of the mental health workforce.

SOURCE


Deakin Human Services Australia, Deakin University, 336 Glenferrie Road, Malvern, VIC, 3144, ph: (03) 9244 5266.
INVARING CONSUMERS IN IMPROVING HOSPITAL CARE: LESSONS FROM AUSTRALIAN HOSPITALS

Mary Draper

Key features

- This report analyses what makes consumer partnership work in hospitals.
- It outlines the context, discusses research methods and results, notes some hospital attempts to use its findings, and offers a set of conclusions.

Overview

- The premise is that not only do consumers have a democratic right to exercise a voice about their health treatment and services, but also that listening is an effective way for hospitals to get good information about what needs to be done to improve the quality of their services.
- A list of 15 lessons learned with regard to effective consumer participation forms part of the text.
- A list of resources, including publications, consumer organisations, and information on patient surveys is given.

Good practice

- Hospitals involving consumers in improving hospital care need to be clear about the purpose.
- The role of consumer representatives needs continual clarification. Representatives need to represent not just their own, but the needs of consumers as a whole, and to be accountable for the positions they take.

SOURCE

WORKING WITH COMMUNITY COUNCILS:
A TRAINING PACKAGE FOR HEALTH SERVICE MANAGERS

Far West Area Health Services, New South Wales Health

Key features
- A training package for health service managers in the NSW Far West Region.
- Aligned to the Health Council orientation package for members of Health Councils and supports the role and work of Health Councils.
- Provides managers with information on effective use of the package.

Overview
- Aims to clarify the role of Health Councils and that of health service managers in supporting the work of Health Councils.
- Developed following consultations with managers. Consultations included a questionnaire directed at identifying training needs.
- Includes guidelines and practical examples of good practice and proformas that could be used by managers.
- A number of proformas have been included in the package as a guide to publications that could assist Health Councils.
- Comprises of an implementation manual providing background information and a computer disk with examples, proformas, press releases, letters, and guidelines for Health Council members.

Good practice
The alignment of training for health service managers with orientation provision for Health Council members contributes to clarifying the role of Councils and enables managers to be clear on their role.

The training program facilitated much informal learning and enabled managers to exchange ideas and experience on the implementation of the new arrangements.

SOURCE
Far West Area Health Services, NSW Health 1997, Working with Community Councils: A Training package for Health Service Managers, Rural Health Support Training Program 96/97 RH Grant 423.

Further information can be obtained from Ms Marg O’Malley, Population Health Unit, Far West Area Health Service, PO Box 457, Broken Hill, NSW, 2880, ph: (08) 8080 1218, email: momalleyfwhs@doh.health.nsw.gov.au


This package is available from the Community Relations Department, New South Wales Health, Locked Mail Bag 961, North Sydney, NSW, 2059, ph: (02) 9391 9815, fax: (02) 9391 9580, email: lmcmn@health.nsw.gov.au
HANDBOOK FOR DISTRICT HEALTH FORUMS

Department of Health, Tasmania

Key features
- A handbook was developed for District Health Forums when they were first formed in Tasmania. Community Consultation groups have now superseded them.
- Material is used from other states, including Victoria and South Australia.

Overview
- Sets out the underlying principles of community participation and the justification for the formation of the Health Forums.
- Sets out the roles and responsibilities of members of the forum as well as staff of the Department of Health that liaise with the forums.
- Guidelines are provided for the forums with particular emphasis on the legislative and administrative requirements.
- Information is provided on support and resources available to the forums with an emphasis on funding resources.
- Outlines the working relationships of the Health Forums with other stakeholders.
- Operational functions of the forum are also outlined, including strategic planning, media liaison and evaluation.

Good practice
- Sets out Department of Health expectations of Health Forums.
- While the information provided is valuable, it could be argued that it is prescriptive and does not address the principles of adult learning, and of the shift in partnership development behaviour that has occurred.

SOURCE
Department of Health Tasmania 1992, Handbook for District Health Forums
This handbook is available from Ms Helene Delaney, Department of Community and Health Services, GPO Box 125B, Hobart, Tasmania, 7001, ph: (03) 6233 3247.
PARTNERSHIP FRAMEWORK

Department of Community and Health Services, Tasmania

Key features

- A document produced by the Tasmanian Department of Health to develop staff thinking and activities around partnership development. The potential partners are both internal and external and include consumers or the community.
- An example of introducing the concept of consumer participation within the broader context of a general partnership framework.

Overview

- Theoretical discussion on the meaning of partnership, and a justification for a partnership approach.
- Some of the underlying elements of partnership such as trust, respect, commitment, longevity, equality, equity, and legal agreements are discussed.
- Phases of partnership development are suggested, think, explore, build and progress.
- Key elements of the partnership framework are outlined vision, key objectives, underlying principles, structural arrangements, supporting business processes and action plan for next steps.
- A checklist of criteria for partnership and partnership planning and a proforma agreement is given.
- Some case studies illustrate the framework in a practical way.

Good practice

- A good theoretical framework for partnership development. It addresses some of the difficulties, particularly from a departmental point of view.
- Provides a simple step-by-step model for partnership development.
- Provides useful tools and checklists.

SOURCE

Department of Community Health and Services Tasmania 1999, Partnership Framework

This handbook is available from Ms Helene Delaney, Department of Community and Health Services, GPO Box 125B, Hobart, Tasmania, 7001, ph: (03) 6233 3247.
HEALTH COUNCILS: REPORT OF THE COMMUNITY CONSULTATIONS AND RECOMMENDATIONS

Mid Western Area Health Service, New South Wales Health

Key features

- This report details recommendations on the formation of Health Councils in the Mid Western Area Health Service of New South Wales. The main vehicle for consumer representation for health care decision-making in the region. The recommendations came from a process of community participation.
- A section details the recommendations for education and training of Health Councils.

Overview

The recommendations include a statement that Health Councils themselves must be in control of and define their own training, identified as:

- orientation training for both consumers and health staff;
- understanding and defining the roles and responsibilities of members of councils;
- further training of councils would be determined according to the skills and knowledge gaps that the groups identified; and
- noted that training needed to occur on-site and early in the life of the council.

Good practice

This report highlights important adult education principles of:

- allowing the learner to take responsibility for learning and then direct it;
- meeting the learning needs of the trainee as defined by the trainee; and
- making clear that education and training of all parties in a partnership development process should be planned.

The report also describes how the Health Council partnership model must be jointly developed by the partners at all stages.

SOURCE

Mid Western Area Health Service 1997, Health Councils: report of the community consultations and recommendations.

This report is available from Ms Marion Wilson, Mid Western Area Health Service, Bloomfield Hospital, Orange, NSW, 2800, ph: (02) 6360 7709.
STRENGTHENING HEALTH PARTNERSHIPS IN YOUR RURAL COMMUNITY: NATIONAL RURAL PUBLIC HEALTH FORUM WORKSHOP REPORTS AND COMMUNIQUÉ

National Rural Health Alliance

Key features
This resource details workshop reports from a national rural Health Forum held in October 1997. It also outlines the forum’s aims, and sets out a six point plan on rural public health.

Overview
This report discusses a considerable number of issues (over 20) relating to rural health. Topics include environmental health, farm safety, rural health indicators, healthy schools, indigenous health, and issues relating to men’s, women’s and children’s health within a rural environment. There is a particular focus throughout the report on ‘strengthening health partnerships in a rural community.’ The format used is to state the major issues raised in each workshop, and to then discuss future directions and proposals for action.

Good practice
The development and discussion of a six point plan emphasises the need for community organisations, government agencies at all levels, and non-health bodies to be able to work closely with health agencies on the provision of illness prevention and health promotion campaigns.

SOURCE
National Rural Health Alliance et al 1997, Workshop Reports and Communiqué, October, Canberra.
National Rural Health Alliance, PO Box 280, Deakin West, ACT, 2600, ph: (02) 6285 4660, fax: (02) 6285 4670, email: nrha@ruralhealth.org.au, web site: http://www.ruralhealth.org.au
THE LITTLE PURPLE BOOK OF COMMUNITY REP-ING

North West Suburbs Health and Social Welfare Council

Key features

• A 44-page booklet seen as a ‘classic’ by many. It arose from a Consumers’ Health Forum funded project, ‘Not Just a Token Rep’, in Adelaide.
• A series of six two-hour workshops brought together a cartoonist and a range of people with a commitment to, and experience in, consumer participation.
• It is produced by Reps, for Reps, with the message ‘Hang in There!’

This booklet is meant to be taken seriously. It is meant to be laughed over ... It is meant to provide families, friends and partners of that strange breed who ‘go to meetings’ with an idea of why their ‘meeting goer’ often comes home blue in the face ... or joy of joys, crying jubilantly, ‘WE DID IT!’ (pi)

Overview

• What is participation?; introductory explanation of international, national and local policies, includes ‘why participate’;
• Working outside the system; strengths and limitations of individual and community action;
• Definitions of participation; from manipulation to citizen control;
• Being effective; includes the politics of the chairperson, meeting dynamics, getting support, blocks and the representative role;
• Have you been consulted lately?; guidelines for the consulter and consultee;
• References and resources.

A companion kit to this booklet The Community Participation Workshop Kit is also available. The workshop kit uses the stimulation and humour of the cartoons developed through this project. It includes notes on running the workshops and exercises. The 18 sessions encompass the individual, group and system level, and emphasise sharing successes as well as analysing problems.

Good practice

• Cartoons can work! They can raise touchy issues in a lighthearted way. However to successfully support learning they must be followed-up with skillfully facilitated discussions and debate.
• This is a resource that does not require strong literacy skills.
• The integration of quotes and advice from experienced consumer reps adds a reality base and impact.
• The checklists for consumer reps and others are invaluable. Especially for the consumer rep who cannot easily network with other reps or support people.
• Service providers focus means that this resource could be usefully integrated into training and awareness raising for service providers.

SOURCE


Parks Community Health Service, Cowan St, Angle Park, SA, 5117, ph: (08) 3243 5611
Adelaide Central Community Health Service.
COMMUNITY CONSULTATION AND PARTICIPATION RESOURCE KIT FOR AREA HEALTH SERVICE MANAGERS AND PROJECT LEADERS

New South Wales Health Department

Key features
This is a resource kit designed for health managers to use at an individual level, although it could be useful in designing workshops.

- It provides a good step-by-step outline of how to undertake community consultation and how to set up processes for consumer participation.
- It could be useful to both a beginner or experienced operator in the area.
- It uses resources that have been developed elsewhere, so is clearly not ‘reinventing the wheel’ or portraying only one view.
- It will be evaluated soon.

Overview
It uses a range of resources developed by others presented in the following groupings:

- Definitions and framework; this section explores the theoretical framework for consumer consultation and participation;
- Techniques; this section describes a full range of techniques that could be used to begin consultation and highlights when different techniques might be used. To name a few examples, techniques include focus groups, committees, polling and public hearings or inviting consumers into the current operations of the organisation eg quality management activities or planning meetings. The ingredients of effective decision-making are also outlined;
- Planning; a checklist is provided for effective planning processes;
- Working with target groups; specific information on groups is provided eg Non English Speaking Background consumers, Aboriginal and Torres Strait Islander peoples etc;
- Evaluation; there is an important section on evaluation of any activity; and
- Case Studies; a series of case studies help bring the rest of the kit to life.

Good practice
- This is an easy to follow comprehensive and step-by-step package that presumes no prior knowledge.
- It builds on other materials very effectively.
- Provides real case studies to give the kit relevance.
- Provides both information and skill development.

SOURCE
New South Wales Health Department 1998, Community Consultation and Participation Resource Kit for Area Health Service Managers and Project Leaders, Sydney.

Pharmaceutical Society of Australia (PSA)

Key features

- Providing training to pharmacists and their staff in communicating with their customers on health care issues.
- Providing resources to better inform consumers on the treatment of conditions and the maintenance of a healthy lifestyle.
- Emphasises the role of the pharmacist as a partner with health organisations, community groups and other health professionals.

Overview

In its Draft Professional Practice Standards (May 1999) the Pharmaceutical Society of Australia adopts a number of definitions of ‘health promotion’ including:

Through health promotion the public can gain knowledge, skills, motivation and confidence to pursue healthier ways of life; those who advise the public about their health can develop the communication skills they need; decision-makers in organisations can be advised on introducing health policies and on the health implications of other policies; and a climate of opinion can be created which supports comprehensive strategies to promote the health of people.

The draft standards emphasise the professional development of pharmacists in the area of health promotion, the provision of health information and counselling to consumers at the individual and community level and development of strategic links with a range of organisations.

Pharmacy Self Care was launched by the society in 1986 ‘in response to the growing recognition of the need and value of involving consumers in their health (the principal aim of health promotion).’ The program provides accessible health information through pharmacies to consumers, provides educational materials to pharmacists and their staff in health education and consumer support and works in partnership with consumer organisations, governments, other health providers, other health organisations and the pharmaceutical industry.

In 1995 the Queensland Branch of the society together with Pharmacy Guild of Australia and Queensland Health conducted a pilot program in Bundaberg based on establishing a set of indicators of attitudes, knowledge and dissemination of self-help principles through pharmacy, consulting key stakeholders and decision-makers and establishing training procedures for pharmacy staff to meet community health care needs. The evaluation of the pilot found, among other things, that pharmacists confirmed the importance of continuing education, particularly in conjunction with other health professionals, that customers’ demands for health information will increase, that a register of community support groups was a valuable initiative and that pharmacy customers appreciate and value the knowledge of drugs and medication that the pharmacist has as well as the accessibility and willingness of the pharmacist to give advice in this area.
Good practice

• The quality of the content and presentation of the Self Care information made available through pharmacies to consumers.
• The emphasis on partnerships with consumer groups, other health care professionals, and others.
• The emphasis on continuing education for health professionals.

SOURCE

PSA 1999, Pharmacy Self Care Fact Cards, Canberra.
Pharmaceutical Society of Australia, National Office, PO Box 21, Curtin, ACT, 2605, ph: (02) 6283 4703.
Pharmaceutical Society of Australia, Queensland Branch, PO Box 8171, Woolloongabba, QLD, 4102, ph: (07) 3844 4900.
**RACGP TRAINING PROGRAM CURRICULUM**

Royal Australian College of General Practitioners

**Key features**

- This document provides a unique and comprehensive statement of general practice vocational training in Australia.
- The development, implementation and evaluation of this document involved consumers at every level, both in the overall conceptual framework and the disease specific content areas. As such it is a good example of consumer participation in the curriculum development of training for health professionals. Consumers, clinicians, academics received no specific training for this task of participative development. However, it was a good example of ‘action learning’ around a specific task. Aboriginal and Torres Strait Islander consumers were also involved.
- The content of the curriculum contains learning around the doctor patient relationship and defines a core set of competencies in this area for GPs. It does not, however, address consumer participation at the health system level.

**Overview**

This curriculum was developed with extensive input from stakeholders external to the professional group being targeted ie General Practitioners. Consumers and non-medical educational experts and other health professionals all participated in this unique and groundbreaking development process. No such national curriculum document for general practice postgraduate training existed elsewhere in the world. It provides an innovative and substantial template for GP education and training in this country. While it does not specifically address the issues of consumer participation at the system-wide level, it does provide a good platform of skill sets in five domains of general practice that could be further built on. The five domains outlined are:

- communication skills and the doctor patient relationship;
- applied professional knowledge and skills;
- population health and the context of general practice;
- professional and ethical role; and
- organisational and legal dimensions.

All new GPs in Australia must undergo this training.

**Good practice**

The production, use and evaluation of this curriculum is an example of interdisciplinary action learning that has involved the health consumer in the production of an important and central learning statement for general practice. It has laid some foundation for learning about the next level of consumer participation in the health system as a whole. It is an example that could be emulated by all medical colleges in Australia.

**SOURCE**

Royal Australian College of General Practitioners 1999, Training program curriculum

This curriculum document can be obtained from Ms Janie Smith, RACGP Training Program, 1 Palmerston Cres, South Melbourne, VIC, 3205, ph: (03) 9214 1414. Further information on its development can be obtained from the Training Program staff.
A MODEL FOR SELECTING AND SUPPORTING
CONSUMER REPRESENTATIVES FOR BREAST
CANCER NETWORK AUSTRALIA

Breast Cancer Network Australia

Key features

- A project to develop a model to recruit, select and support consumer representatives from the community of those affected by breast cancer.
- The particular focus was to identify, prepare and support participants in committees, broadly defined.
- The project developed a resource guide and package for use not only by Breast Cancer Network Australia (BCNA) but also by other consumer based organisations.

Overview

The project was part of the Consumer Focus Strategy designed to progress the goals of the Consumer Focus Collaboration established in 1997 by the Commonwealth Department of Health and Aged Care. The outcomes of the project are to provide:

- interested women with information about being a consumer representative on breast cancer related committees and to recruit them for this activity;
- a database of potential consumer representatives;
- guidelines and resources for organisations requesting BCNA consumer representatives;
- a process for nominating and selecting BCNA consumer representatives;
- a model for training BCNA consumer representatives (the Breast Cancer Advocacy and Science Training Program);
- guidelines and resources for consumer representatives on being appointed to a committee;
- a resource guide for BCNA that may be used by other consumer groups; and
- an overview of the challenges involved in establishing an effective consumer representative program.

The training component of the program is designed to prepare people for participation in all types of committees, whether clinical, administrative, policy or research and is based on the recognition that to be effective consumer representatives have to have knowledge beyond that associated with their condition.

Good practice

- A very ‘hands on’ project involving extensive consultation within the Breast Cancer Network and trialling of various options and draft documents.
- The resources of other consumer organisations were drawn and an effort made to achieve a common standard and to produce outcomes of value beyond the Breast Cancer Network.
- Attention has been given to the dissemination of the outcomes of the project.

SOURCE

Further information can be obtained from the National Resource Centre for Consumer Participation in Health web site: http://nrccph.latrobe.edu.au
THE CARE PARTNERSHIP: COMMUNICATION AND EDUCATION STRATEGIES FOR HEALTHCARE PROFESSIONALS

Royal Melbourne Hospital

Key features

This training package has been designed to assist health care providers to understand the theory behind education and to incorporate it into working processes, so as to help customers participate as equal partners in their own health care.

The package sets out to:

• assist health professionals to develop insight into a systematic, deliberate process for designing effective customer focused learning resources;
• review health care processes and customer feedback to isolate and define information and learning needs;
• meet their customers’ information and learning needs through the integration of education principles into the care process; and
• design effective education resources which will enable customers to participate in their own health care.

The manual is about two distinct but related types of partnerships:

• the partnership amongst the members of the health care team; and
• the partnership between the health care team and the patient or customer.

The manual focuses on the individual relationship between a health care team and a consumer. It does not cover the relationship between providers and consumers at the systemic level.

Overview

A team at the Royal Melbourne Hospital produced this training package with the assistance of external consultants. It was supported by the National Demonstration Hospitals Program and has been distributed to all public hospitals in Australia.

Its content was developed and tested in three distinct case types: diabetes, various elective surgery and peritoneal dialysis. It is a simple, step-by-step guide to identifying customer education and information needs. The package covers 10 steps covering system expectations and the care process, developing effective learning resources, reviewing and verifying the adequacy of the health care process, defining learning needs, designing for the learner, integrating into the care process and evaluating and refining information and learning resources.

By working through the package providers will have systematically reviewed the way their health care process works and the way it gathers customer feedback. The manual stresses that the information generated is likely to challenge providers perceptions about the efficiency and effectiveness of the process and to have highlighted gaps between health professionals’ and customers’ perceptions of the process.
Good practice

The manual is written in plain English and is well laid out. The steps required for developing learning resources are explained simply but comprehensively.

SOURCE

Royal Melbourne Hospital, The Care Partnership: Communication and Education Strategies for Healthcare Professionals
HEALTH COUNCIL ORIENTATION PACKAGE
RURAL HEALTH SUPPORT UNIT

New South Wales Health

Key features

• A comprehensive orientation package prepared for members of NSW Health Councils.
• Modules in the package cover basic information on health care in NSW and Australia, the NSW Health Service, and the role of Health Councils.
• Modules also offer guidance on how consumer representatives can be effective in their role in such aspects as consulting the community and understanding health needs.

Overview

This orientation package was prepared for the Rural Health Services of NSW by the Rural Health Support Unit. It is intended for use by presenters at orientation sessions for new Health Council members. Modules are available both in a loose-leaf folder format and on a floppy disk. There are eight modules in the package with the modules directed at sessions ranging from one-hour to two-hours and forty minutes in duration.

While most modules provide basic information on the health care system and the role of council members, there is also a module on conducting meetings, negotiation, and conflict resolution. Appendices are included on communication strategies and risk management.

Good practice

• The package provides comprehensive information on the health care system and the role of council members.
• The loose-leaf format, and floppy disk option, enables the modules to be adapted to local conditions. Modules can also be updated and extended.
• The package provides for progression beyond basic information needs of council members to address key skill needs in making councils effective.
• Further skill modules could be added to the package.

SOURCE

Rural Health Support Unit, New South Wales Health 1997, Health Council Orientation package, NSW Health. Community Relations Department, New South Wales Health, Locked Mail Bag 961, North Sydney, NSW, 2059. For a copy of the package ph: (02) 9391 9815, fax: (02) 9391 9580, email: lmcme@health.nsw.gov.au
Spice Consulting

Key features

- The Kit is the product of the national Community Development Project conducted over 12 months in 1997 and 1998, as an initiative of the National Mental Health Strategy. The project goal was ‘to enhance advocacy activity through increasing knowledge and strengthening skills with the health community sector.’ (pv)

- The resource has been designed to be used in a range of ways, by individuals and by groups. It has been designed with exercises and strategies to appeal to the diversity of learning styles and is written in plain English and includes a bibliography and index.

Overview

This is a large and complex resource, comprising a 275-page loose-leaf kit and a 114-page complementary ‘Knowledge and Attitudes’ book. It contains:

- an introduction which provides a background and context to the materials and to the history of the Community Development Project;

- a separate booklet which discusses knowledge and attitudes that have an impact on the experiences of carers and consumers today. There are nine knowledge and attitude areas; within each, different viewpoints may be presented and discussed;

- a series of skills and strategies which can be selected, mixed, matched and adapted. The skills, strategies and related tools are numbered and grouped into five clusters to assist with their practical application: advocacy and the individual, getting organised, specific exercises, advocacy and the organisation and getting strategic. Each skill and strategy has both practical and motivational information including a brief background, some concrete ideas, and often a tool like sample forms, tables and diagrams, actions to try, reminders and questions for you to consider; and

- a glossary of key words which are particularly useful or which have been used in a specific way in the kit.

Good practice

- Although some sections focus particularly on mental health issues, much of the booklet contains transferable information.

- This kit covers a lot of territory and is best seen as a training ‘resource’. Although the authors stress it can be used in many ways, its sheer size and range of issues may be daunting to an individual consumer using it for self-directed learning.

- Consumer focus: the frustrations and challenges for consumer advocates at all levels are delineated. Examples are drawn from a range of contexts in an inclusive way. Although there is some information on service providers and the roles of professionals, this is not a strong focus.

SOURCE

CONSUMER FEEDBACK AND
STAFF–CONSUMER COMMUNICATION,
CONSUMER PARTICIPATION PROGRAM:
ORIENTATION AND JOB MANUAL
STAFF–CONSUMER CONSULTANTS IN
MENTAL HEALTH SERVICES

Victorian Mental Illness Awareness Council (VMIAC)

Key features
This 105-page resource has been designed to support the work of staff-consumer consultants in mental health services. The staff-consumer consultant is a paid position aiming to involve consumers, in collaboration with staff, in regularly reviewing and improving the quality of services.

Overview
This manual was designed as part of the Victorian Health Promotion Foundation funded consumer research project ‘Understanding & Involvement’ undertaken by the Victorian Mental Illness Awareness Council. The manual was the result of extensive trialing with consumer consultants.

The manual contains:
• Part A, purpose of the program, background research and rationale;
• Part B, area-based infrastructure for achieving the fundamental purpose and related mechanisms and activities; and
• Part C, Staff-Consumer Consultants (role, purpose and tasks; future planning; knowing the setting and context; facilitating Quality Assurance inquiry by action oriented and participative research and evaluation; keeping records; developing communities of interest; communication and facilitating communication; working as a consumer, with a consumer perspective; deciding what is a priority and support, strengthening and replenishing mechanisms).

Good practice
• The manual sets the philosophy, principles, practice and process in clear inter-relationship.
• An effective presentation for self-directed learning and individual development.
• Some sections, especially appendixes, could provide the basis for training exercises.
• Many transferable ideas for other health sectors, although most relevant for mental health services.

SOURCE

Victorian Mental Illness Awareness Council, 23 Weston St, Brunswick, VIC, 3156, ph: (03) 9387 8317.
DEVELOPING EFFECTIVE CONSUMER PARTICIPATION IN MENTAL HEALTH SERVICES: THE REPORT OF THE LEMON TREE LEARNING PROJECT

Victorian Mental Illness Awareness Council (VMIAC)

Key features

- The 135-page report on the Lemon Tree Learning Project articulates a model which promotes participative approaches to learning. The project aimed for system and individual change and focused strongly on the process of consumers and service providers learning together.

- The report provides a mixture of theory, practical examples and tips from personal experience which combine to be a rich resource, however as the model is a multi-leveled and integrated, it is necessary to read through the whole report to gain maximum benefit.

Overview

The Lemon Tree model of learning comprises four components. Each is clearly described in both process and content. Strengths and challenges are explained in a way that enables the project learnings to be transferable.

- ‘root’ learning; where the training is nourishing an infrastructure to support consumer participation; describes incremental developments from small regular meetings to documenting needs through to gaining funding for staff-consumer consultants.

- ‘branch’ learning; where the training is adding to or modifying existing knowledge, skills and attitudes developed around consumer participation:
  - Consumer Consultant Training Course, processes for learning included stories, reading, quizzes, consumer-to-consumer teaching and some ‘expert’ presenters;
  - Content Based Workshops, for example an activist workshop;
  - Resourcing Specific Consumer Groups, for example an incorporation workshop;
  - Consumer Facilitation Courses, this model has been designed to utilize the consumer perspective and experience without exploiting the emotional reserves of the consumers involved. It is an active learning exchange; and
  - Deep Dialogue, here the learning exchange emerged from the less structured (agenda-less) opportunity provided for people to speak together in a way that they came to know each other as more than ‘just another nurse/consumer’;

- ‘leaf’ learning; where the training is providing information about consumer participation where little or no infrastructure to support it exists; are one-off learning situations, such as guest speakers, talks etc, which are not integrated with real, ongoing consumer participation within services.

- ‘trunk’ learning; training for effective consumer participation needs to be premised on a theory of effective consumer participation. The Lemon Tree Project draws on the earlier project ‘Understanding and Involvement’ (1992–96). The principles common to both projects are elaborated.
Good practice

- The Lemon Tree model highlights the need to facilitate learning at a number of levels and in a number of ways.
- The project foregrounds the need for continuous dialogue and exchange as the key factor of change.
- Material developed ranges from conventional skill development and information strategies to creative approaches using stories, games and the like.

SOURCE


Victorian Mental Illness Awareness Council, 23 Weston Street, Brunswick, VIC, 3156, ph: (03) 9387 8317.
UNDERSTANDING AND INVOLVEMENT (U & I): CONSUMER EVALUATION OF ACUTE PSYCHIATRIC HOSPITAL PRACTICE

Victorian Mental Illness Awareness Council (VMIAC)

Key features

- These three volumes are the result of a three-year project undertaken by the Victorian Mental Illness Awareness Council, funded by the Victorian Health Promotion Foundation. The project was located primarily at the Royal Park (now Royal Melbourne) Hospital, although experiences examined arose from a range of acute psychiatric hospitals.
- Although not a training or education kit, it provides valuable description, analysis and position on the challenges of system change when the mutual learning of consumers and service providers is facilitated.

Overview

Enables the reader to learn from both the process and the content of the project. There are examples of project material, individual experiences, theory and process and impact evaluation. The context of change in acute mental health services and many of the dynamics described can be found in other health settings.

- **Volume 1**: A Project's Beginning, this 88-page report documents 'the beginnings of a dialogue about what might be methods or mechanisms for seeking consumers' evaluative feedback' through a series of discussion papers.
- **Volume 2**: A Project Unfolds, in this 232-page volume, the story of the U & I project is continued. This volume documents a range of issues that needed to be addressed as the consumer feedback methods were trialed.
- **Volume 3**: A Project Concludes, this 200-page volume documents the comprehensive model for consumer evaluation within psychiatric acute care services.

Good practice

- The integration of consumer and staff personal responses and stories provides strong impact and reality for the learner.
- Wide range of presentation methods, from actual proforma examples, process description to further reading and theory
- Encourages self-directed learning by the reader and provides sections that could be used as material for training courses for consumers and staff.

SOURCE

Wadsworth Y & Epstein M 1994, Understanding and Involvement (U & I): Consumer Evaluation of Acute Psychiatric Hospital Practice, Vol 1: A Project's Beginnings


Copies of these volumes are available for $15 (each, 1997 price) from the Victorian Mental Illness Awareness Council, 23 Weston Street, Brunswick, VIC, 3156, ph: (03) 9387 8317.
THE COMMUNITY PARTICIPATION WORKSHOP KIT

Parkes Community Health Service, Adelaide

Key features

• A 40-page loose-leaf manual containing 18 full-page cartoons and six pages of small sized cartoons designed as a follow-up training kit to The Little Purple Book of Community Rep-ing.
• Designed for training community representatives and primarily draws on health sector examples.

Overview

The workshop kit contains:
• notes on how to run a workshop using cartoons;
• list of terms used;
• exercises for use in the workshops;
• handouts;
• copies of cartoons; and
• a copy of the Little Purple Book of Community Rep-ing.

The workshops aim to develop an understanding of what is needed to make community representation work, for the individual and the community. Topics covered include: choosing a focus; what a rep needs to know; speaking out; being heard; the effects of labelling; creating an open atmosphere; is the community Rep included; running meetings; effects of tradition; acknowledging difference and expertise; negotiating competing priorities; dealing with token consultation; dealing with the system; building a partnership; representing a community; accountability; resources; and real representation.

Good practice

• Exercises are well designed with learning outcomes, time needed, clear instructions and special advice for the facilitators clearly stated.
• All exercises are linked to the development of action plans.
• Useful in situations where low literacy levels is a feature.

SOURCE

Page N & Aldridge G 1997, The Community Participation Workshop Kit, Parkes Community Health Service, SA.

South Australian Community Health Research Unit, C/- Flinders Medical Centre, Bedford Park, SA, 5042, ph: (08) 8204 5988, fax: (08) 8374 0230.
PLANNING HEALTHY COMMUNITIES: A GUIDE TO DOING COMMUNITY NEEDS ASSESSMENT

Southern Community Health Research Unit

Key features
- A 298-page manual plus appendices designed to provide a framework to collect information for planning healthy communities. It includes descriptions of tools for this task, explanations of possible processes and an analysis of possible benefits and pitfalls.
- Accompanied by a video, Best Laid Plans.
- Designed for use by community members and/or service providers, and provides a consultative community development approach.

Overview
The manual is divided into six sections:
- assessing needs for planning for a healthy community (defining the task and methodology);
- before you start (preparation steps);
- surveys and questionnaires (easy to follow ‘how to’);
- qualitative research (includes participant observation, in depth interview and group work);
- reporting back and planning; and
- guide to other resources.

A range of presentation styles introduces theory, and provides pro formas, local examples, cartoons etc. It could be used as a self-directed learning guide for a team or individual or could provide a basis for training exercises.

Good practice
- Easy to follow as it utilises a local project as the example.
- Clearly written with further reading offered.
- Suitable for those with little or no experience in needs assessment.
- Video is an excellent discussion trigger, especially concerning consumer/paid staff relationships.

SOURCE
South Australian Community Health Research Unit, C/- Flinders Medical Centre, Bedford Park, SA, 5042, ph: (08) 8204 5988, fax: (08) 8374 0230.
PLANNING HEALTHY COMMUNITIES, RURAL FOCUS: A GUIDE TO DOING NEEDS ASSESSMENT IN RURAL COMMUNITIES

Rural Health Training Unit, South Australia

Key features

• A 32-page booklet produced by the Rural Health Training Unit of South Australia is a supplement to the Planning Healthy Communities Manual.
• Highlights planning and consultative issues for rural communities and illustrates them with excerpts from Australian settings.
• Designed primarily for the use of employed staff but does feature a consultative approach.

Overview

• The booklet explores the special features of researching community needs in a rural community, noting the importance of involving the community and identifying existing networks.
• Two methods for rural needs assessment are described: social surveys and the rapid appraisal process.
• Other methods covered include using electronic media, and how to work with expert bodies.

Good practice

• Features the special needs of rural communities
• Although it does not have increasing consumer participation in health services as a direct aim, the booklet provides staff with a process that would be complementary.

SOURCE

Women’s and Children’s Hospital, 72 King William Rd, North Adelaide, SA, 5006, ph: (08) 8204 7000, web site: http://www.wch.sa.gov.au
THE PREPARING THE GROUND FOR HEALTHY COMMUNITIES MANUAL

Rural Health Training Unit, South Australia

Key features

- A 57-page loose-leaf folder designed to share the outcomes of a primary health care training and development project conducted in the mid-north of South Australia.
- Although it does not directly focus on consumer participation, one of its main commitments is to involve community. This could be a first step to full consumer participation.

Overview

- Illustrates how the new approach to primary health care demands a changed approach to workforce planning and development.
- The nine features of the approach are that it is planned, integrated into a broader framework for primary health care, collaborative, multidisciplinary, intersectoral, involves the community, is regionally and locally relevant and must be sustainable.
- Sections describe how to establish a core group and steering committee, prepare project plans and implement and evaluate projects.

Good practice

- Provides clear guidance for staff to expand their workforce planning and development in a multidisciplinary way.
- The ‘Healthy Communities’ approach can be a starting point for a more productive collaborative long-term relationship between consumers and health service providers.
- Relevant for health service administrators as well as staff.

SOURCE


Rural Health Training Unit, 55 King William Rd, North Adelaide, SA, 5006, ph: (08) 8226 8160.
WORKING TOGETHER TO IMPROVE HEALTH:
A TEAM HANDBOOK

University of Queensland Primary Health Care Reference Centre

Key features

• A 129-page handbook developed in a pilot program for health care workers funded by the National Reference Centre for Continuing Education in Primary Health Care.
• Although the handbook states that it is designed for health care teams, community groups, self-help and self-care groups, its primary application is for service providers.
• All sections include aims, notes for the facilitator, team activities and complementary information sheets.

Overview

• The handbook is divided into sections including: Getting Started (team & service issues); What is health; Whose health; Making a difference; Partnerships to improve health; Planning and evaluating services and programs; What health care workers can do to improve health; and Where to from here?
• Partnerships to improve health (section 5) has particularly useful activities to explore ‘partnerships with patients, clients and communities’ as well as other service providers and organisations. Activities and information sheets in this section could be used by consumers and/or service providers.

Good practice

• Well designed and easily followed format.
• Activities include information on time needed, method preview, material needed and step-by-step instructions, plus facilitators notes.
• Suitable for health teams beginning the process of consumer participation.

SOURCE

Roe M 1995, Working together to improve health: a team handbook, University of Queensland, Queensland.
University of Queensland Primary Health Care Reference Centre, C/- Department of Social and Preventative Medicine, University of Queensland, Herston, QLD, 4006, ph: (07) 3365 5419
THE RIGHT TO HAVE A SAY: A KIT OF TOOLS FOR CONSUMER PARTICIPATION

Intellectual Disability Rights Service

Key features

- A 103-page loose-leaf kit designed to support service providers with resources to encourage ‘real opportunities for genuine participation’.
- There are two types of training materials: the first provides in-service training sessions for staff and management, the second provides lesson plans for workers to use with consumers.

Overview

Following an introductory rationale for consumer participation and service issues, two key sections are:

- **Section 4**: Activities for Staff and Management Development, this provides nine group activities ranging from situations of new consumer projects through to further development of existing consumer participation.
- **Section 5**: Resources for Use with Consumers, features training activities and resources effective with people with an intellectual disability. Cartoons and visual material are featured.

Good practice

- Particular relevance for consumers with an intellectual disability.
- Many activities and resources could be adapted by other consumer and staff groups.
- Creative training strategies are a feature.

SOURCE


Redfern Legal Centre, 73 Pitt St, Redfern, NSW, 2066, ph: (02) 9698 3066.
IMPROVING HEALTH SERVICES THROUGH CONSUMER PARTICIPATION: A RESOURCE GUIDE FOR ORGANISATIONS

Flinders University and South Australian Community Health Research Unit

Key features

• The resource guide provides comprehensive resources which can be used in fostering consumer participation.

• The resource guide has been structured to follow a cycle of strategic thinking, action, and reflection about consumer participation.

• The orientation is towards a practical ‘how to do it’ approach.

Overview

The resource guide for organisations complements this Resource Guide and offers practical guidance on how to promote consumer participation. The tools in the resource guide include strategies, techniques, and methods that can be applied in areas such as planning and assessment, evaluation, and managing change. Links are provided to other sources of information and guidance. In addition to strategic and conceptual components, the resource guide offers practical guidance on methods such as workshops, focus groups, hotlines, and public enquiries.

Good practice

• The resource guide combines a sound conceptual basis and sense of strategic direction, with useful information on techniques and methods that can be applied.

• It will have considerable value as a reference document across wide areas relevant to consumer participation.

SOURCE

Flinders University and South Australian Community Health Research Unit.

Available from the National Resource Centre for Consumer Participation in Health web site: http://nrcoph.latrobe.edu.au
LIFELONG LEARNING: VET IN THE LEARNING AGE

National Centre for Vocational Education Research

Key features

- This report, published in 1999, discusses the implications of the mounting pressures for lifelong learning for vocational education and training (VET) in Australia.
- It includes an overview of international trends and identifies six key challenges which need to be addressed.

Overview

This study was commissioned by the National Centre for Vocational Education Research (NCVER) in 1998 to assess the implications of the growing pressures for lifelong learning for VET in Australia. Case studies were undertaken in five regional areas, and an overview of international trends was undertaken. The contextual influences which are driving the demand for lifelong learning (globalisation, new technologies, changes in work and in the labour market, shifts in values and social attitudes) are discussed. Emerging concepts such as learning organisations and learning communities, and the key role of new technologies, are discussed.

Good practice

- The report provides an up-to-date account of emerging trends in lifelong learning and is a convenient source for those who want to learn more about this subject.
- Individual chapters, such as ‘Building Learning Communities’ and ‘Developing Learning Organisations’ could be used in workshops as a background to a planning process.

SOURCE


This report consists of two volumes and is a sale item from the National Centre for Vocational Education Research, PO Box 115, Kingston Park, SA, 5068, ph: 1800 009966, fax: (08) 8331 9221.

A shorter discussion paper is also available.
SOUTH AUSTRALIAN CONSUMER REPRESENTATIVES NETWORK

Key features

• This organisation is a network of people who represent consumers on a variety of committees across South Australia.
• Its function is purely as a network which supports consumer representatives.
• It runs formal and informal training sessions.

Overview

• The organisation is run by a small steering committee of experienced consumer representatives.
• They organise three or four meetings for consumer representatives a year.
• Some meetings are run as both formal training sessions with a facilitator and/or guest speaker/trainer.
• Topics vary and include lobbying skills and information about the political environment and government activities.
• Some of the meetings focus on the skills needed in being a consumer representative, covering topics such as what a representative needs to know and how to deal with different situations.
• Other meetings are more informal, where participants share information, provide support to, and learn from each other.
• The network has also prepared an information leaflet for committees seeking a consumer representative. The leaflet requests that the committee clarify why it wants a consumer representative, what is their role to be, what induction processes are to be available and whether any formal training is provided.
• The organisation does not have any permanent paid staff or an office, and relies a great deal on the voluntary time put in by its members.

Good practice

• Provides both formal and informal training.
• There is an emphasis on learning from, and supporting each other.

SOURCE

Further information about the South Australian Consumer Representatives Network (SACRN) can be obtained from Ms Kathy Mott, Steering Committee—(SACRN), C/- 329 Brighton Rd, North Brighton, SA, 5048, ph: (08) 8358 1055, fax: (08) 8377 2138, mob: 0416 258 889, email: kmott@bigpond.com, or Ms Margaret Charlton, Steering Committee—(SACRN), 28 Minchinbury Tce, Marion, SA, 5043, ph: (08) 8276 2103, email: chasmarg@ozemail.com.au
MENTAL HEALTH CONSUMER REPRESENTATIVE TRAINING PROJECT

Health Consumers’ Council WA

Key features

- The project involves running a number of professionally facilitated training workshops for mental health consumer representatives.
- The project actively seeks out more marginalized groups.
- Written material is also provided to participants in the training course.

Overview

The project is auspiced by the Health Consumers’ Council of Western Australia. Funding is provided by the Western Australian state government. Prior to designing the training program the project officers looked at material from around Australia and identified the essential qualities for consumer representatives as a basis for developing a training package.

Topics covered in the workshop include:

- committee dynamics; meeting procedures, stages of group development, roles within groups;
- communication skills; networking and consultation with fellow consumers, active listening, assertiveness, non-verbal communication; and
- negotiation and conflict resolution; anger and conflict, stress and relaxation, forming partnerships and allegiances.

Good practice

- Values and draws on experience of being a mental health consumer.
- Has positive focus on forming partnerships and alliances and having shared visions between consumers and providers.
- Training is given in small parcels, backed up by written information.
- Draws on practical examples.

SOURCE

Health Consumers’ Council WA, 4 Lord St, Perth, WA, 6000, ph: (08) 9221 7860.
GUIDELINES FOR CONSUMER REPRESENTATIVES: SUGGESTIONS FOR CONSUMER OR COMMUNITY REPRESENTATIVES WORKING ON COMMITTEES

Consumers’ Health Forum Australia

Key features
- A 31-page booklet supplemented by five fact sheets.
- Both orients a representative to their role on committees and provides advice on possible challenges ahead.
- Although written for the consumer member, it would be valuable for anyone with committee obligations.

Overview
- The seven sections cover the following:
  - consumer representation—the big picture;
  - you’ve just agreed to be a consumer representative;
  - before you start;
  - before, during and after a meeting;
  - dealing with difficulties;
  - being effective; and
  - a conclusion.
- The facts sheets:
  - eight consumer rights;
  - before you start;
  - dollars and sense resource checklist;
  - common problems and solutions;
  - effective representation—you’re OK.
- There is a combination of definitions or terms, explanations of process, supplemented by many tips and examples.
- The booklet is interspersed with quotes from consumer reps which encapsulate some of the challenges and rewards in the job.
- Applicable to a wide range of committee types.
**Good practice**

- Effective use of examples and quotes.
- A good combination of introductory information and more strategic advice.
- Highlights both the formal and informal processes of committee work.

**SOURCE**

Consumers' Health Forum of Australia 1999, Guidelines for consumer representatives: suggestions for consumer representatives working on committees, 4th edn, CHF, Canberra.

Consumers' Health Forum of Australia, PO Box 52, Lyons, ACT, 2606, ph: (02) 6281 0811, fax: (02) 6281 0959, email: info@chf.org.au, web site: http://www.chf.org.au.
A GUIDE TO PARTICIPATION BY OLDER VICTORIANS

Aged Care Branch, Department of Human Services, Victoria

Key features
This guidebook has been developed to assist aged care planners, service providers and consumer organisations to further involve older people in decisions that affect their lives. It aims to:

- clarify the practical meaning of participation in aged care;
- raise the awareness of consumer involvement in service planning and delivery;
- identify practical techniques for participation; and
- strategically link consumers into service planning and delivery.

Overview
- The guidebook ‘will assist policy makers, planners and service providers in the challenge to not only increase involvement and acceptance of the role of consumers as stakeholders, but also effectively utilise the experience and knowledge that older people can bring to add value and benefit to programs and initiatives’.
- Issues discussed include the self-image of older persons, the concept of ‘respect based on understanding’, empowerment, participation and cultural differences. A variety of opportunities, techniques and models for the participation of older persons is presented and advice given the consultation process.

The guidebook concludes with seven case studies of consumer participation.

Good practice
- The guidebook is written in clear language, is concise, well illustrated and gives much practical advice.
- It is evident that the preparation of the guidebook involved extensive consultation with all relevant groups and in particular with older persons.

SOURCE

Copies of the guide are available from the Aged Care Branch, Department of Human Services, 10th Floor, 555 Collins Street, Melbourne, VIC, 3000, ph: (03) 9616 8274.
BRINGING IN THE VOICE OF THE
CONSUMER: A PRACTICAL GUIDE TO
CONSUMER PARTICIPATION

Adelaide Women’s and Children’s Hospital

Key features

The second edition of the Practical Guide to Consumer Participation was released in September 1999 and was designed to support the development of consumer participation policy, program implementation processes within the Adelaide Women’s and Children’s Hospital. The guide has been underpinned by a hospital-wide policy regarding consumer participation and is closely linked with the hospital’s Quality Evaluation and Quality Improvement Program (EQuIP).

Overview

This workbook’s introductory section covers topics such as:

- where consumer participation fits in with other structures within the organisation;
- models of change management;
- philosophical and ethical perspectives;
- detailed exploration of degrees of consumer participation with examples; and
- examples of consumer participation successes.

The other three sections contain guides to:

- the development of a team approach;
- the techniques and tools necessary for consumer participation; and
- actual resources to use such as worksheets, checklists, example letters, plans for running focus groups, responses to roadblocks and commonly held staff reservations about consumer participation.

The content of the second edition has been built from the experiences of staff with their activities in fostering consumer participation in various areas of the hospital and so has a high degree of face validity. In addition the experiences have fed into the development and revision of the hospital’s policy in an iterative fashion.

Good practice

This guide is a good example of a living document that summarises policy and theoretical ground. In addition it provides detailed step-by-step guidelines for actually implementing a consumer participation program within a health care institution that would be readily generalisable within the Australian health care context.

SOURCE


Copies can be obtained from the Women’s and Children’s Hospital, 72 King William Rd, North Adelaide, SA, 5006, ph: (08) 8204 7000, web site: http://www.wch.sa.gov.au
PART 5

STRATEGIES

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5.2 Building high quality partnerships 136
5.3 Building Learning Organisations 140
PART 5: STRATEGIES

In part 2 of this guide we comment on a number of learning strategies that can be used in fostering consumer and provider collaboration. In part 5, we provide more detailed information on three of the key strategies that can be used for this purpose:

- experiential and action learning;
- building high quality partnerships; and
- building learning organisations.

These strategies involve three of the most significant approaches to learning in the emerging conditions of the 21st century. In part 2 we pointed out the increasing importance of learning strategies in the workplace, institutions, and in the community. In section 5.1, we discuss how people learn from experience and comment on a particular strategy, action learning which can be used to sharpen the learning skills of individuals.

Partnership building is the essential foundation for consumer and provider collaboration. It is also a development of growing significance in business and industry, and in the community, so that there is a developing pool of experience on good practice in partnership building. Section 5.2 draws on international experience in discussing approaches to building high quality partnerships.

There is a growing international interest in the concept of learning organisations where three levels of learning come together: learning by individuals, in teams, and in the organisation overall. Several case studies in part 3 illustrate learning organisation development in a hospital and other health contexts, while the Healthy Cities Illawarra case demonstrates how these principles can be applied to a whole community.

It will be useful to read the case studies in association with this part of the report so that the case studies provide concrete examples of the themes and issues discussed in the part 5 articles. This will enhance insights into ways in which these strategies might be applied in your situation.

5.1 EXPERIENTIAL AND ACTION LEARNING

Learning is so basic a human function that people learn all the time in a wide range of situations. These include learning at work, in the family, and in ordinary social activity. The learning of young children, for example, offers many insights into learning processes. However, learning is not always effective because of barriers which impede learning processes. The existence of these barriers may be unknown to the individual. Barriers may include ineffective learning styles, attitudes to learning, as well as cultural barriers and other impediments in the environment of the individual.

Understanding these barriers and addressing them means that learning-to-learn skills can be improved so that individuals and groups become more effective learners in a range of contexts. Jobs and work can be designed so as to enhance the learning value of the work undertaken, while much learning can occur in normal day-to-day community activities.

Building effective learning habits and skills in all stakeholders can contribute much to the quality of consumer/provider partnerships in the health sector. Strategies such as action learning can be used to enhance learning that occurs from everyday experience.
Some useful terms

- **Tacit learning**: learning that proceeds in an unconscious manner.
- **Situated learning**: in a situated learning approach, knowledge and skills are learnt in the contexts that reflect how knowledge is outlined and applied in everyday situations. These may include workplace learning and learning in community contexts, e.g. organising a town festival.
- **Action learning**: this involves deliberate, conscious effort to review and reflect on action of the individual, a team, or an organisation. Action learning often links work and learning and is usually undertaken in teams which are usually called sets. This approach is discussed below.
- **Mental models**: these are deeply held internal images of how the world works which limit people to familiar ways of thinking and behaving (mindsets).

Some barriers to effective learning

Informal learning, such as tacit learning, can be very effective ways to acquire new knowledge and skills. This often happens when we observe and imitate expert practitioners. Much apprenticeship and medical training, for example, is built around this approach.

However, a number of barriers can impede effective learning habits and skills. Understanding these barriers, and addressing them, can contribute much to learning effectiveness.

Barriers to effective learning include:
- the influence of mental models or mindsets which limit us to customary ways of thinking. These often reinforce obsolete stereotypes, e.g. stereotypes relating to careers for girls and women;
- inadequate understanding of self as learner including understanding of your learning style and preferences;
- negative attitude towards learning, sometimes as a result of unfortunate school experience;
- lack of confidence and self esteem; and
- poor literacy and communication skills.

Figure 4: A process for experiential learning and personal development

This diagram illustrates the key concept that effective experiential learning depends critical on understanding self (mindsets, learning style etc) and understanding others.
Each of these barriers can be addressed so as to improve learning to learn skills and the general learning capability of an individual. While some of these barriers relate to particular individuals (e.g., lack of confidence), others are more broadly based in particular cultures or environments and are difficult to shift in the short-term.

What makes for effective learning?

Research on learning in the workplace has pointed to a number of ways in which learning skills can be improved. These include:

• increased understanding of self as learner;
• increased capacity for reflection and self-monitoring of learning processes as we go about ordinary activities; and
• more realistic understanding of the nature of knowledge and how knowledge is generated and acquired.

In addition to these requirements, it is important to develop the habit of surfacing our mental models so that we are aware of the assumptions and values that we bring to understanding any new situation. This habit requires deep reflection, but is important in building effective partnerships.

What can be done?

There are many strategies that can be applied in improving the learning skills of people so that the value of ongoing informal learning is enhanced.

These strategies and techniques include:

• the role of mentors in working with small groups or individuals. Volunteers can be used in this role;
• techniques such as active learning can be used so that individuals learn from each other in problem solving in teams;
• workshops can be useful in developing sensitivity to learning needs and strategies; and
• individuals can be encouraged to keep notebooks or diaries which provide a structured way of reflecting on experience. Many of the most creative people in human history such as Leonardo da Vinci, Isaac Newton, and Thomas Edison had the habit of using notebooks or diaries to record observations and reflections.

Remember

• Improving learning skills is a dialectical process of understanding self and others.
• ‘Surfacing’ mental models is a necessary habit.
• Providing for regular habits of reflection is important.

Action learning

Action learning is a process through which participants learn with and from each other as they work on real issues or practical problems in real conditions.

It is usually conducted in teams or sets so that the process facilitates skill in both team and individual learning. The interaction of these two levels drives the learning process.

Action learning involves:

• the integration of work and learning;
• experiential learning;
• team learning;
• action undertaken by the group to solve a real problem; and
• reflection by the group on both the problem and the learning process.

The team learning dimension is crucial. Members of the team share addressing the problem, and offer mutual support, advice, and criticism to each other. The process therefore fosters team learning skills and a co-operative, collaborative culture.

Figure 5 shows the three key phases in action learning.

![Figure 5: An action learning model for staff development](image)

**Components of action learning**

The usual components in an action learning program are:

• **the set**: a small group of people, say five or six, who meet regularly—perhaps one day a month or two half-days a month for the prescribed period (eg six months);
• **the task**: the problem given to the set, or decided by the group itself with work shared among members of the set;
• **the process**: that the group adopts when working which is determined by the group (eg the set members may decide to email each other with ideas/observations between meetings);
• a **set adviser** (or facilitator) who helps the group as it works and learns; and
• **duration of program** which is normally from three to six months with reporting on the outcome at the end of the set period.

These components can be applied flexibly and can be varied to suit particular needs and requirements. A key aspect is the support given by the group to the individual.

**The rationale and benefits**

By integrating work and learning in a team situation, this strategy brings a range of benefits to the participants and to the organisation.

• Team learning skills are refined in a supportive environment.
• A forum is provided where people can share difficulties and problems without fear.
• Problem solving, listening, and communication skills can be enhanced.
• Motivation for ongoing learning can be increased.
• The process contributes to a cooperative, collaborative culture in organisation where staff share insights and problems.
• The process can enhance the creativity of an organisation and its capacity to innovate and respond to changing conditions.

Whether these benefits are achieved depends on how well the process is implemented and facilitated. Staff need a clear understanding of what the objectives are.

Applications

Action learning can be applied in a wide range of ways. An example is given below of an application with operative staff in a brewery. In the health sector, action learning could be applied with mixed teams of providers and consumers addressing specific problems. Cultural change programs (examples are given in part 4 of this guide) often use action learning strategies.

Operative staff in a brewery

An Australian brewery decided to introduce action learning as an aspect of a strategy to develop a more highly skilled and flexible workforce. Sets comprised three shop floor workers, a member of management, and an external facilitator. The group met once a week for four hours over a period of four months. An action plan was decided at the initial meeting. The group decided to work on the development of a competency matrix for use in the brewery. Where technical difficulties were encountered, the group requested training. This included a two-day workshop on a particular analytical technique being used in this project.

The group identified 13 work areas in the brewery for introduction of competency-based training and wrote material for use in these areas. The competency matrix developed by the group was validated with workers. The outcomes of the project had practical value for the brewery while the workers involved improved their learning skills and played an active role in workplace reform in their company.

SOURCE

PROFILE OF THE LIFE-LONG LEARNER

Mind and Curiosity
• A sense of curiosity and question asking
• A love of learning and discovery
• Reflective habits
• Can apply strategies to enhance creative resourcefulness

Helicopter Vision
• Has a sense of the interconnectedness of things
• Is able to apply systems perspectives and ‘see the big picture’
• Has capacity for strategic thinking
• Has a vision that goes beyond own job or field of study

A Repertoire of Learning Skills
• Has learning-to-learn skills
• Knowledge of own strengths, weaknesses and preferred learning styles
• Has a range of strategies for learning in various contexts
• Is able to learn from others in teams
• Understands different kinds of learning

A Commitment to Personal Mastery and Ongoing Development
• Has motivation and desire for learning throughout life and confidence in own learning capability
• A commitment to ongoing personal and career development
• Has self-esteem and a positive concept of self as capable and autonomous
• Has the capacity to deal with change

Interpersonal Effectiveness
• Is able to learn from others in teams
• Is able to give and receive feedback in team learning situations
• Has a group orientation and can contribute to team learning
• Has cultural understanding and can learn in situations involving cultural diversity in Australia and overseas

Information Literacy
• Ability to locate, evaluate, manage, and use information in a range of contexts
• Can use modern information technologies for these purposes
• Has a good sense of knowledge acquisition and generation and can contribute to turning workplace learning into shared knowledge

SOURCE
This profile has been adapted from a profile devised by Philip Candy, Gay Crebert and Jane O’Leary and which was included in their report Developing Lifelong Learners through Undergraduate Education (NBEET, 1994)
5.2 BUILDING HIGH QUALITY PARTNERSHIPS

As Australia enters the new era of the 21st century, it is evident that one of the important features of this era is the growth of a wide range of partnerships in many fields of economic and social activity. These partnerships take many forms. Some examples are: alliances of firms, education/industry partnerships, the development of Learning Cities, networks, and communities, and coalitions with a range of stakeholders.

Partnership development reflects the conditions of the 21st century, and is a necessary response to these conditions. This new era has been variously called an information society, knowledge-based economy, risk society, while the British Government has used the term The Learning Age (Secretary of State for Education and Employment 1998). Each label reflect key aspects of the new world which make partnership development essential.

One of the key drivers of these developments is the exponential pace of change, aligned with the key role of modern information and communication technologies, and the impact of a globalised world economy. The cumulative impact of these developments is blurring many familiar boundaries (Davis & Meyer 1998), and making many traditional habits and mindsets obsolete. The shock of the new requires innovative approaches to the provision of services in all social and economic sectors. A key requirement is lifelong learning in this context of exponential change, risk, and uncertainty.

A further key requirement is to build quality partnerships. In the environment outlined above, partnerships have the following benefits:

• stakeholders collaborate in adjusting to change;
• new ideas flow more easily;
• special expertise is shared;
• there is improved feedback; and
• synergies can be created so that outcomes are value added.

In addition to these general benefits, there are specific further benefits in particular economic and social areas. While partnerships have many benefits, quality partnerships don’t just happen.

What are the barriers?

Building effective partnerships is often impeded by a range of factors. These include:

• inadequate planning and information;
• the reluctance of either party to let go of power and to share power and responsibility;
• inadequate partnership and team skills;
• lack of understanding of how partnerships grow and develop; and
• lack of trust between the partners and dated stereotypes and mindsets

Each of these barriers, if present, may need to be addressed by strategies that address the barrier so that a partnership culture is fostered. Such a culture will be marked by mutual understanding and trust, open communications, and a commitment to advancing the objectives of the partnership.

The existence of the barriers listed above means that a culture change strategy is likely to be needed. Some of the case studies in part 3 of this guide illustrate culture change
strategies, as do a number of the resources in part 4. Healthy Cities Illawarra shows how a partnership culture can be built up over a period of years, while the Adelaide Women’s and Children’s Hospital case study shows change management in a hospital environment. A change management resource manual is given as a resource in part 4. It is useful to compare the strategies adopted in the different environments to identify the common elements, and those distinctive to the particular environment.

**How to make partnerships grow and develop?**

There is considerable evidence from around the world that effective partnerships progress through a number of stages of development with different strategies required in each stage of development if the partnership is not to stagnate and wither.

Professor Rosabeth Kanter (1994) of Harvard identified five phases of development in a study of 37 business partnerships in 11 parts of the world. However, a common finding has been to identify three phases of development in the life-cycle of partnerships and this finding provides a practical approach to planning and developing partnerships. Some models of these phases of development are given below.

**School/community partnerships**

The American Annenberg Foundation (1997) has devoted substantial resources to developing models of school/community partnerships. Its work on public engagement led to a three phase cycle of development:

- **Coming Together**—Starting conversation and dialogue, building trust and safe spaces.
- **Moving Forward**—Converting dialogue into concern-driven activity, reaching out beyond the core group.
- **Sustaining Momentum**—Building structures to sustain momentum, sustaining leadership, assessing and improving programs.

**Learning Cities**

There is a network of over twenty Learning Cities in Britain which exchange information and ideas on how to develop as Learning Cities with strong partnership development. Cities such as Sheffield, Nottingham, Derby, and Liverpool are members of the network. A study commissioned by the British Department for Education and Employment (1998) to support Learning City development identified three levels of partnership development:

- **Level 1** Getting Organised; the planning and building phase.
- **Level 2** Towards Shared Understanding; promoting dialogue and shared understanding.
- **Level 3** Cycles of Learning; this is the reflective phase of mature partnerships where the main pay-off occurs.

This study developed a matrix (see figure 6) for use in planning and monitoring progress in the partnership. A key feature of the Learning City approach is the need for careful monitoring and evaluation of progress.
The matrix suggests a number of activities which can be used in each phase of partnership building to progress the partnership. This matrix could be used in planning for your partnership.

**Industry/education partnerships**

A study was undertaken in 1995 of industry/education partnerships in Australia with 20 cases of partnerships examined across Australia. This study also identified three phases of development in the life-cycle of partnerships (Kearns, Murphy & Villiers 1996).

1. **Start-up**: The ‘getting to know you’ phase with initial contacts directed at building confidence and trust.
2. **Development**: Joint planning for the partnerships with implementation of the operational phase of the partnership. Strategies are developed for interaction and collaboration.
3. **Mature partnership**: The recognised common interest sustains the partnership. Mechanisms are in place to sustain, review, and extend the partnership.

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**Figure 6: Partnership matrix**

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Lessons for consumer/provider partnerships

Each of the models outlined above provide insights into good practice in building high quality consumer/provider partnerships in the health sector. Key aspects include:

- partnerships need to progress through a number of phases of development with appropriate strategies in each phase;
- careful joint planning is necessary;
- building mutual understanding and trust is essential in gaining commitment to the partnership;
- the objectives of the partnership should be clear to all stakeholders;
- there should be regular monitoring and evaluation of progress; and
- shared ownership is essential.

These insights have much in common with a set of good practice principles and guidelines for industry/education partnerships developed by the Curriculum Corporation. These guidelines are given below.

<table>
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<tr>
<td>Understand the background environment of each partner.</td>
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<td>Develop a framework of mutual understanding.</td>
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<td>Identify the benefits for each partner.</td>
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<td>Ensure commitment at the top.</td>
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<tr>
<td>Identify and empower champions. Champions communicate the vision.</td>
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<tr>
<td>Develop a vision that is shared by all stakeholders.</td>
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<tr>
<td>Translate the vision into planning.</td>
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<tr>
<td>Establish good communication and trust.</td>
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<tr>
<td>Invest in marketing.</td>
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<tr>
<td>Ensure a high level of coordination.</td>
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<tr>
<td>Allow ownership by all stakeholders.</td>
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<tr>
<td>Integrate the partnership into the culture of each of the partners.</td>
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<tr>
<td>Manage continuity and succession.</td>
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It is useful to consider how these principles have been applied in case studies of good practice. This could be discussed in a workshop with any of the part 3 case studies such as the Adelaide Womens’ and Children’s Hospital or Healthy Cities Illawarra case.

A key requirement in culture change is to develop motivation for partnership. In the case of Healthy Cities Illawarra this included:

- involving all stakeholders from the beginning;
- joint planning;
- developing a shared vision at an early stage which led to the charter;
- joint ownership is reflected in the organisational arrangements; and
- getting ‘runs on the board’ through the work of task forces so that the benefits were clear to all partners.

The application of these principles has meant that Healthy Cities Illawarra has been able to be sustained over a period of twelve years. The strategies adopted have inculcated the values, such as trust and respect for others, that underpin partnership.
development. Applying the techniques listed enable progress to be monitored as a partnership culture is built up over time.

**Remember**

- Perhaps the most important general feature is that partnerships evolve over time, rather than being executed in a single stage according to unchanging criteria and objectives. A partnership is a moving picture, not a still photograph.  
  Organisation for Economic Cooperation and Development (1992)
- They are living systems that evolve progressively in their possibilities ... the connection offers the parties an option on the future, opening new doors and unforeseen opportunities.  
  Rosabeth Kanter (1994)
- Modern information and communication technologies offer many creative ways of building and extending partnerships. Technologies such as email can be used to keep partners in contact so as to sustain dialogue without being intrusive in time.

**5.3 BUILDING LEARNING ORGANISATIONS**

All organisations, whether public or private, now operate in a context of radical change and discontinuity which is characterised by the exponential pace of change.

This new environment has been produced by the impact of globalisation, new information and communication technologies, and changes in work and labour markets which have accompanied the change. Shifts in social attitudes and values have also accompanied the changes. The pace of change has let to the blurring of many traditional boundaries (Davis & Meyer 1998) so that people everywhere are confronted by ‘the shock of the new’.

These forces have led to pressures for lifelong learning so that individuals can maintain their employability as skill needs change, and maintain their quality of life in a world that combines risk and opportunity in a precarious balance. For this reason the British Government has termed the new era ‘the learning age’.

In this environment not only must individuals continue learning as the world changes, but so also must organisations and communities. For this reason there has been an international surge of interest in concepts such as the learning organisation, learning community, and Learning City. Examples of these concepts being implemented may be found around the world.

The health sector is subject to these pressures and challenges in the same way as all other sectors of social and economic activity. Building learning organisations, networks, and communities in the health sector therefore promotes an opportunity for innovative collaboration and partnership between providers and consumers in addressing the challenge of 21st century conditions. There is mutual advantage in this happening so that health systems can be responsive to the challenges and opportunities of the 21st century environment and conditions.

**What is a Learning Organisation?**

Peter Senge (Senge 1990) in his influential book on learning organisations defined a learning organisation in the following terms:

‘an organisation that is continually expanding its capacity to create its future’.

This means that a learning organisation must go beyond ‘survival learning’ and progress to what Senge calls ‘generative learning’—learning that enhances our capacity to create. In a learning organisation:
• work and learning are integrated;
• the capacity of staff is continually expanded and developed;
• a culture of reflection and continuous improvement is fostered; and
• the organisation is closely linked to its environment and so is receptive to changes in this environment.

In a health organisation, such as a hospital, health centre or health system, consumer/provider collaboration would be an important aspect of linking the organisation to its environment. Providers and consumers would learn together and would share a commitment to continuous improvement in the work of the organisation.

How do we build Learning Organisations?

A number of approaches to building learning organisations have developed around the world. There is no single best way. It all depends on the situation of the organisation, its stage of development, and its environment.

The strategies recommended by influential writers on learning organisations are outlined below to illustrate the range of possibilities.

**PETER SENGE: THE FIFTH DISCIPLINE**

Senge (ibid) discusses five disciplines for building a learning organisation. These are:

- fostering personal mastery among people in the organisation;
- enabling people to shift mental models that inhibit new learning;
- developing a shared vision among stakeholders (e.g., providers and consumers);
- using team learning effectively; and
- developing systems thinking in the organisation. The ability to see the big picture (helicopter vision) and to see how things connect.

All of these disciplines could be built into an education and training program for consumers and providers using strategies such as workshops and action learning.

**KAREN WATKINS AND VICTORIA MARSICK: SCULPTING THE LEARNING ORGANISATION**

This book is useful in its discussion of the four levels of learning that need to be addressed in building a learning organisation (1993). These levels are:

- individual learning;
- team learning;
- organisation learning overall (empowering people towards a collective vision; establish systems to capture and share learning); and
- society, connect the organisation to its environment.

This approach by Watkins and Marsick is illustrated in the following figure which illustrates the importance of effective team learning in linking individuals and the organisation. Teams provide opportunities for ongoing development of learning skills and habits. The importance of dialogue is also evident in this approach. At a societal level, systems thinking helps to connect the organisation to its environment to facilitate continuous learning.
MICHAEL MARQUARDT: BUILDING THE LEARNING ORGANISATION

This book offers a practical approach to building a learning organisation based around integrating five key systems in an organisation: people, learning, organisation, knowledge, and technology (1998).

While Marquardt, like Senge, emphasises systems thinking, his approach is valuable in its emphasis on the need to harmonise all systems in an organisation. Effective learning will not occur if organisational structures and practices, or the role of technology, are not compatible with the learning objectives. This means that careful planning is required to achieve the best fit between these key systems in an organisation. Providers and consumer collaboration could be an important part of this process.

Strategies

It will be seen that the Senge, Watkins and Marsick, and Marquardt approaches share certain common features yet also offer complementary insights into strategies for building a learning organisation.

• There is a need to develop a shared vision through ongoing dialogue.
• Continuous learning opportunities should be created for staff and other stakeholders (eg consumers).
• Team learning is a necessary strategy.
• Systems thinking should be encouraged so that all stakeholders see the big picture, and are sensitive to change.
• Personal mastery enables people and organisations to change, to be adaptive and responsive to changing conditions.
• Partnership is a key dimension to any learning organisation.
• There should be systematic provision for review and reflection.
These principles could be used in developing a learning organisation strategy for your organisation with all stakeholders involved in this process.

Relevance to health sector

Most learning organisation development to date has occurred in private sector firms, in particular in firms operating in competitive global markets (Watkins & Marsick, op cit). These firms understand the need to be receptive to changing conditions, and to be responsive and adaptive in this environment. This has been called ‘when giants learn to dance’ (Kanter 1989).

Health organisations also need to ‘learn how to dance’ in the conditions of the 21st century, and to have the same agility and responsiveness to change as private corporations. A learning organisation strategy can offer much in this environment in providing a framework for fresh thinking and innovation in addressing this challenge with all stakeholders contributing.

A shared vision will need to accommodate consumer and provider interests in a fresh concept of the organisation relevant to the 21st century. Much inquiry dialogue, and leadership would be necessary in progressing to such a shared vision with the barriers discussed in this resource guide addressed.

A learning organisation or learning community strategy could also accommodate and link all the individual education and training strategies discussed in this Resource Guide.

Progressing a learning organisation (or learning community) requires that information needs, skill needs, and cultural change all are addressed in this journey.

It has become increasing evident that ad hoc changes (and ad hoc education and training) do little to address the real issues that individuals, organisations, and communities face in the new world of the 21st century, and that systemic change is needed which links and integrates initiatives. A learning organisation approach offers a systemic strategy with its face to the future, not the past.

An information and risk society, in the world of exponential change, is by its nature a partnership and learning society. Adapting health organisations to this environment presents a critical challenge where consumers and providers share a common interest.
PART 6

Appendixes

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APPENDIX 1: OTHER CURRENT CONSUMER FOCUS PROJECTS

National Resource Centre for Consumer Participation in Health

The National Resource Centre for Consumer Participation in Health (NRCCPH) is managed by a consortium that comprises of the Health Issues Centre; the Women and Children’s Hospital, Adelaide; and the Australian Institute for Primary Care, La Trobe University.

As the first of its kind in Australia, the NRCCPH provides a unique service as a clearinghouse for information on consumer feedback and participation methodologies for health care providers and consumers. In the longer term it will become a centre of excellence offering expertise to client users and critically analysing new methodologies and models.

Structural and cultural marginalisation in health care project

This project aimed to identify documented ways that health services have involved or sought feedback from groups of consumers who have generally been excluded from existing processes.

Improving Health Services through Consumer Participation: a Resource Guide for organisations

This project was been developed jointly by the National Health and Medical Research Council’s Health Advisory Committee, the Consumer Focus Collaboration and the Consumers’ Health Forum. It produced a tool catalogue of approaches and strategies to assist service providers and consumers to achieve effective consumer participation in the planning, delivery, monitoring and evaluation of health services. The resource guide presents resources, strategies and best practice approaches to assist people at all levels within organisations to undertake their work.

Reporting to consumers on health service quality

The objective of this project is to identify from existing models of reporting on quality to consumers, the principles or strategies that contribute to their effectiveness in order to inform future initiatives in this area. The Stage 1 report will include a literature study and summary of approaches, and an identification of some of the most effective approaches.

Consumer participation in the accreditation of health care services

This pilot study is evaluating consumer involvement in the health services accreditation. It is being developed and run by a partnership consisting of a consumer organisation, an accreditation agency and a health care facility

Publications resulting from these projects will be available from the National Resource Centre for Consumer Participation in Health web site (http://nrccph.latrobe.edu.au), or by free call on 1800 625 619.
APPENDIX 2: ABOUT THE AUTHORS

Global Learning Services (GLS) Pty Ltd (ACN 076 483 406) is an international consultant network with extensive experience in conducting policy and program reviews in education and training and related areas and developing resources for lifelong learning. As in this project, GLS regularly invites consultants in specialised areas to join multidisciplinary teams in order to address complex briefs.

The Commonwealth Department of Health and Aged Care (DHAC), as part of its program with the Consumer Focus Collaboration, commissioned GLS to:

a) identify the key characteristics of successful education and training methods to prepare health consumers, administrators and providers to create partnerships across health care;

b) describe examples of education and training for consumers, providers and administrators which are successful in doing this and include these in a resource guide;

c) identify key issues and gaps in education and training for the various stakeholders.

Through consultations with a wide range of organisations across Australia and a literature search of relevant theoretical and practical issues and local and overseas examples of successful programs, the project team prepared reports to DHAC and the Consumer Focus Collaboration in addition to this Resource Guide.

**Project team members**

**Dr Jennifer Thomson**  
Management consultant; Policy Adviser, ACT Division of General Practice; Medical Consultant, Australian Medical Association

**Dr John Grant**  
Director of GLS; Chair of ACT Accreditation and Registration Council; previously Deputy Vice-chancellor, University of Canberra

**Dr Barbara Pamphilon**  
Head of School (Acting), Professional and Community Education, University of Canberra

**Ms Fiona Tito**  
Executive Director, Enduring Solutions

**Dr Barry Cameron**  
Director, HudCam; GLS Associate

**Mr Peter Kearns**  
Managing Director, GLS

**Mr Jake Keller**  
Education and management consultant

**Mr David Francis**  
Managing Director, Caithness Robson Consulting; previously Chief Executive Officer, Curriculum Corporation

**Dr Christopher Holmwood**  
GP supervisor Modbury Hospital; Adelaide Southern Division Mental Health Program Manager

Global Learning Services Pty Ltd  
38 Ambalindum St, Hawker ACT 2614 Australia  
Phone: + 61 2 62541155; Fax: + 61 2 62542628; Email: johgrant@ebm.net.au  

A Consumer Focus Collaboration publication
Definitions marked with an asterisk have been adapted from the glossary of terms in 'The Kit' (1997)

**Action learning**: a continuous cycle of learning in which the learner observes, reflects, develops new ideas then tests these in a new learning situation. Can be an individual and/or group process.

**Advocacy**: promoting and/or supporting a cause, such as consumer/carer rights to services, information, basic human rights.*

- **Advocate**: 1. (noun, as in ‘John is my advocate’): a person who actively supports another person’s cause. 2. (verb, as in ‘I advocate that consumers and carers should be involved in evaluating the program’): to provide active support to another person’s cause.

- **Self advocacy**: what an individual does to represent his/her own needs/rights.

- **Peer advocacy**: the activity undertaken by more than one person to represent the needs/rights of his/her peers (that is, consumers addressing the needs/rights of other consumers).

- **Systems advocacy**: these activities directed specially towards the systems, structures and forms that are instrumental in the conditions that create injustices and inequalities.*

**Briefing**: preparing a person for an event/experience through advance discussion and preparation.

**Carer**: people close to (often living with) someone who lives with a physical or mental illness/distress. Includes ‘family carers’ and friends or allies who offer support in times of need. Many people ‘care about’ what is happening to a friend or relative but do not identify with the term ‘carer’.*

**Carer perspective**: a way of seeing the world through the eyes of someone who has experienced the role of ‘caring about’ another person who lives with physical/mental illness/distress. Includes a recognition of the emotional strain and despair of seeking appropriate services and support for one’s self and a loved one. Also includes a feeling of solidarity with others in the same or similar situations, and a determination to bring about improvements.*

**Chairperson/chair**: a person who heads a committee (or similar formal group), and is responsible for ensuring that meetings are orderly and topics listed for discussion are addressed.*

**Collaboration**: cooperative processes between two or more people towards an agreed goal.

**Collaborative learning**: a process in which individuals agree to share their knowledge, perceptions and understandings in order to learn together.

**Community development**: is concerned with enabling and empowering people as they work towards an agreed goal of social change, through a wide range of processes, most of which are informal, non-institutional and not formally considered to be education or training.

**Community campaign education**: usually takes the form of some kind of organised campaign to increase people’s awareness and understanding of a particular issue or set of issues. A campaign might include advertising in the media; distribution of
pamphlets; appearances on radio and TV talk shows; talks and workshops run for school students and others.*

**Competencies**: the behavioural outcome (skill) that provides the goal of a particular education strategy.

**Continuing education**: (also known as professional development education) the ongoing education undertaken by a professional after initial qualification. In some professions, for example in some areas of the medical profession, there are mandated minimum requirements.

**Constituency**: the group of people who are represented by those elected as their representatives.*

**Consultant**: 1. a person who consults others, gathers their views and provides advice based on the experiences and knowledge gathered from this wide and diverse source 2. a person considered to have expert knowledge who uses this expertise to assist those who consult him/her.*

**Consumer perspective**: a way of seeing the world in the light of experience/s of physical/mental/emotional illness/distress. Includes experiences of seeking support (of various kinds), of stigma in the community and within services. Also incorporates a sense of solidarity with others who have had similar experiences.*

**Content**: the issues which are under discussion and for which decisions will be made (contrast to ‘process’).*

**Convenor**: a person responsible for organising a meeting, conference, workshop; a person responsible for bringing people together for a specific purpose.*

**Curriculum**: a framework for what will be taught and how it will be taught in an educational institution.

**Debriefing**: the act of discussing or talking through a recent experience, such as a crisis of some kind, a presentation, experiences at a conference or committee sitting.*

**Dialogue**: an experience of exchange of ideas between two or more people for mutual learning.

**Didactic teaching**: one-way transmission of information from the ‘expert’ to the ‘uninformed’. Also known as ‘empty vessel’ education. Compare to dialogue. Learner-centred education and problem-based learning.

**Deep dialogue**: a structured sharing of views, experiences within a small group. The important ingredients are that the group includes a range of individuals with differing experiences and that group members are respectful of each other’s contributions.*

**Empowerment**: used to encapsulate a complex set of issues around an individual’s subjective and objective experience of the world, his/her position in it and his/her ability to undertake certain things. No one can ‘empower’ another person, but individuals, institutions, systems, social traditions and practices can and do disempower individuals and groups of individuals. When an individual is empowered he/she feels able and strong enough to make decisions about his/her life; to ask questions rather than blindly accepting the opinions of others who hold greater status; to make mistakes and to enjoy successes.*

**Enabling**: the process by which empowerment occurs.*

**Equity**: an abstract principle that applies to deciding relative fairness. Advocacy activity is often aimed at ensuring that equity is established and maintained.*
**Evaluation:** assessment; appraisal; examination; judgment of the worth of something.*

**Experiential learning:** learning that arises from the experiences of everyday life or a designed educational activity.

**Facilitator:** a person who works with a group to assist it to make decisions and achieve outcomes by focusing on the process (see ‘process’) of group decisions and decision making. A kind of leader, who doesn’t get involved in the content (see ‘content’) of the discussion.*

**Feedback:** information, opinion, commentary, revision received from concerned individuals or groups in response to proposal, project, process that has repercussions for that person or group. Feedback can be verbal or written, formal or informal.*

**Formal learning:** where the learner experiences education that usually has a defined curriculum, is organised by qualified professionals and often results in qualification or certification.

**Guided discovery learning:** a structured learning experience in which the learners are given the opportunity to determine their own questions and information priorities within a given situation.

**Health promotion:** any combination of education and related organisational, economic and practical interventions designed to promote behavioural and environmental changes conducive to good health. This may cover a range of strategies including legislation, health education, community development, advocacy, and the like (Richmond 1998).

**Healthy Cities** a World Health Organization initiative in which a city works uses intersectoral cooperation for wide-ranging improvements in physical, social and environmental health.

**Informal learning:** the learning from everyday life that is apparent through reflection when people try to consciously learn from their experiences.

**Information:** data relevant to a specific concept(s).

**Jargon:** technical or otherwise limited/specific terminology; a kind of ‘slang’. Different professional and other groups use certain kinds of words that have little or no meaning beyond the context of their area of expertise. While most people use jargon to some extent, medical, bureaucratic, scientific, psychological, or other jargon can be used in a way that alienates and disempowers consumers and carers.*

**Knowledge:** a fluid mix of experience, values, insight and contextual information that provide a framework for incorporating new experiences and information.

**Learner-centred education:** an approach to education that focuses on the range of learner needs and learning styles.

**Learning Cities:** a city which unites all the diverse providers of learning to meet the needs and aspirations of all its citizens.

**Learning community:** any group of people, whether linked by geography or shared interest, which addresses the learning needs of its members through pro-active partnerships. It explicitly uses learning as a way of promoting social cohesion, regeneration and development.

**Learning Organisation:** an organisation where learning rather than training is the priority, and is therefore flexible, adaptable and multi-faceted in its support of learners.
Learning society: a society in which everyone who wants to do so is able to participate in education and training throughout their lives. Information about learning opportunities is widely available and education provision is driven by learner needs.

Learning styles: also known as learning preferences, this refers to the tendency of adults to have developed preferred ways of learning, for example, through visual or auditory sources or through hands-on experiences.

Life-long learning: recognises that learning occurs across all life stages, in many situations such as the workplace, home and community generally and that there are many different techniques and methods that can be used to learn, both formal and informal.

Lobbying: representing particular interest to others to influence the outcomes.*

Mental models: deeply held internal images of how the world works which limit people to familiar ways of thinking and behaving (mindsets).

Mentor: a person who, through their knowledge and experience, acts as a trusted personal advisor to another.*

Needs assessment: a research process that enables the mapping of all levels of needs or a defined type of need (eg training needs) of a specified group.

Networking: (jargon) getting to know and connecting with people who may be helpful to one’s cause, career, task, project, organisation; developing a range of helpful contacts.*

Non-formal learning: where the learning experience has not been designed solely for education, but is organised in some way, for example being trained on-the-job.

Orientation: the provision of an introductory learning experience for new participants.

Partnership: collaborative relationship that features reciprocity and mutual exchange.

Popular education: involving people in a process of critical analysis so that they can, potentially, act collectively or individually to recognise and change oppressive structures. Drawn from the work of Paolo Freire.

Pre-service training and education: initial education undertaken in order to be qualified for a particular role, for example under-graduate medical training.

Primary health care:

1. a radical reinterpretation of health services that would redress health inequalities through a commitment to greater justice and equity in health resource allocation. Equity and participation (community involvement) are the central pillars of this intersectoral approach (Germov 1998).

2. health care professionals also understand primary health care as a first level of service delivery that is preventive in orientation.

Proactive: carry out activities, put forward ideas in order to set the agenda (contrast to ‘reactive’).*

Problem-based learning: a learning experience that has been designed to draw out the issues from a real-life situation or simulation.

Process: the manner in which issues are discussed and decisions are made; a set of operations that are applied to specific issues (contrast to ‘content’).*

Professional development education: see continuing education.
Quality assurance: processes or practices to ensure services and their means and manner of delivery are appropriate to the needs of consumers and carers. Includes ensuring that consumers and carers are listened to both individually and through representatives. Quality assurance requires that user-friendly complaints mechanisms are in place, and that decisions about health services and issues are not made in the absence of those who are most affected by them.*

Reactive: carry out activities, put forward ideas as a response to an agenda set by someone else (contrast to ‘proactive’).*

Representativeness: the ability to reflect the views and concerns of one's constituency.*

Self-directed learning: most adult learning is self-directed whereby the learner sees a need for further learning and manages the necessary learning experiences. Also refers to the current approach to adult education where the learner’s path is facilitated by the educator rather than rigidly prescribed.

Situated learning: knowledge and skills learnt in the contexts that reflect how knowledge is outlined and applied in everyday situations. May include workplace learning and learning in community contexts, e.g. organising a town festival.

Service provider: includes doctors, nurses, psychologists, occupational therapists, psychiatrists, social workers and the institutions in which their work takes place.

Socially critical education: a process that is deliberately designed to enable the learner to become aware of the social, historical and cultural power dimensions of an issue.

Stakeholders: the different groups that are affected by decisions, consultations and policies.*

Tacit learning: learning that proceeds in an unconscious manner.

Team learning: a process of learning in which the needs of the individuals and the whole team are considered.

Transformative learning: the result of a learning experience that challenges the learner’s previously taken-for-granted assumptions about an issue.

Vocational education and training: accredited courses that qualify a person to work in a specific position, and/or ongoing training within the job.

Workshop: seminar, instruction session; educational gathering; discussion group.*

WHO: World Health Organization.
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