Mental Health Community

Stephanie White

Mental Health (MH) is a group or sub-community that along with other varied groupings, make up the wider Manawatu region and the Palmerston North community. Although MH provides selected services in the Wellington area, the core business is in Palmerston North and the surrounding region. MH is composed of a core, the Board of Trustees working with the Chief Executive Officer, and four peripheral layers. Layer one is the support staff, people who have no direct contact with MH's clients. Layer two is operations management. Layer three is the array of services that MH provides, including residential and social support services. Layer four is the clientele of MH. Looking up the ladders, The Health Funding Authority is the largest financial backer of MH and therefore holds both financial and political power over MH. It sets guidelines for expenditure and defines the services MH must provide. As The Health Funding Authority is part of the New Zealand Government, the NZ Government has ultimate political power over MH.

MH believes that clients are their primary focus. However, when applying the ideas derived from General Systems Theory (Gregory, 2002), it appears clients gather at the bottom of a large hierarchy and have little real power. Extending beyond the core and four layers, the wider community is also important for MH as they provide "community care". Stigma attached to mental health is a major concern.

MH Trust was developed in 1990 as the result of the pending closure of the nearby Psychiatric Hospital, which closed in 1992. Thus MH Trust represents an example of 'deinstitionalisation' in New Zealand. Previous to deinstitionalisation, the most important niches (habitat within a given creature can survive) for people with mental illness were mental hospitals, now niche breadth has enlarged and mental health clientele are found in many different communities (Levine and Perkins, 1997), one of which is Palmerston North. MH is a Non-Government Organisation (NGO) bonded by the Charitable Trust Law (1957). It provides community care for those going through a rehabilitation process after a mental illness. "The goal of rehabilitation is to assure that the disabled person possesses those physical, emotional and intellectual skills needed to live, learn and work in his or her own particular community" (Anthony, 1980, p.7). The MH mission statement is to "promote the empowerment of people with disabilities through the philosophy of self- help and with due regard to the Treaty of Waitangi" (Annual Report, 2001, p.3). As stated in the Annual Report (2001, p.5). MH values:

- People as our greatest asset;
- Partnerships with Tangata Whenua;
- Personal empowerment and diversity among individuals;
- Open communication, collaboration;
- Shared responsibility, integrity, commitment;
- Responsiveness to community needs.

G.A. Hilley (1955, cited in Warren, 1996) compared 94 definitions of community and concluded: *"Community is a collectivity of people who occupy a geographical area, who are engaged together in economic and political activities, who essentially constitute a self-governing social unit with common values and who experience feelings of belonging to one another"* (p.3). MH adheres to all these points and therefore constitutes a community. In this report the MH community will be discussed from the core to the wider community (environment) outside the barrier. General Systems Theory will be applied with ideas adapted from Gregory's 175.301 lectures (2002). All information about MH (unless otherwise referenced) has come from personal communication with the MH Chief Executive Officer.

MH has approximately 123 staff members (management, staff and support workers) and approximately 160 high support clients (residential), 75 community supported clients (live in own home) and 850 clients from the general mental health sector.

The Core

The core of the community is the 10 member

Board of Trustees, of whom two are clients. The board works closely with the Chief Executive Officer (CEO) and together, this core has the most power within MH. *"In line with the MH constitution (1999), the board oversees the provision of all services, through the CEO and the management team"* (Annual Report, 2001, p.6).

Layer One – Support Staff

The first layer of the community is the support staff (as shown in Fig. 1).

The support staff controls finances and staff training, having no direct contact with the clients. Collectively the support staff makes up a subsystem within MH.

It costs approximately $4.2 million to operate MH annually. This is largely funded by contracts from the Funding Authority, plus grants, other contracts and services provided for customers in the ordinary course of business (Annual Report, 2002). The tracing of funds demonstrates a cycling of resources as shown in Kelly's (1966, cited in Levine and Perkins, 1997) second principle of ecology. MH's largest funding source is The Health Funding Authority. Although MH is a non-government organization, The Health Funding Authority receives its money from the Government. The Government in turn receives its money from taxes. Therefore, employed people within Palmerston North (including MH clients previous to referral and in some cases - workmates - currently) pay taxes, which in turn funds MH's operations. This process is shown Figure 2.

As The Health Funding Authority provides funds (derived from The New Zealand Government) they also have political power over the operations of MH (discussed in the section titled "The Wider Community"). The National Mental Health Workforce Development Plan 2000-2005 provides for a total expenditure of $90,655,000 over five years for staff training. Some $6,660,000 of this is earmarked specifically for support staff training (Annual Report, 2001), as MH are actively encouraging their support staff to work towards their National Mental Health Support Worker Certificate (Annual Report, 2001). They also provide practicum opportunities and preceptorships for students (Business Plan, 2002). This benefits both the staff and the clients. Figure 3 shows the hierarchical structure of the support staff within

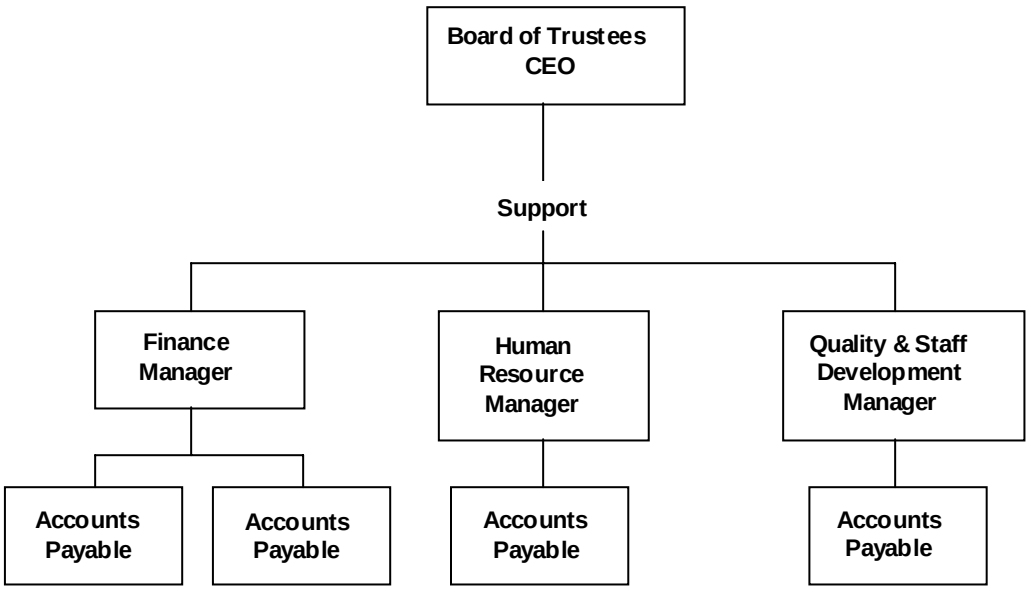

Fig. 1. MH support staff

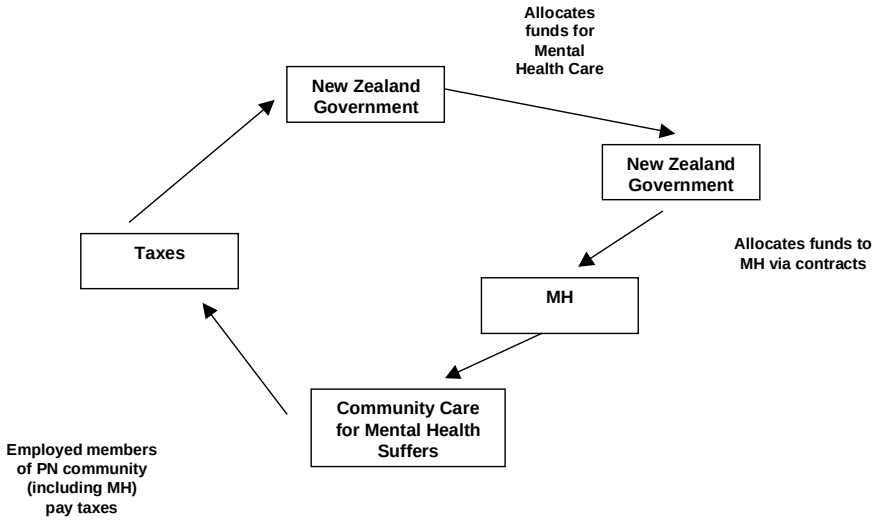

Fig. 2. Cycling of resources-tracing the money flow

MH. The direction of the system peaks towards the goals and values of MH. For the support staff, these are the "Business Objectives". Outsiders are The Health Funding Authority and accountants who audit expenditure and revenue.

Figure 4 shows the subsystem of the support staff where specialisation is apparent. The Board is the decision-maker. Staff further down the hierarchy (management and subordinates) regulates the input (revenue or new staff) and controls the output (expenditure and training outcomes). Management, subordinates and the Board are sensory devices that monitor the

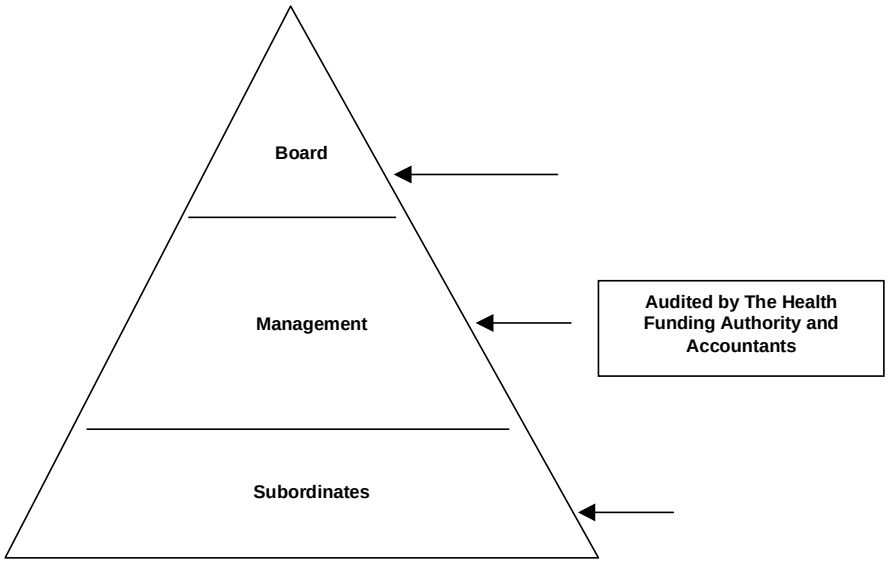

Fig. 3. Structure of Support Staff within MH

internal environment (use of financial statements and staff appraisal systems) and monitor the external environment (looking for funding opportunities). Internal maintenance is carried out during meeting.

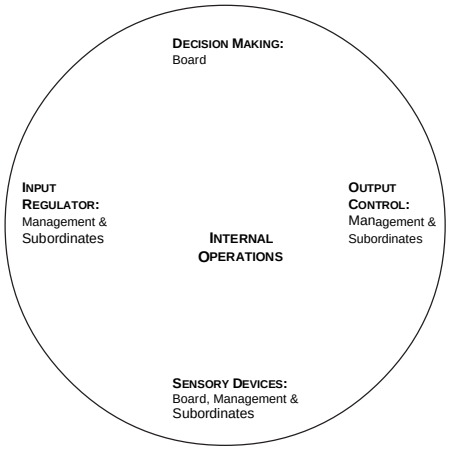

Fig. 4. MH support staff subsystem

Layers Two, Three and Four

Layer Two (operations management), Layer Three (support staff), and Layer Four (clients) make up the operational levels of MH. These three layers are divided into two segments. The larger segment represents Palmerston North's Operations and the smaller segment represents Wellington's Operations. Figure 5 illustrates layers two, three and four and how each layer is divided. It also illustrates how the operation of MH appears to have both a formal power hierarchical relationship and an informal/ friendship relationship.

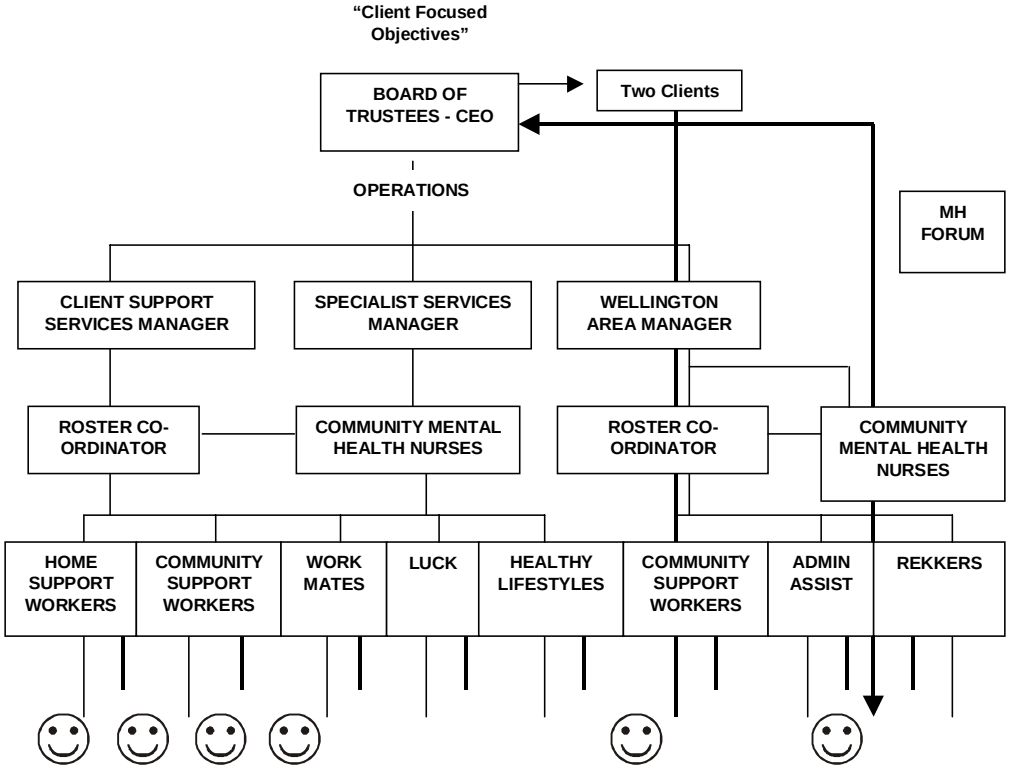

Fig. 5. Composition of MH operations. Formal power hierarchical relationship and informal/ friendship relationship.
(Information obtained from Business Plan, 2002)

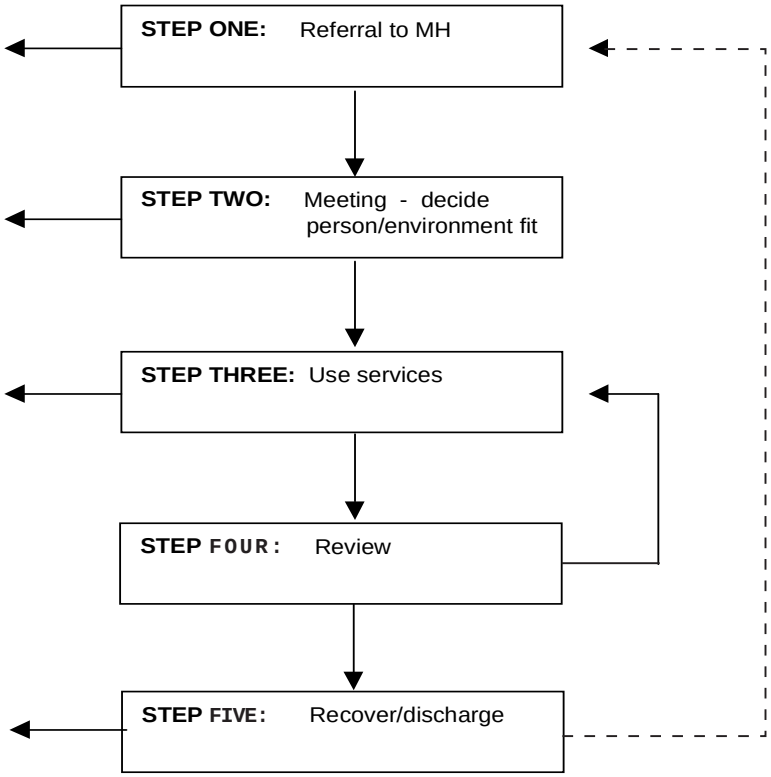

Fig. 6. MH client from initial contact to discharge

Formal Hierarchy

The Board makes the overall decisions and sets the *"Client Focused Objectives"*, which are the goals and values of operations. As the pyramid widens people lose decision-making power.

Informal/Friendship Relationships

Two clients are democratically voted onto the board. All clients can be nominated for board membership and once voted on, have a right to stay on the board for a period of three years with full voting rights. These clients can voice opinions and vote not only according to their own perspective, but can also voice the perspective that they may have received from other clients due to friendship relationships at the bottom of the hierarchy.

Informal relationships are also developed between support staff and clients as MH emphasizes clients' involvement in their own rehabilitation. The MH Forum meets monthly in both Palmerston North and Wellington and is held to "consider specific issues raised by clients in relation to the governance of MH, the management of houses and the services provided by MH generally" (*Business Plan*, 2002). This provides the opportunity for clients to have a say and provides empowerment for clients to make decisions. It also provides feedback within the system that enables decision-makers to maintain direction. This is a strength for when the hierarchy is as big as that of MH's, feedback may not be heard.

The outer boundary of the MH community is closed. Although clients function within the wider community (environment), to be a member of MH (as a client) you must be experiencing or recovering from a mental illness.

Figure 6 following shows the process of a client from initial contact to discharge; the process of a client entering and exiting the community.

Step One - Referral to MH

Clients can be referred to MH in the following ways:

- Direct referral from the Court System as an alternative to other punishment
- Self or family/whanau referral. Although MH would never deny a client access to their services, they would normally ask to contact the person's doctor. MH advertises its services in brochures that are placed in doctor's surgeries and other organisations within the Palmerston North, Wellington and the surrounding Districts.
- General Practitioner referrals.
- The main stream of clients is referred through psychiatric wards of hospitals. MidCentral Health in Palmerston North and Capital Coast Health in Wellington.

Unfortunately, sometimes people who could benefit from MH's services never use them because *"negative attitudes interfere with a persons ability to access treatment by delaying self referral and diagnosis"* (Mental Health Services, 1994, p.25). This is a matter unique to communities whose membership comes hand in hand with negative attitudes. MH advertising their services within the community might help some people overcome the barriers to accessing treatment. A weakness of MH is that referral can only be carried out in normal business hours. (LUCK drop in center is open Saturdays). A possible consequence of this weakness is that the help may not be available at times when people need. For example, a person who lives alone may display symptoms of mental illness when they are at home alone at night, whereas symptoms are not as severe when they are at work with colleagues during the day.

Step Two - Meeting and Deciding Person/ Environment Fit

Clients meet with MH staff and a formal documentation process is completed. This step involves a needs assessment (administered by a psychiatric professional) using the "Support Needs Assessment Form" (psychometric tool) and the creation of an individualised treatment and recovery plan. The need assessment covers 15 areas of life. The professional, with the input

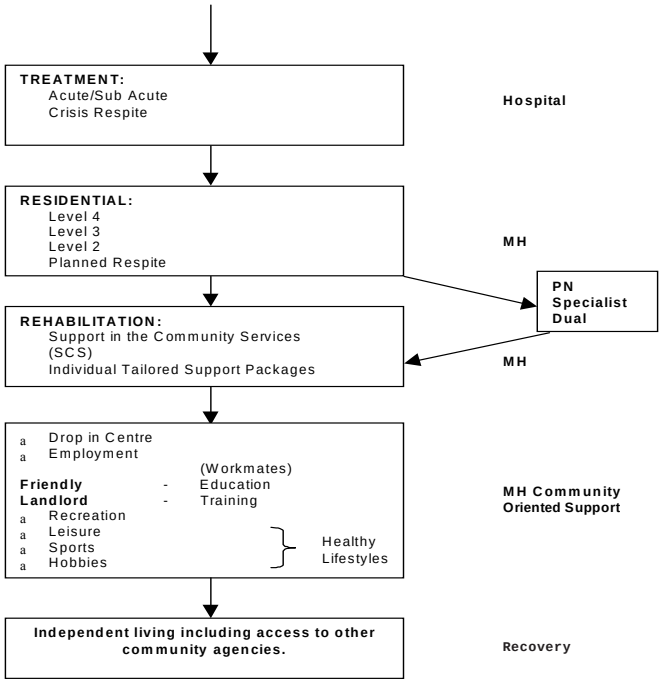

Fig. 7. Continuum of treatment, rehabilitation and support services in the recovery process (Business Plan, 2002, p.14)

of the client, must allocate a number from zero to four, for each of the sections of the 15 life areas. Zero is "none at all or does not apply" and four is "need someone to take full responsibility, i.e., 90-100 percent of time". This assessment is a possible use of ideas of Moos (1976, cited in Levine and Perkins, 1997) about social climate (see Levine and Perkins, 1997, p. 150-155 for discussion of Moo's Perceived Social Climate). A potential problem in this form of assessment is that as Brains et al. (1969 cited in Levine and Perkins, 1997) demonstrated, patients can manipulate their presentation of themselves. So, if a potential client does not want to be in Level Four Resi-dential Care, they can manipulate themselves to provide a more well adjusted view or if they do want to be placed in Level Four Residential Care (there are many possible reasons such as being frightened at the prospect of having to survive virtually independently, specially if they have come from institutionalized care) they can present themselves to be less "well adjusted".

Step Three - Use Services

Once assessment has been carried out, clients are placed at the level of support needed. Figure 7 shows a continuum of treatment, rehabilitation and support services in the recovery process.

Clients are able to enter the system at any point and cannot be made or forced to use services they do not wish to use. Lamb (1976) also emphasizes this approach where he discusses how every client can not be expected to participate in every phase of every program, stressing that plans should be tailored to individuals requirements (emphasising the importance of client input during assessment), because if the plans are too rigid clients will leave, causing problems for the client and the community at large. This can also be considered a weakness of MH as clients may refuse to get the level of help they need, possibly putting themselves and/or the community in danger.

Residential care provides 24 hour, seven days a week support, either face to face or by telephone. This support acts as both situational and psychological mediators, as laid out in Dohrenwend's Model (Levine and Perkins, 1997). These mediators can reduce the length of time and impact of transient stress reactions after a stressful life event, preventing a new psychopathology or recurrence of one. The services provided by MH may, in themselves, prevent stressful life events by providing housing, employment and reducing boredom and inactivity. From an ecological perspective it illustrates Levine's (1969, cited in Levine and Perkins, 1997) third principle of practice in community psychology. This states: "To be effective, help has to be located strategically to the manifestation of the problem" (Levine and Perkins, 1997, p. 145).

Living in a home with people who suffer similar problems may also rebuild relationships that may have been lost due to mental illness. MH residencies operate just like a flatting situation, with all members having set tasks and rules. Support workers help clients manage finances, all these skills learned in residence help clients learn to be able to function in their own homes as their rehabilitation advances. Alcohol is allowed, but recreational drugs are not.

When suffering a mental illness, some people find it hard to continue in employment and therefore lose the formal (and sometimes informal) relationships with employers and other employees. Downward mobility occurs with unemployment. The Workmates program helps rebuild relationships and provides skills for upward mobility as it is seen as the "transitional stepping stone to mainstream employment" (Business Plan, 2002). MH also employs clients wherever possible, providing clients with an understanding employer. For example, if a client suffers a relapse of their condition, MH will give staff the time off they need, where as other organisations may terminate employees contracts due to long term absence. This may also be a weakness of MH. Lamb (1976) explores the point that people can come to favour the role of stereotyped deviants. For example, even when clients recover and are working for organisations other than MH they may be 'slack' at attending work and blame 'mental illness' when, in fact, the symptoms they have (if any) are not severe enough to prevent attending work. Employers cannot tolerate this and people may lose jobs resulting in downward mobility. Lamb (1976) comments:

> *"Mental health professionals must accept the responsibility to encourage and in some cases to push clients towards higher levels of social participation and work performance. It should be stressed to client and public alike that the need for*

sheltered facilities does not exempt a person from taking his place in society to the full extent of his capabilities" (p.11).

MH Healthy Lifestyles Programs and drop in center (LUCK) is also providing social relationships for clients that may have been lost due to the stigma of mental illness.

Step Four – Review

Most clients stay with MH for a period of years and in this time they may make use of a wide range of services. A review assessment is completed every six months. If the professional who completes the assessment feels the client is ready to function alone in the community, the client will be encouraged to leave, but never made to leave. MH believes that by empowering individuals they will gain enough self-esteem to discharge themselves.

Step Five – Recovery/Discharge

Recovery involves independent living but clients can still access other community agencies. Hopefully clients will have the empowerment to move through the barriers that once stopped them gaining upward social mobility. Clients are free to leave MH when they feel ready, but unfortunately these are the clients that are most likely to renter the system at a later stage. If clients break rules, such as use of recreational drugs or engaging in criminal activities, they can be discharged before recovery. Normally a meeting between staff and client will talk place, but if behaviour by clients is not adjusted they will be referred to another mental health service or possibly be placed back into hospital care. Overall, the operations of MH create a subsystem as shown in Figure 8.

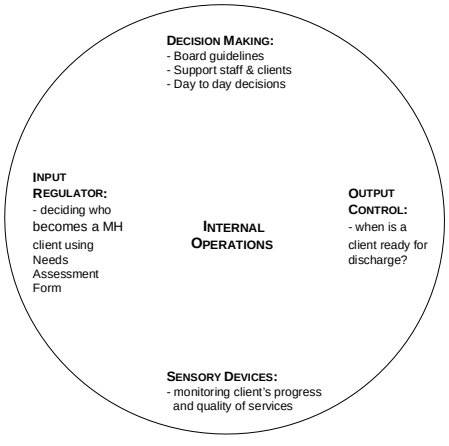

Fig. 8. MH operations subsystem

MH can only accept a limited number of clients at a time for some services (contract volume), sometimes, where possible, they may extend their services, but if a client cannot be accommodated for, they will not be left unsupported in the community. Options may include leaving the client in the psychiatric ward till a position becomes available or, referring the client to another service provider. MH does not make use of voluntary staff as voluntary staff is not bound by contract. Clients and staff build up strong relationships and a staff member leaving can have a major impact on the rehabilitation of a client.

Overall, MH is a system comprised of many subsystems as shown in Figure 9. Exchan-ges take place between the various sub-systems. Although the boundary of MH is clear, that only mental health sufferers can have membership to the community, "community care" is the idea and therefore the wider community of Palmerston North and Wellington (environment) are important.

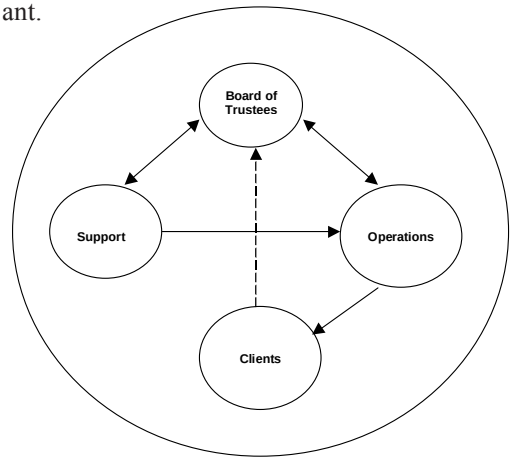

Fig. 9. MH system

The Wider Community

A major concern about community care is stigma. Even though the rights of mental illness sufferers are protected, stigma still affects them (Levine and Perkins, 1997). Sheff (1996, 1984, cited in Levine and Perkins) the refiner of Labelling Theory believes that the 'taint' of mental

illness never leaves a patient even when they have returned to the community. This can affect employment opportunities and "equally important, other people will tend to interpret the individuals behaviour in light of the history of the mental illness' (Levine and Perkins, 1997, p. 195). It is also possible that clients of MH will interpret their own behaviour in light of their mental illness history. This could result in clients having the view that they are having re-episodes of their illness, when in fact they are experiencing emotions and reactions to events that a "mentally healthy" person would also experience. One possibility could be to teach clients to differentiate between symptoms of reoccurrence of their mental illness and normal emotions and reactions to certain events. Attempts in New Zealand are being made to reduce the stigma to mental illness suffers. Television advertisements and the radio provide examples of celebrities who suffer mental illness (for example, a previous All Black Rugby Player) and state, "one in five New Zealanders suffer from mental illness". These ads are designed to reduce the stigma attached to mental illness by showing that everyday New Zealanders and New Zealanders with higher status suffer from mental illness and that there should be nothing embarrassing about it. The message is that people should not judge others by it. Unfortunately (Levine and Perkins, 1997) we know little about the relationship between attitudes and behaviour. So although attitudinal levels of stigma towards mental health sufferers may have reduced and people say that they are not biased towards mental health sufferers, they may in fact act with a bias. Scheff (1966, 1984, cited in Levine and Perkins, 1997) believes that stigma causes secondary deviance. A critic of this view is Gove (1982, cited in Levine and Perkins) who claims: "the primary determinant of any social reaction (cause of secondary deviance) to a former mental patient is the person's current behaviour" (p. 195).

Family and friends are part of a wider community. Some studies (Levine and Perkins, 1997) have shown that families of persons who are mentally ill are more tolerant than the general public. Literature by Tebes (1983) found that "family members often reduce the frequency of their visits to mentally ill persons and that many are reluctant to accept the person back into the home" (Levine and Perkins, 1997, p. 197). Some people with mental illness exhaust the social support system found in their friends and family by asking for help too often or at inappropriate times. MH's range of services hopefully prevents this from happening as their clients can use services as a social support network. Unfortunately, in some cases it is too late and clients have already lost the social network provided by family and friends. MH recognise this and does not view family and friends as necessary for their recovery efforts and simply sees family and friend support as an added bonus. Levine and Perkins (1997) state that it is difficult to distinguish between rejection from family and friends as resulting from stigma or from the strain of having to deal with a mentally ill person. As MH does not put a focus on family support they do not provide any forms of support services for family of their clients. Other services, however, such as The Schizophrenic Society, do provide this form of support.

Fraser (1999) discusses a concept of "not in our street". MH experiences this from some people when planning the purchasing of a property for establishment of new programs. People fear their safety and a decrease in the value of their property. A Listener/Heylen Poll (O'Hare 1994, cited in Mental Health Services, 1994) found that "after criminal and heavy drinkers, emotionally unstable people were the people those surveyed would least like as neighbours" (p.25). Mullen (1991, cited in Mental Health Services, 1994) concluded that schizophrenics do present an increased risk of behaving in a criminal or dangerous manner, this is not the case for mental health sufferers as a whole. But, some MH clients are schizophrenic and therefore their services may be endangering the general public. Dolan and Wolpert (1982, cited in Levine and Perkins, 1997) show that "the presence of a group home has little or no impact on any measurable aspect of neighbourhood property value" (p. 198). AG, a Real Estate Agent for First National Manawatu also believes that property value would not decrease in neighbourhoods where a community group home is present. The development of one of MH's homes in a neighbourhood is introducing change to that neighbourhood. Levine and Perkins (1997) dedicate a chapter to "The Problem of Change" (chapter 10, p.338-369). They identify seven sets of social interests that may be affected when change occurs. The seventh of these is information and communication. Information (for example, neighbourhood members knowing of the coming of MH's residential service to their neighbourhood) can

facilitate change or give the opposition (the neighbourhood) time to prepare to organise retaliation. The issue for MH is whether or not to inform the neighbourhood that they plan to situate one of their residential services in their area.

Miller and Iscoe (1990, cited in Levine and Perkins, 1997) believe that neighbourhood members should be brought into the planning process to win their support. Another view is to not include them for fear that they may retaliate. MH does not in any way try to hide information about where they will be developing their residential services.

MH sometimes receives community complaints, which they take very seriously (formal complaints procedure) as they value their relationship with the larger community. Most of the time these complaints are just 'grizzly' complaints, for example, loud music, but serious complaints do arise, such as clients exposing themselves indecently. In this case a support worker or member of the mobile team intervenes quickly. These incidents can be related to Labelling Theory, defined by Scheff (1966, 1984 cited in Levine and Perkins 1997). The theory involves a primary deviant – "specific act that violates one or more social norms" (Levine and Perkins, 1997) - and a secondary deviant. Secondary deviant is when the primary deviant becomes publicly noted and labelled as having performed an inappropriate act. Scheff (1966, 1984 cited in Levine and Perkins 1997) identifies five sets of variables that decide when a primary deviant becomes a secondary deviant. One of these is "irrespective of cause, the degree, amount, and visibility of the rule breaking are determinants of whether there will be any public reaction and effort at social control" (Levine and Perkins, 1997, p. 185). This relates to MH in that they encourage their clients to suppress norm-violating behaviour while in the community. Another example of this is The Fairweather Lodge (Levine and Perkins, 1997) where clients were encouraged to "act crazy" within the lodge but to refrain from norm-violating behaviour in the community. Most could do this, and most MH clients appear to be able to also.

This form of treatment recognizes that societal reactions have consequences for continued living in the community. In Scheff's view, to the degree that symptoms are "invisible", there is no illness (Levine and Perkins, 1997, p.185). MH uses the number of complaints they receive as an indicator of the effectiveness of their services, along with their customer satisfaction survey (carried out in 2000) which showed that 96 percent of clients were mostly or very satisfied with the service. The areas identified as needing improvement (weaknesses) were:

- Client comfort about raising issues concerned with their support
- The need to develop self confidence
- The need to further support educational opportunities for clients
- Need to investigate the reasons why older clients are less satisfied with the service than younger clients.

(Annual Report, 2001, p. 8)

The Workmates program contracts clients with people in the wider community to carry out specific work tasks. Generally, MH experience no negative attitudes from consumers of their services to clients and have no problems with client behaviour. MH works in collaboration with other community agencies. They also work with local Iwi (Te Runanga o Raukawa), a local Fellowship and a school located in nearby Fielding.

The Health Funding Authority appears to have the greatest influence on MH. As they provide a large amount of the revenue, they, along with accountants, audit the expenditure and provide regulations for services. Originally these regulations or guidelines for provision of services came from the New Zealand Government, so both the Health Funding Authority and the Government have political control over MH. If they are not complying, MH risks losing the contract to provide services to Palmerston North's mentally ill. MH is an open system that responds to turbulence, "by which system theorists mean a change in the relationship between the organisation and one or more of the factors on which it depends" (Levine and Perkins, 1997, p. 348). This turbulence may be created by The Health Funding Authority (on whom MH is dependent on for funding); therefore MH must react to the turbulence (regulations set out by The Health Funding Authority) or, as stated above, risk losing their funding. If that occurred, then would not be able to continue to provide their service.

Palmerston North (and Wellington) and the region have relatively little influence on MH. The Palmerston North City Council reviews planning consents proposed by MH for the placement of their services. However, MH is given no more consideration then the normal

person proposing plans. The Palmerston North City Council also provides low cost accommodation in the form of the 16 council flats that MH occupies.

In summary, MH is a large and wide spread community with a core and four layers. Membership is reserved for those suffering or recovering from a mental illness and those who are involved in prevention, treatment, and rehabilitation. The community is divided into the Palmerston North and Wellington regions and also into support and operations. Both support and operations are sub-systems; these along with the Board of Trustees and clients generate a system with exchanges between the sub-systems, allowing MH to function as a whole. Power within MH appears to be largely given to the Board and although MH may feel that the clients are the focus, unfortunately they appear to be at the base of a pyramidal hierarchy of power. MH emphasises client participation at all levels of the organisation, and this is indeed, available to a few. One area identified as needing improvement from the clients' perspective is that they do not always feel comfortable raising issues about the overall support available to them. This may inhibit a client's recovery. If clients do not raise issues, they cannot be attended to. However, some clients may become disheartened by the lengthy processes. Although MH proposes to improve, it may be the situation that relationships between staff and clients are not as strong as MH's philosophy states. There are arguably many possible reasons for this. Two possibilities are a lack of true empowerment on the client's part to decide on their own recovery and clients not wanting to be helped. As 'community care' is provided, the people of the wider community are considered. The part of the Palmerston North region that has the most power is The Health Funding Authority (via the District Health Board). MH appears to have a strong future. They have identified a possible first order change (Levine and Perkins, 1997) where they intend to diversify. MH has strengths and weaknesses but overall, appears to provide a well-used, much needed, quality service to Palmerston North, Wellington and their surrounding regions.

KEY WORDS Mental Health. Systems. Structures. Treatment Processes

ABSTRACT Mental illness affects many people, especially given the many economic, social and other strains and stresses so evident these days. Supportive programs may emerge and experts, specialists, and volunteers may try to treat and maintain people in the community, and prevent illness from occurring. The author looked at a major and complex program that serves mental health needs in the community and beyond. Those who work in this program form a sub-community of their own, with guiding values, rich structures, practical activities, leadership and co-ordinating structures. Through their work, the larger community of Palmerston North benefits, as do those who receive direct or indirect help.

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B.G. (M.A.S.H Trust Chief Executive Officer). *Personal Communication*, Thursday 14 March 2002. Palmerston North.

A.G. (Real Estate Agent – First National Manawatu). *Personal Communication*, Thursday 16 May 2002. Palmerston North.

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