



Rural Community Mental Health

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Rural Hawai'i: Challenging Landscape for Education and Delivery of Interdisciplinary Mental Health Services

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The Recruitment and Retention (R&R) Project for psychiatric/community mental health nurses began in 1990 as a partnership between the University of Hawaii at Manoa, (UHM) School of Nursing (SON) and Adult Mental Health Division (AMHD). From the start, the R&R Project sought to improve and support the delivery of psychiatric/mental health nursing care at the Hawaii State Hospital (HSH) as well as to promote continuing and higher education for the hospital nursing staff. In 1996, AMHD requested the UHM SON provide advanced practice nurses (APNs) for rural clinics on the Big Island of Hawai'i. At that time, the School of Medicine (SOM) had one psychiatrist deployed at Kona, a more urban clinic, on the Big Island of Hawai'i. The collaborative effort has now evolved to include five faculty (three psychiatrists and two APNs) working in partnership with the public sector's multidisciplinary staff to serve the seriously mentally ill on the Big Island.

Geographically, the island of Hawai'i is the youngest and largest in the State of Hawai'i. It continues to grow in size daily with volcanic eruptions constantly adding to its island mass. Sociologically, a lethargic state economy, unemployment (highest in the state), closures of the sugar plantations, and increasing crime statistics have, in recent years, made life on the Big Island more stressful and challenging for residents who are familiar with a simpler, predictable lifestyle.

The major urban centers of Hawai'i are Hilo and Kona. The rural clinics managed by the APNs are located in the district of Ka'u (larger than the main island of Oahu) and Honokaa on the north end of the island. Both settings are sparsely populated, but encompass several distinct communities calling for multicultural sensitivity and emerging attention to the diverse needs of the population.

The presenters in quality care have evolved from the collaborative work on the Big Island of Hawai'i. Innovations in the management and delivery of quality care have evolved in four areas

from the collaborative work of the authors on the Big Island of Hawaii.

- Collaborative leadership and administration of a rural mental health service delivery model.
- The advanced practice nurse's role as primary mental health care practitioner and clinic manager.
- The consulting circuit-rider role of a psychiatrist covering multiple rural areas.
- Telecommunications strategies addressing staff development, service delivery, quality improvement and research.

Collaborative Leadership and Administration
Imua, the psychiatric/mental health collaboration project between the UHM/SON & SOM in partnership with the State of

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Hawaii, Department of Health, AMHD, has developed mental health programs to treat the most isolated rural populations on the Big Island. Key to the delivery of care model that has emerged has been the focus on developing community resources as well as developing the community as a resource for consumers' reintegration into public life.

Collaboration faculty have dual roles as educators and service providers. As academicians and clinicians they model competency in leadership, teaching, practice and scholarly activities — inviting colleagues in the public sector to see possibilities for treatment with fresh and creative eyes.

Together with faculty mentors, the Imua Collaboration continues with its mission

“to develop new models of mental health service delivery to persons with serious mental illness in under-served rural settings.”
Imua objectives are:

- 1) to increase access to mental health care for persons with serious mental illness
- 2) to recruit, train and retain mental health professionals, paraprofessionals and lay volunteers for underserved rural areas
- 3) to enhance the delivery of primary and mental health care through consultation to providers and direct service to patients.
- 4) to carry out research involving persons with severe mental illness, emphasizing program evaluation, treatment outcomes and population assessment.
- 5) to provide consultation to hospitals, jails, social agencies and other institutions that provide services to the severely mentally ill population in rural under-served areas.

Imua philosophy believes that supportive communities, empowered by education and lived experience with mental illness, allow clients to have their needs met closer to home. The collection of outcome data will contribute to more effective interventions designed specifically for rural residents and shape future models for mental health care delivery in isolated areas.

Role of the Advanced Practice Nurse

The APN in psychiatric mental health nursing offers a unique combination of clinical competencies and a systems perspective that provides solid leadership for establishing mental health

ROLE OF THE ADVANCED PRACTICE NURSE

The APN in psychiatric mental health nursing offers a unique combination of clinical competencies and a systems perspective that provides solid leadership for establishing mental health services in an isolated community. The APNs delivering services in rural Hawai'i have been challenged by the immense need for services in some areas where mental health services have previously been unavailable or very minimally accessible at best. Combining skills in physical assessment with psychiatric evaluation, the APN is able to deliver high quality clinical care to rural consumers seeking help for Diagnostic and Statistical Manual-IV (DSM-IV) Axis I diagnoses which include treatment for psychotic symptoms, depression and anxiety disorders and panic as well as Axis II personality disorders and interpersonal distress. Along with delivering direct services, the APN also provides clinical supervision for other unlicensed clinical staff. Staff development, precepting/teaching nursing students and providing opportunities for medical students to collaborate across disciplines are some of the ways APNs implement their university faculty role.

As consultation becomes readily available to primary care providers in the community, the community providers also become more able to diagnose and treat psychiatric symptoms. They treat or refer for treatment at local mental health clinics. As collaboration increases, so does education about mental illness. Ultimately, developing the community as a resource of support for the mentally ill lightens the APN's job. As she empowers more members of the community to become instruments of healing, the APN can begin to ease into the role of consultant to family and friends as they share in the clients' journey to recovery.

The APN is also instrumental in creating change where practice and treatment of clients are outdated and substandard. The APNs, particularly those affiliated with Universities, elevate the standard of treatment by bringing the latest trends found in the literature to the attention of those with whom they work. The nursing process, which is a prototypical problem solving approach, is also valuable in helping the bureaucratic system become more responsive to the needs of consumers.

Role of the Circuit Riding Psychiatrist

The psychiatrist in this model of care delivery requires much energy, personal commitment and professional excellence. The Imua collaboration has been fortunate to have enjoyed the contributions of two talented psychiatrists on the project. Two more psychiatrists will be joining the project as the first psychiatrist of the collaboration moves into a more strategic role as consultant to AMHD administration. In addition to delivering quality care to understaffed clinics in the more urban areas of Hilo and Kona, psychiatrists provide the expert consultation needed for psychiatric management of clients served by the APNs in the more remote parts of the island. They have brought a long desired continuity not possible when the Big Island clinics were served mainly by locum tenens doctors.

As SOM faculty, psychiatrists are instructors and preceptors for medical students. Last fall, as the Ka'u clinic was in the process of being established, two medical students in integrated rotations spent a day a week training in rural psychiatry. Such experiences provide first hand exposure to both the challenges and satisfactions of rural mental health as well as an excellent practicum experience in interdisciplinary collaboration.

As academicians, the psychiatrists also conduct clinical research and collaborate with the APNs in their research. Some of the topics studied include the patterns of interface between psychiatrist and primary care physicians, treatment patterns of depression in primary care, and improvement of insight post treatment with olanzapine. Improved community linkages with the hospitals have also been forged by the “University docs” as they address the challenges inherent in creating a seamless system of care for clients served in the public sector.

Collaboration has also flourished in the clinical domain as psychiatrist and APNs developed an interdisciplinary structured clinical evaluation (ISCE) tool to promote consistency, quality and continuity of care. For the clinicians themselves, working

together has served the purpose of mutually informing and expanding regard for each other's discipline and practice.

Tele Mental Health - Rural Applications

Booming telecommunications technology has offered the isolated Big Island collaboration several applications that address problems inherent in rural mental health care delivery. These problems include access to expert psychiatric/mental health consultation, the inflated cost of staff development because of distance to educational sites, and the isolation of professionals residing in such underserved areas. Advanced technology has been used to address these problems in innovative ways.

The collaboration faculty developed a televised interactive series of "grand rounds" topics which linked two college campus sites on the Big Island with the University of Hawaii at Manoa site on Oahu. The "Kukulu Kumuhana: Pooling of Resources" 15-week series provided 26 hours of interactive instruction. Members of the mental health community were invited to present on specific topics. Topics included: Substance Abuse Assessment, Assessing and Managing Suicidal Behaviors, Crisis Management, Treatment Planning and Ethics. Discussions also involved consumers from the various sites who added their per-

spectives to the topics. In planning the fall curriculum, more of the Hawaii Island center staff are slated to present at these sessions.

In addition to "tele-education" efforts, teleconferencing technology enabled faculty to experiment with tele-consultation. However, picture quality was poor and rural technical support was not available at the time. Grant funds have been received to establish wider band width lines to improve reception and hopefully expand current applications. Future directions include linking regularly with UHSOM's Department of Psychiatry Grand Rounds, non-emergency consultations of complex clients, case conferencing, and center committee meetings between sites.

Conclusion

The challenge of providing care to mentally ill clients in rural areas is unending. However, working as a University and Public sector interdisciplinary team allows for creativity and innovations. The team building that occurs through partnerships between faculty, mental health professionals and the community brings a renewed vitality to the seamless care issues and professional education and training. Linkages of services provides better utilization of existing mental health care personnel and contributes to the overall health in rural areas.

Maximizing Community Resources In a Rural Setting

By Janet E. Ordway, M.D.

Rural mental health presents many problems not present in large, more densely populated areas of the United States. Low population density in a geographically large area, poverty, difficulty in recruiting and retaining psychiatrists and ancillary staff, and the absence of public transportation all contribute to challenge the service delivery system. All these problems have existed in Northern and Eastern Maine, but in the past two decades, there have been additional major health changes compounding these problems. Deinstitutionalization and shrinkage of funds for mental health the development of managed care, the need for interagency collaboration, and the problems with the funding stream because of a Consent Decree has made it necessary to develop new ways of meeting the mental health needs in the state. The state's mental health system had been fragmented need for interagency collaboration, and the problems with the funding stream because of a Consent Decree has made it necessary to develop new ways of meeting the mental health needs in the state. The state's mental health system had been fragmented for a long time. It had poor accountability, lacked long-range planning, suffered from poor distribution of resources, and was without clear channels for client/patient and family influence. Maine is a state of 1.2 million people divided into three mental health regions with 1/3 of the population in Region III, composed of five counties covering 18,000 square miles. Most of the area's population is in the southern part of the state.

History of Northeast Networking and Support

Because of these problems, in March of 1993 a concerned clinician addressed a letter to representatives of mental health Agencies and two psychiatric hospitals in the greater Bangor area, inquiring about interest in working together more effectively on behalf of the long-term chronically ill. Responses

were immediate and enthusiastic. Members of the group include administrators and clinicians from two mental health hospitals and the community mental health center, 17 agencies, two crisis services, an ACT team, family and child treatment agencies, a homeless shelter, alcohol and substance abuse services, housing, wrap-around services and social services. Husson College, the University of Maine, the Department of Mental Health, Mental Retardation and Substance Abuse Services, area Legislators, and clients and family members are represented on the committee. That same month a group met and has begun meeting and has continued to meet monthly for the past five years. The new program was called Northeast Networking and Support (NENS), with a logo for stationary, and a mission statement. NENS has operated without a budget. Services were donated by different continued to meet monthly for the past five years. The new program was called Northeast Networking and Support (NENS), with a logo for stationary, and a mission statement. NENS has operated without a budget. Services were donated by different agencies and hospitals. For example, monthly meetings were sponsored by the Arcadia Hospital, a 100-bed acute mental health facility, in one of their conference rooms where supper was supplied for attendees. Our member's secretary types up the meetings' notes and sends out 45 meeting announcements of each month.

A literature search did not turn up other voluntary organizations such as ours but cooperation, collaboration, education and innovation were stressed in research papers on rural mental health.

The Process Activities

Since the arrival of Commissioner Peet in 1994, and with the full support of Governor King. There have been major changes

at the state level in the Department of Mental Health designed to develop a long range plan. The plan has been to distribute services and resources to the communities so that treatment, crisis services, housing, and support can occur within each local community. Changes are always disruptive to the old way of doing things, but these changes at the state level have made much sense. Additionally, there has been an expansion of the department to include mental retardation and substance abuse, and most recently children's services. There also have been efforts to collaborate with the Department of Human Services, the Department of Education, and the Department of Corrections. This permits troubled children and adolescents to be identified much earlier and to get the needed help sooner and more effectively.

What Northeast Networking and Support Does:

- Shares information among agencies, hospitals, the state and clients.
- Helps legislators be informed of mental health issues for future legislation.
- Helps legislators inform us of their activities.
- Provides a mechanism for sharing equipment, grant writers, or other resources with each other.
- Provides a forum for exchanging ideas among persons directly involved in the provision of Mental Health services in Maine (a think and action tank).
- Writes letters on important issues to the Commissioner of Mental Health, the Bangor News, Region III, etc.
- Supports comprehensive and interdisciplinary inclusion.
- Assists and supports the institution of new programs in the area.
- Provides continuing education via guest speakers on mental health issues.
- Surveys gubernatorial candidates on issues of mental health in Maine and present their replies to the Bangor Daily News.

The committee is open to all interested parties. Anyone can present problems or seek help on long-term mental health issues, or join the committee to listen, talk or act.

We are a letter-writing committee. Members have written to the Commissioner of Mental Health and to the presiding Judge on our concerns about a Consent Decree that we felt deprived Region III financially. We have not only written letters to the Editor of the regional Bangor Daily News, but also have met with the Editor in 1994 concerning the need to have crisis stabilization services in the area. Several such contacts produced supportive editorials.

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We also sent questionnaires to the gubernatorial candidates in 1994 about mental health issues asking for their replies and explaining that we would turn them over to the Bangor Daily News. We did and the News wrote an appropriate editorial. We are doing the same thing again for this year's candidates for governor.

As far as the mission of educating members of the group, we

have had many guest speakers, including both the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services and the Commissioner of Human Services, the Executive Director of the Maine Chapter of the Alliance for the Mentally Ill, a legislator who spent her time in the legislature getting parity for mental illnesses, the Medical Director for the Department of Mental Health, the Program Manager for Children's Services for the Department and the Director of the School of Social Work at the University of Maine. We have had speakers from both academic institutions speak to us on topics such as the undergraduate social work program, graduate level psychiatric nursing program, and the national effective systems. We have had a presentation on substance abuse problems in Maine children.

A valuable asset of the NENS committee has been the ability to discuss issues as individuals, rather than as representatives of agencies. Various topics have been discussed concerning the chronically mentally ill - safety issues, adequate staff coverage, geographic, supplies, 24 hour need for trained staff, financial issues, and the dissemination of information. After discussion in many instances, actions have been taken.

We have addressed many important issues:

- Involuntary commitment under state care.
- The right of 14 year olds, under state care, to refuse mental health treatment.
- The grant proposal process - both the short-running time from announcement to deadline for the proposals and the process of collaboration the state is encouraging.
- Discussion of social systems and how to keep services viable.
- The need to have an interlocking and shared computer system between the Department of Mental Health and the Department of Human Services.
- The high incidence in Maine of teenage substance abuse, including alcohol abuse and smoking.
- The problem of expanding community services too quickly and having too few qualified mental health professionals to run these services.

The Accomplishments/Outcomes

In the last five years there have been significant changes with

The Accomplishments/Outcomes

In the last five years there have been significant changes with increasing mental health alternatives for care for the chronically mentally ill. There has been a tremendous expansion of available housing alternatives, such as subsidized and supervised housing and wrap-around services. In the past there were two major alternatives for the mentally ill — either inpatient or outpatient services. Now there are many more options available with much more outreach. There is still the traditional inpatient hospital for the acutely mentally ill, but there are also day hospital programs at The Arcadia Hospital, day programs at the Counseling Center, intensive case managers, a very successful ACT team, aftercare workers and increasing development of rehabilitative programs to either further educate or help in transitioning people into the work force.

There is an increase in collaboration in the development of some

new programs. Arcadia Hospital and Hope House have joined in an effort to develop a detoxification unit at Hope House, where those who are working on their addictions can stay while in rehabilitation. Northeast Crisis Services is also a collaborative effort involving three agencies. A greater Bangor area crisis stabilization program covering a 50-mile area, presently called Northeast Crisis Services, has been established which now has 24 hour, 7 days a week psychiatric coverage. Two more crisis stabilization services in Hancock and Washington counties have been recently established. A graduate level psychiatric nursing program was launched last year which will supply much needed psychiatric nurses to many underserved areas of Region III. The Community Health and Counseling Center, that for years and years has had only one psychiatrist, has recently hired six new psychiatrists who will cover the outlying rural areas and develop and oversee much needed new programs. Other outreach psychiatrists will be supplied by Bangor Mental Health Institute, one of two downsized state mental health hospitals, and by The Arcadia Hospital.

The State has established a "safety net" for those seriously mentally ill patients who have not yet become involved with mental health services or, at this point for one reason or another, refuse to access the traditional mental health system. They are covered by 10 intensive case managers who cover the enormous 5-county area and are handling people with some very serious problems in their lives and who need much help in connecting with the services that they need. Though still less than what is needed, especially outside the greater Bangor area. There has been an increase in transportation sources.

Because we lost several community psychiatrists in the last decade to retirement or moving, the remaining psychiatrists have had to become more innovative. They had often taken the pharmacological responsibility for psychologists and now, more recently, they are working with family practitioners, supporting Lambert and Hartley's (1998) contention that motivation to do so is in our best interest. Currently, because there are only three active private practicing psychiatrists in the Bangor area, often evaluation and medication are done by the psychiatrists and then the patients are turned over to the Family Practitioners. The psychiatrists then act as consultants to them when they need assistance. Currently the Family Practitioners are also included in the lectures given to the area psychiatrists, and they seem eager to upgrade their skills in the area of psychiatry.

Conclusions

The model of Northeast Networking and Support is one that can be duplicated anywhere as long as there are caring people focused on a cause, such as mental health needs. We have been able to more clearly discover and correct the gaps in the programs that do exist over a broad rural territory, work out ways of spreading services while still trying to maintain quality, educate ourselves on legislation and educate legislators on mental health needs, and develop new ways of solving problems.

We have supported one another as the many transitions have

been made and as we get more community services on line, not only in our immediate area but out in the five-county area. In most instances, we have worked well collaboratively, stretching dollars and in cutting reduplication of efforts. At times the collaboration has broken down and there have been setbacks as old rivalries reoccur. This is inevitable as we all give up old ways of doing things and learn how to cooperate and collaborate more effectively with each other.

Like the daily stock market, the ability to collaborate goes up and down; but like the market - the ability to work with one another collaboratively and flexibly has gone up slowly over a period of time. Old habits can change, but they change slowly, and only with concerted effort by involved persons.

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Recovery: A Working Document

Washington County Mental Health Services

The Washington County Mental Health Services (WCMHS) Recovery Discussion Group met to identify the nature of Recovery and the strategies that can promote recovery. Participants included consumers and staff from the Community Rehabilitation and Treatment Programs, WCMHS administrators, and consumers and staff from other mental health organizations in the Vermont.

The following represents a brief summary of report developed by the group. The report is too lengthy to published in Rural Community Mental Health but is available upon request from the Washington County Mental Health Services, Inc. (P.O. Box 647, Montpelier, VT 05601-0647 attention: Roger Strauss, Ph.D. Director.

The recovery model is designed to help individuals truly become blended into the community. Unfortunately, the rehabilitation model often served to perpetuate separate communities between consumers and others in the community with power differentials between consumers and staff that promoted dependency by con-

sumers. The recovery model requires a set of expectations and behaviors on the part of consumers, providers, and community members. The emphasis is upon healing. All participants must treat each other with respect and be responsible. The process recognizes the individual nature of the path taken by individuals and the important role of spirituality in this path. Integration into the community is an important goal. Carrying out the recovery mode requires a mindset on the part of consumers and providers that moves beyond dependency to genuine partnership. Choices are important. People need to take responsibility for their actions and to be held accountable in an appropriate manner. Communication among consumers, providers, and the community is essential. Plans for recovery should be tailored to the individual needs and culture of the consumer. Consumers should be permitted to take appropriate risks, to recognize that failure is a part of life. At the same time consumers need to have a crisis plan in place for their lives. Consumers should be encouraged to assume normal roles in the community, for example, work. Advocacy and education are important to help others understand the Recovery movement.

A VISION FOR RURAL COMMUNITY MENTAL HEALTH CENTERS FOR THE 21ST CENTURY

by Roger Strauss, Ph.D.

Washington County Mental Health Services, PO Box 647, Montpelier, VT 05601-0647

OVERVIEW

There must be three major thrusts for rural community mental health service development over the next two decades if rural community mental health is to survive at all into the 21st century. The first is a bottom up, community organization model which envisions rural Community Mental Health Centers (RCMHC) as the major facilitators in the development of a "caring community". The second requires a more traditional, professional approach. Here RCMHCs carve out a managed care niche (if it is not too late) in assertively deinstitutionalizing (RCMHC) as the major facilitators in the development of a "caring community". The second requires a more traditional, professional approach. Here RCMHCs carve out a managed care niche (if it is not too late) in assertively deinstitutionalizing the state hospitals (SPMI populations) and the state training schools (DD/MR populations) and ensuring that Severely Emotionally Disturbed children are treated in their own communities and not sent out of state or to large, costly, institutional settings where whatever is learned is non transferable back into the community. The third thrust requires the RCMHCs to determine their long term goals so that at the same time they deinstitutionalize and develop caring communities, they deinstitutionalize themselves. This requires transferring treatment services for adults with severe and persistent mental illness, children with severe emotional disturbances, and persons with developmental disabilities to the general community while retaining case management (redefined to meet the situation) and crisis services for themselves as their final evolutionary development for the first half of the 2100s.

DEVELOPMENT OF A CARING COMMUNITY

Purpose: To develop wellness in the community by fostering interdependence between persons with defined disabilities and general community members so that those with defined disabilities are fully integrated into and thereby supported by community structures as a first line of service delivery.

This interdependence not only relieves costly service provision by RCMHCs, but creates a self-conscious tradition and sets in motion prevention efforts for unforeseen events in the future

This interdependence not only relieves costly service provision by RCMHCs, but creates a self-conscious tradition and sets in motion prevention efforts for unforeseen events in the future lives of community members. It also establishes "wellness" as a general concept for the community at large. Community members without defined disabilities will soon become aware that we all have disabilities of some sort, and will seek the help of others in a community which is self consciously caring, instead of isolating themselves when problems arise. This "sharing" from "non disabled" members will foster the caring community networking process even more.

Any movement of this nature with such goals will not be achieved in the short term. It will take at least 20-50 years to reconstruct a truly caring community with all the good points of community as existed in the past but with none of its parochialism that was so suffocating and intolerant. There are no short term solutions.

First Line of Service Delivery:

Volunteerism/Neighboring: The first line of service delivery is volunteerism in its many forms. This is a substitute for professional or paraprofessional services and does not take the place of case management, therapy, and medication. It does, however, have connotations of prevention, wellness, and other intangibles that the RCMHC has been hard pressed over the years to provide from within given its own structural limitations.

Community is difficult to establish when families have to work two jobs to survive and have little energy to give someone else who is needy. Yes we need to start now on the development of this concept. No matter how poor or stressed the community, there is someone or some group of people or organizations (like senior citizens, churches) who are willing to make a start. The RCMHC's job is to develop, foster, nurture and expand these pockets. It requires individuals and families to take a personal interest in individual persons with disabilities and to introduce them to other community members. It requires that neighbors and families in the community rally around other families in trouble and provide support over long, long periods of time - maybe until all the children have grown up. Developing a system to get people interested is relatively easy. Maintaining it is extremely difficult. Accomplishing this requires CMHCs to be perceived as part of the community rather than strangers. The "Law of Maintenance" also requires that RCMHCs support the volunteer system continuously with a system of rewards, education, information and other professional support including immediate access needed.

We must rearrange our RCMHC agencies to meet these needs. Unfortunately, it may require a type of restructuring and attitude change on the part of all staff that have never been needed before. While all we have always given lip service to the function of Community Organization/Integration, we built our agencies around a professional service delivery model. The question is - How can we make the organization of community efforts the key feature of the RCMHC movement?

Educating, informing, helping community volunteers, neighbors, helpers, etc., can and should be done not just by the face-to-face contact with the RCMHC staff, but through the electronic world - the Internet, E-mail, etc. The RCMHC needs to hook up people, organizations, institutions, etc., with the capability of getting this information in their homes or in key places in their contact with the RCMHC staff, but through the electronic world - the Internet, E-mail, etc. The RCMHC needs to hook up people, organizations, institutions, etc., with the capability of getting this information in their homes or in key places in their communities, e.g., schools, churches, senior centers, hospitals. The new cracker barrel could be the PC with Internet capacity at the local general store and coffee shop.

One caveat. We do not want to reproduce communities of old. We do not want to look back to the "good old days" when extended families and communities (often defined as your village of 100 to 2500) supported you, directed you, helped you, stifled you, made you conform, and banished you when you didn't. We need to redefine communities. We must teach/develop/nurture the concept of diversity so that all members accept, not shun, differences of opinions and approaches. Communities can no longer be closed minded.

We also need to redefine community boundaries because today where someone lives, works, and socializes may define three separate communities for that individual. With travel, transportation, and cyberspace, etc., giving us so much more freedom, a person's community may have to be defined in concentric circles, the first being family and neighbors, the second being the area where she or he works and finds solace "after hours", the third where she or he shops, the fourth being the World Wide Web, etc!

We must also make the self-conscious tradition of community service portable. It cannot live and die with the community members who provide it because today community members are very peripatetic. Like health insurance, they should take their "habit" of caring and volunteering with them. NARMH should establish an RCMH linkage across the country to help people reconnect when they move to a new community. NARMH can supply them with names and work assignments when they arrive.

Finally, our community members need to provide to the defined disabled population one more service which borders on the professional but which should be provided as much as possible in the community, using professional staff as consultants and back-up. Supportive counseling is part of the no man's land of service delivery which lies somewhere between the general community and the professional community. Giving advice is part of everyday life. It's become an American habit and no one can stop it. So let's accept it as an unbreakable habit pattern and use it to our advantage. Let's consult with our community volunteers and at least tell them how to do it right; where the limits are; where to tread and where not to tread. Let's not pretend that neighbors won't advise neighbors or tell community gatekeepers to steer clear of our territory, only to have them sneak around and do it behind our backs. Let's help create a core of sensible supportive counselors.

Benefits of a Community Approach

As medication is used to complement what is out of balance in our brains, we need to come up with what is missing communal-ly in the treatment of mental illness. How do we promote community wellness? A community with a strong helping identity will not reject hurting/disabled members, but will surround them with help and support. Disabled members, therefore, will not ly in the treatment of mental illness. How do we promote community wellness? A community with a strong helping identity will not reject hurting/disabled members, but will surround them with help and support. Disabled members, therefore, will not feel isolated and will retain a community identity, especially if the community not only supports the person through the difficult time of their disability but then integrates them into the everyday workings of that community. The community provides them with meaningful roles and functions. If someone has not been isolated, can retain their identity, and doesn't feel rejected or like a freak, we have won half the battle.

Helping communities breed new generations of helpers just as non helping communities breed non helpers. By establishing healthy habits, we help perpetuate wellness. If we receive help, we are obligated to go out and help others with disabilities, the same or different from our own. If we think of it as a slow growing effort and have patience, we will succeed

Why Can't It Be Done

The barrier is our professional attitudes. Perhaps if we ever succeeded, our professional selves would feel very slighted. Why did I go to school to learn all this extremely sophisticated material if it's going to be "apple pie and motherhood" that saves the day and not my power laden advice about what to do and where to go? My professional side makes me very ambivalent about this approach.

Then there is reality. The sense of community has been eroded over the past 25 years. When I moved into Moretown, Vermont, everyone in the village of 250 knew about me and my wife within one day of my arrival in town. The news spread like a wildfire. Twenty-seven years later my neighbor, two houses down, was dying and had been for three months. I did not find out about it until three days before he passed away. Redeveloping a sense of community will not be an easy job. We have all been part of that erosion. How many of us live anywhere near our community of origin? We ourselves want to talk about community, but long ago we ourselves eschewed community. We retreat from being part of community under the name of professionalism.

Politics also gets in the way. Republicans tout "volunteerism" to save money. Democrats tout categorical programs to promote centrism in government. We view volunteerism as demeaning or condescending. These views prevent us from creating truly caring communities.

Each year there are descriptions of community programs at the NARMH conference. We have failed in not systematically and systemically promoting them (not as models) but as STANDARDS. We have not studied these programs, distilled the essence of their success, and turned those "essences" into standards. When you tie funding to standards, they become implemented. Managed care has tied payments to standards and now everyone is putting them to work.

In Washington County, Vermont, we started a community integration program about seven years ago. The major difficulty was getting it started. Now the momentum has begun. Still very slow, but fast enough so that we got lots of support for a total parity bill for mental health, from the community (even small businesses). Currently a quarter of our SPMI consumers are linked one to one with a community member. In the Developmental Disabilities arena we have a number of circles of friends for our consumers. The difficulty is in keeping the circle nourished and flourishing. The circles tend to dissolve once the crisis in the person's life has been navigated. We have a long way to go, but we're seven years down the 20/50 year path toward total community participation and the momentum is growing.

It's Already Happening— We Don't Have a Choice

This movement is already happening. People are looking for new identities, not as the frontier individualists who want what they want when they want it, but as members of some communi-

ty, maybe multiple communities, with one or more community identities. The rise of charismatic, fundamentalist religion is one example of people seeking a new, spiritual community identity. We now hear the phrase "it takes a community to raise a child" frequently. Conversion to Judaism, conservative and orthodox, are on the increase and converts have no problems telling you that Judicium creates a self conscious personal (maybe religious) identity, 24 hours a day, within a living community.

The "back to community" movement is fact not myth. If we don't join it, the movement will pass us by and we will be in a constant defensive position. We must join the movement, we must help shape it, and we must bring the myths to reality, or at least make the attempt. Because even if we fail, in our failure we will understand where we need to go next. If we stand on the sidelines and let the movement pass us by then, even if it eventually fails, we will have nothing to offer in its place.

Integrated, Professional Care/Second Line of Service Delivery

The second line of defense consists of mental health professionals. There are two good reasons why RCMCs should work toward creating new integrated delivery.

First of all, if your design is to make a caring community, then why segregate your treatment of the population from the generic providers of community services? People go to generic doctors and generic dentists. Why not try to establish generic therapists, substance abuse counselors, specialty counselors, etc. They will be seen then as part of the community, not part of the institution up the hill or over in the next town. It will not be easy and we must determine funding structures that do not punish persons going into private practice (like the loss of fringe benefits). But in the long run, therapy should be just like any other service: like doctors, dentists, pharmacists, car repair operators. That's community and that's what we want to have happen down the road. In fact this is where the urban model supercedes the rural model. Professionals in cities do provide generic services side by side with other health professionals and few people think twice about it.

Second, sixty percent of people coming to hospitals, and up to eighty percent of people who frequent doctors' offices, are coming side with other health professionals and few people think twice about it.

Second, sixty percent of people coming to hospitals, and up to eighty percent of people who frequent doctors' offices, are coming in because of mental health/substance abuse problems, masked as physical complaints. When I talk about integrated delivery systems, I am talking about delivering mental health services in the doctors' offices in a manner that people who frequent those offices can hear and understand. We have to change our styles, our manner and our approach to patients when we're working in the doctor's office.

We all know this is a tough one. Not only do we have to change, but so do the physicians. If they tell their patients that they drink too much and this is causing gastritis, the patient will go elsewhere. But what if there is no "elsewhere" to go? What if managed care won't pay anymore for gastritis unless the alcohol issues are dealt with at the same time? What if there is a

mental health professional in every doctor's office in town so the patient can doctor shop all she or he wants but she won't escape the mental health? It's already happening. NIMH and Robert Wood Johnson are starting to put out model integrated service programs. States like Vermont are toying with the idea of pilot projects. Managed care companies know the statistics, too. They've seen the cost offset data. It's only a matter of time perhaps before this is going to happen. Why wait for someone else to set the trend? Let's get RCMHCs and NARMH and SAMSA making policy statements about what should be happening. Let's make the federal government recognize that Medicaid waiver dollars should be spent in an integrated manner that will maximize success and minimize health costs. NARMH should take the leadership role

THE SECOND THRUST/LONG TERM CARE POPULATIONS, DEINSTITUTIONALIZATION.

Long Term Care Populations

If RCMHCs are to survive over the long haul there must be a niche for them. The long term care populations are that perfect niche: SPMI adults, SED kids, and persons labeled MR/DD. Why are these populations so important for us to serve? First, they are a great expense. These populations represent the mental health costs that are the greatest to the state. Then, of course, these are the populations that are the most difficult to treat over the short and the long haul. These are the populations the private sector cannot handle so they have ended up being institutionalized. They have also been turned out of institutions, but without any adequate funding to provide for treatment. But that is true in part because RCMHCs were not assertive in claiming them and so never had a national lobby strong enough to make sure that funding followed discharge. This has changed as a result of the rise of AMI groups across the country and the growing strength of patient advocacy.

Second, the severe chronic population offers little potential profit. So, though managed care companies are starting to flock to collect the public dollar, they will find that long term care client will create havoc with the community, public safety, and fiscal institutions when managed care doesn't provide adequate treatment. Therefore, the only real possibilities for these populations are warehousing in state institutions (state hospitals, training schools, or jails), or long term care under the continuity provided by a community institution—the RCMHC.

Most RCMHCs have been ambivalent players in the long term game. They have not aggressively tried to deinstitutionalize state institutions. They have not sought out the model programs that have succeeded in different places around the country in closing institutions or in keeping persons from going into institutions. They have talked the talk but not really walked the walk.

Instead of forming strong alliances with the state Departments of Mental Health and Mental Retardation, they have created ambivalent relationships so that when managed care comes to town the established bureaucracies don't fight fiercely to keep them out. Even if Managed Care Organizations (MCOs) do get the bids we find RCMHCs not aggressively offering their services to the MCOs who usually would be happy to pass risk down

to an established provider organization with a good reputation in the community. Nor are RCMHCs restructuring themselves to bear or to risk or to court risk in concert with state Departments. These actions, could make them competitors with, or providers to, national managed care organizations which bid for state long term care dollars.

The stage is set. The script has been written. But the obvious actors are not auditioning? RCMHCs have not yet filled these roles which seem such perfect casting! How ironic that the caring community argument needs an author, while the long term populations need a provider. The money and the power that go with the organization that is willing to deal with these groups would alone establish the RCMHC as players in the game for many years to come. And, interestingly enough, the money that is brought into a center that provides these services can eventually be used to help deal with the acute care population as well as with community organization. The chronic complaints that "we never have enough money to do what we want" would disappear after a while because long term care money would eventually be used to set up programmatic structures in an RCMHC for a number of different projects. As the acute crises of the long term patients subside, the energies and resources spent on them could be transferred through these same structures to the needs of the acute care client and the community in general.

Creating caring community is for persons with long term disabilities. Can a community be really caring if persons with long term disabilities are not handled communally? Except for the crisis stage of a mental illness which needs protection for society or for the consumer from him/herself, why shouldn't the long term consumer be absorbed into the natural, healing functions of the community. We have even been able to communalize death itself through Hospice. Nothing has been more persistently horrifying over the millenniums than the behavior of adolescents. Yet we bear with it for years on long suffering end, and only throw up our hands when someone labels our child "mentally ill", "emotionally disturbed", etc. With the advent of new drugs for brain disorders the next ten years will create further possibilities for integration. It is just natural, therefore, for the RCMHC that is developing a caring community to have that care extend to its long term clients.

Deinstitutionalization

Deinstitutionalization is just naturally necessary for the RCMHC that is developing a caring community to have that care extend to its long term clients.

Deinstitutionalization

The argument above focuses on keeping consumers out of state institutions. The other side of the coin, of course, is to take persons out of institutions who are already there. The arguments are the same. Yet, the solutions are also the same. The RCMHCs have been as ambivalent here as they were in treating the long term consumer in the community.

The real difference with this side of the coin lies in the political power of the state institutions themselves. The power of the unions is tremendous. The power of the professionals at the institutions and of the communities in which the institutions are housed and on which their economy is based is also tremendous. Should we fight it? No. There is no reason to come up against this power block face to face. Remember this is a long term solution. First, get the RCMHC's commitment to serve the long

term population. Then develop programs that will keep people out of institutions. Then support legal aid and client rights organizations which will constantly pressure, through legal means, the diversion of consumers away from state institutions at admissions and out of institutions once they have been admitted if they don't need 24 hour supervision and care. Eventually the only persons in institutions will be those who are a current danger to themselves or others, or those who chose to be there. Let that stand for the basic institutional population for the time being.

Since fewer consumers will be going into state institutions, and more will be coming out than before, the institution's staff can slowly be decreased through attrition. This will happen over the years, gradually, and not create the political crisis that comes from closing a facility. When it becomes obvious that it is too costly fiscally to keep two hospitals half empty rather than one full, the Legislature or the Governor will take the responsibility for closing one. By putting governmental buildings in the empty spaces, or by selling them off as commercial property, you diversify the economic base of the community. As community members see themselves as enjoying a more prestigious fiscal structure they will want to end the "stigma" of having a state institution in their midst and actually become an ally in the final dissolution of the system. In this way you will get "stigma" against the disabled to work in your favor. Also, by broadening the economic base of the community, you will have an appealing golden parachute for all but the most senior state institution employees to use if they are forced into a reduction in force situation. And don't forget, we're talking about a 10 to 20-year time frame for this evolution to occur.

WHERE ARE WE GOING

If we develop a "caring community", if we deinstitutionalize by not letting people into institutions and taking them out and then giving them to the "caring community" - why do we, as RCMHCs, need to exist? There are four reasons: case management, maintenance of caring community, crisis care and advocate for recovery, why we need to exist, though not in the same form, were we to fully achieve our goals.

Case Management: There are at least two case management responsibilities necessary for the staff of an RCMHC to maintain even in a fully realized caring community:

Case Management: There are at least two case management responsibilities necessary for the staff of an RCMHC to maintain even in a fully realized caring community:

We need to recognize for acute as well as long term care, the goal of coordinating services can only be done by a case manager who is aware of all the needs of the consumer and all the potential services in the community. If we are doing our job well then almost all the services the consumer is receiving will come from very diverse parts of the community. RCMHCs will not foster large mini community institutions where one provider provides a myriad of services to a consumer. That would defeat the purpose of our community concept. Since there will be a variety of community providers in the client's life there must be a coordinator, a referral source, facilitator, a convener, etc. The case management positions would reside in the RCMHC.

Case managers must also protect consumers from potential exploitation. Shouldn't this be the state Department of Mental Health's job? In theory, perhaps, but the fact is that even in a small state such as Vermont, the Department barely has the personnel to oversee the 10 comprehensive mental health centers and the six free standing specialty centers. If we are to create a caring community and privatize the providers in it so there is a diverse array of services, only a regional center, acting as an arm of the state, can offer the necessary, comprehensive oversight.

Caring Community Maintenance: If we build it, we must maintain it. Maintenance that constantly keeps evolving is the hardest of all things to provide. Human beings (subject to individual differences) need to have a tangible reward system in place as a payoff for volunteering their time and energy. We have more to learn on upkeep of a community system than we do about establishing one. Constant education and training on an individual or small group basis will be necessary for many years to come. Computer networking will make education easier but will force us to redefine community in new ways. We need to be flexible in our expansion of that definition and see that one definition of community does not destroy another

Crisis Care: No matter how well we do in developing our community and provider system, nor how advanced drug companies get in creating new chemical compounds, there will still be setbacks and regressions in the lives of our consumers. Treatment delivered as close to the consumer's community as possible will resolve the crisis quicker and allow more efficient reintegration into the community. Consequently, we cannot keep centralized state institutions for crisis. They are too costly and too ineffective. Each RCMHC will be the keeper of crisis beds, perhaps in conjunction with the local. Many CMHCs have short term and even long term wraparound beds for children and a few for adults which take the place of a state institution. In the next decades these models should become the standards for crisis intervention with the RCMHC bearing the ultimate responsibility for consumer and community safety in times of crisis, the catcher in the rye for the system as a whole.

The Final Advocate for 'Recovery': The essence of the new Recovery movement is total independence from the professional provider system. As RCMHCs will no longer be direct providers except in crisis, they will remain the professional

The Final Advocate for 'Recovery': The essence of the new Recovery movement is total independence from the professional provider system. As RCMHCs will no longer be direct providers except in crisis, they will remain the professional advocates in the system for Recovery, in all its aspects. As they are also the keepers of the purse, they may well become the final arbiter of decisions which have Recovery consequences, supporting one particular type of treatment vs. another, or even deciding whether treatment should be offered or not.

Conclusion:

Integrated care represents an important model of care that includes community volunteers and supportive structures and linkages between mental health professionals and medical providers and community members. Rural Community Mental Health Centers must take the leadership in establishing and maintaining these systems.

“TELEMEDICINE AND THE MENTAL HEALTH CONSUMER WHO IS DEAF”

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Background

The National Center for Health Information Statistics describes hearing loss as the most common chronic health condition, affecting approximately 8.6% of the general population. The barriers created by hearing loss are related primarily to communication. The isolation created by communication barriers potentially increases the risk of need for behavioral health services yet these barriers frequently prevent access to traditional behavioral health services. Specialized and accommodated services are necessary to provide equal access to persons with the sensory disabilities of hearing loss or hearing and vision loss. This paper describes efforts in Virginia to respond to the needs of persons who are deaf.

Virginia Service Delivery System for Persons who are Deaf

Within the Commonwealth of Virginia, the Department of Mental Health, Mental Retardation and Substance Abuse Services administers six distinct treatment centers for persons who are deaf, deafblind or hard of hearing throughout the state. Guiding principles for the development of these specialized services are based on the belief that mental health providers, dually trained in the field of deafness, provide the most accurate assessment and diagnosis as well the most effective treatment to this population. Within this framework, communication needs and preferences can be honored and rights guaranteed by the 1973 Rehabilitation Act and the 1990 Americans with Disabilities Act can be protected.

The Mental Health Center for the Deaf at Western State Hospital (MHCD) provides inpatient psychiatric and substance abuse treatment for deaf, deafblind and hard of hearing persons from any region in the Commonwealth. The unit is staffed by a psychiatrist, clinical psychologist, social worker and nurses with extensive expertise in the field of mental health and deafness. Five Regional Programs for Mental Health Services (Regional treatment for deaf, deafblind and hard of hearing persons from any region in the Commonwealth. The unit is staffed by a psychiatrist, clinical psychologist, social worker and nurses with extensive expertise in the field of mental health and deafness. Five Regional Programs for Mental Health Services (Regional Programs) provide clinical, consultative and educational services in urban centers within each of the five Health Planning Regions (HPR) throughout the state. Each of these programs is staffed by clinicians skilled in the assessment and treatment of deaf individuals, with a thorough understanding of language acquisition, developmental aspects of deafness and cultural factors. Each provider is skilled in various methods of deaf communication, including American Sign Language. These distinct programs serve to positively impact the quality and accessibility of mental health services to Virginians who are deaf, deafblind or hard of hearing and are an unparalleled resource to the state.

Telemental Health Project Development

Barriers to accessing these specialized services by consumers who are deaf include Virginia's predominantly rural topography. To address this gap within the service delivery system, deaf service providers began the development of Deaf-Link, telemental health services for the deaf, in the spring of 1997. With limited funds for equipment purchase, project developers focused on utilization of existing telepsychiatric networks. In May of 1997, the Regional Program - HPR III joined the Appal-Link Consortium, a telepsychiatry project located in southwest Virginia funded by the Office of Rural Health Policy. The Appal-Link Consortium has nine member sites. In the winter of 1998, WSH Mental Health Center for the Deaf joined the project. In the spring of 1998, psychiatric services were added through the University of Virginia Telemedicine Office.

The specific goal of this deaf services pilot project was to explore the feasibility of providing psychiatric, discharge planning, counseling, consultative, and educational services from the Mental Health Center for the Deaf and the Region Programs to the deaf or hard of hearing consumer, family members and his/her local providers at a remote site using teleconferencing. Project objectives included (1) providing psychiatric treatment to the deaf or hard of hearing consumer directly in his/her preferred method of communication, primarily American Sign Language, (2) increasing consumer access to direct clinical services with a provider knowledgeable regarding the impacts of hearing loss and skilled in deaf communication (eliminating the need for an interpreter, whose presence often adds a confounding "third person" to the therapeutic relationship), (3) coordinating hospital discharge planning, (4) increasing opportunities for consultation between specialized deaf service providers and local providers, and (5) providing education and training in deafness related issues for local providers to increase sensitivity to this population.

General Protocol

Deaf-Link currently utilizes 14 sites throughout central and southwestern Virginia. Referrals for outpatient consumers are made by the local clinician directly to the Regional Coordinator or the MHCD psychiatrist. Referrals for individuals receiving inpatient treatment are made by the MHCD treatment team. Referral forms include basic demographic information, history of previous treatment, history of deafness, communication method preferred and presenting problems. Other components of the referral process include obtaining consent to treatment and insurance information. Scheduling is coordinated by each provider's site. A videoteleconference appointment routinely consists of a deaf services clinician at the provider site and a

consumer and a local provider at the remote site. Appointments are generally 30 - 60 minutes in duration. Frequency of appointments varies with need, from weekly, for therapy appointments, to every 2-3 months for routine psychiatric appointments. Treatment notes are completed and mailed within two weeks. Prescriptions can be mailed, phoned to a nurse at the local provider's site, or phoned directly to the pharmacy by the physician. Billing is performed by the remote sites for all services provided by Regional Program; psychiatric services are billed from the University of Virginia Telemedicine Office.

System Specifications

Two different types of teleconferencing equipment are used within the Deaf-Link system. The nine sites of the Appal-Link Consortium and the two sites of the University of Virginia Telemedicine Office utilize board room equipment which transmits at 384 kbps over 3 dedicated ISDN telephone lines. The MHCD and two of the remote sites in central Virginia use PC based equipment which transmits at 128 kbps.

Outcome Measurements

Outcome measurements have focused exclusively on "Consumer Satisfaction." Consumers rated the program in terms of clarity of the monitor picture, clarity of signs/communication, quality of treatment, and comfort with teleconferencing in general. The program received a consistently high rating from deaf and hard of hearing individuals being served. Several remarks noted that the ability of the providers to communicate directly with individuals in their own language or communication method positively impacted the sense of empathy and the effectiveness of treatment. One consumer indicated that even through the teleconferencing monitor, he perceived that his provider genuinely cared about him. He contrasted this with face to face services he had received from local "hearing" providers. Other comments noted that after one or two moments adjusting to the teleconfer-

encing equipment, communication was smooth and easy to understand.

Issues and Concerns

Difficulties encountered during the project reflect logistic, individual and financial issues. Logistical problems included equipment incompatibility, appointment delays and occasional cancellations due to technical problems. Individual issues included some difficulty in communication with consumers who have low language skills or extremely rapid signing. Financial barriers included questions of liability coverage, billing responsibilities, and insurance coverage for telemental health services.

Summary

The deaf service providers in this pilot project believe that telemental health is an excellent tool for serving deaf individuals in rural areas who do not have access to qualified local providers. It is also useful to increase access to psychiatric and clinical expertise in the field of mental health and deafness by local providers. Numbers of referrals, direct clinical hours with deaf consumers and consultations with local providers have increased throughout the project area. This is interpreted by the authors to indicate an increase in accessibility for these sites. Consumer satisfaction consistently rated the provision of services received through teleconferencing high or very high. Services were described as better than those received from a variety of local providers. This is interpreted by the authors to indicate a positive impact on quality of services within those areas.

HEALTH PURCHASE STRUCTURE IN NEW ZEALAND or the Mouse that Roared

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Abstract

Gross Domestic Product

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Abstract

Gross Domestic Product

Preamble

New Zealand comprises two principal islands and a number of smaller islands in the South Pacific. It has a population of approximately 3.4 million people and although no wider than 200km at its widest point has a coast line equivalent to that of the United States. Currently NZ spends 7.6% of its GDP on health. Since 1980, total expenditure has increased by 40% to just over 6 billion dollars per year. In 1996, over 14 million visits were made to general practitioners (primary care physicians) and 70% of all patients received some form of Government subsidy with an average of 6 prescriptions per person per annum.

Structure Pre 1991

The blueprint for the present health care reforms had its roots in the general public sector restructuring of at least a decade ago. The snap election in 1985 found a new Labour Government in

New Zealand was the first country in the world to introduce a full model of socialized medicine but the model has gone through many changes as successive governments have endeavored to control health spending yet maintain services across a diverse and widely spread population.

The paper will discuss the changes that occurred as NZ experimented with new ways of purchasing health services whilst at the same time not significantly increasing the proportion of GDP spent on health. The paper will discuss the implications of changes to health purchase and impact on the third sector, opportunities that have arisen for providers and the increase in quality and type of service provision for consumers. It is argued that New Zealand is developing a model of socialized behavioral health care that will be a unique partnership between government and sector providers.

office that introduced radical reforms for a period of 6 years. The NZ economy was fragile and the public deficit high. In its first term of office, the Labour Government focused on reducing State intervention in the economy by removing economic protectors (for example health care subsidies) and deregulating financial markets. The Government's objectives were to control overall expenditure, improve efficiency and ensure accountability. The beginnings of health restructuring also saw the first attempt at contracting for services (purchasing) as opposed to funding them. Secondary Care and public health services were merged and provided by 14 regionally based Area Health Boards that received capitated budgets on a population basis.

The Area Health Boards structure together with the State Sector Act in 1988, broadly defined the contractual relationship between these Boards and the Minister of Health. Prior to 1984, primary care, secondary care, community support and public health were funded by central government. Primary health care was delivered by primary practitioners, usually subsidized by the State. The secondary sector and community support services were generally managed regionally by locally elected hospital boards that served specific geographic populations. The Labour Government restructured this arrangement.

There are two elements of the restructuring relevant to this discussion. First, the paradigm of contracting for services established a contractual relationship between the Area Health Boards and the Minister of Health. Targets were set demanding Area Health Boards achieve finite health gains for the catchment population. The second important ideological shift was a focus on a regional approach with Area Health Boards given responsibility for the protection and promotion of health for their defined populations, the provision of a balanced range of hospital and community services, and coordination of the Government and non-government sector.

In 1990, the incoming National Government very quickly decided that the Labour Government's restructuring was unable to deliver what it purported to deliver. This led to the legislative and regulatory changes which introduced the next reform phase. In 1993 the Health and Disability Services Act was framed. The budgets for Primary, and Secondary Care and progressively, for disability support remained integrated. The National Government reforms also introduced a purchasing agency - the

and regulatory changes which introduced the next reform phase. In 1993 the Health and Disability Services Act was framed. The budgets for Primary, and Secondary Care and progressively, for disability support remained integrated. The National Government reforms also introduced a purchasing agency - the Regional Health Authority. As a result the responsibility for the production and promotion of health for a defined population, the provision of a balanced range of hospital and community services, and the co-ordination of the government and non government sector shifted from the provider, previously the Area Health Boards, to the purchaser, the Regional Health Authority.

Providers were split from purchasers and were required to contract for the provision of services very much as a de facto managed care organization. For mental health this meant the possibility of several providers becoming involved in the provision of care to a patient. At any given time, and often simultaneously, a patient might receive primary mental health care through his or her general practitioner, secondary mental health care through a Crown Health Enterprise (CHE as hospitals or groups of hospi-

tals were now called), tertiary mental health care through a different CHE, community treatment and rehabilitation services through the third sector and perhaps another agency or sector if they had other unmet social needs. In addition crucially the purchasers had separate contractual arrangements with each other, with consumer organizations, Maori mental health providers, other community support groups and so on and so on. This provided ample opportunity for cost shifting and made co-ordination extremely complicated.

Cost Control and Containment

It was generally recognized that the Health dollar was not unlimited and that rationing in some form or another was inevitable. The National Advisory Committee on Core Health and Disability Services was created to advise the Minister of Health on the kinds and relative priorities of Health Services that should be publicly funded. However, the ambitious project of defining the core services that should be available to all New Zealanders as a right proved too great a challenge and by and large this committee has now been disbanded. A Mental Health Commission was created to give direction to the mental health sector. The impact of this Commission remains to a certain extent uncertain, as it initially had no legislative underpinning or statutory authority. To date it has identified areas where there are serious lack of resources and has been active to ensure that purchasing is appropriate. Its recent Blueprint sets the tasks and direction for purchasers and is indicative of an ideal mix of services and service philosophy.

In Mental Health cost containment has not actually been an issue. For several years there has been a recognition that mental health services were under-funded and had suffered at the hands of more lucrative specialties. One of the key concepts of the current round of health reform was that there would be certain health gain areas that included mental health. The purchasers and Crown Health Enterprises were expected to re-prioritize funding towards mental health services from efficiency gains in other areas and release of monies still locked into old institutions. As for cost containment, one of the problems with the purchaser/provider split arose from the introduction and promotion of a general management model in health care and burgeoning bureaucratic costs. Most of the new CEOs of the CHEs were drawn from industry, but it is interesting to note that within two years 18 of them had resigned citing the impossibility of achieving the political agenda. Coney (1996) noted that in the previous 2 years the cost of running the four Regional Health Authorities had swelled by 40%. The Ministry of Health costs had grown by 11% and more than \$57 million had been spent on the burgeoning industry of consultants who gave advice on the reforms. In the CHEs, large amounts of their revenues, up to 20% in some cases, had been allocated to overhead costs.

Efficiency gains

With the integration of budgets for primary, secondary and community based services introduced by the reforms, contracts between purchasers and providers were expected to provide efficiencies and reduce costs. State owned providers were expected to operate in a competitive market along with other providers;

however, Public Health services were to be purchased and coordinated by a Public Health Commission. Separating purchasing from provision led directly to the creation of a competitive environment under the erroneous belief that competition in the health sector would somehow improve efficiency. Even the creation of the four regional purchasing authorities was done largely so that they could compete with each other and thus the philosophy of competition permeated all areas of health and mental health provision. But since the Government remained the stakeholder in the Crown Health Enterprises, competition was invariably relatively minor and around the edges. Nevertheless, the culture of competition significantly damaged the sector in terms of the inevitable disaggregation of services that previously incorporated. Therefore, in what can only be described as a pseudo competitive environment for both purchasers and providers, market failure could easily be predicted. The monopoly set its prices on what it considered a just price rather than on that indicated by real and actual costs.

In many cases the CHEs were the only provider with which the purchaser could contract. However, their position was somewhat imperilled by the accumulated capital debt transferred from Government into their books following their establishment. Borrowing by the CHEs in NZ and internationally crept up (and at present exceeds \$NZ300 million) to bridge the gap between income through contracts and service commitments that include debt servicing.

Return on investment for the government meant a focus of allocative efficiency. In retrospect, this may not have happened if in the first instance the purchaser was able to re-allocate resources according to need; and secondly, if this reallocation resulted in net health gain. The problem of course is that needs have to be assessed first, and it is very difficult to establish allocative efficiency without information on marginal costs and the benefits of different health interventions.

The contracting process was supposed to result in technical efficiencies. Providers had to continuously reduce the cost of providing services so that they do not lose business. Although the purchaser/provider split may have resulted in making providers more efficient, it has been argued that quality may be a casualty of competitive tendering. Quality, as the name suggests, is a qualitative measure, and therefore not as easy to measure as bed days or number of contacts, which is the only thing that purchasers measure at the moment. Some providers may decide to overlook some non-verifiable aspects of care in the name of efficiency, while others struggling to survive in a competitive environment may decide that quality is worth sacrificing if it means winning and retaining contracts. One of the most worrying aspects of the reforms was providers attempting to achieve technical efficiency by providing minimum care or meeting the minimum requirements of the contracts. As many service specifications were defined by the purchaser, and more importantly, by personnel who did not understand the full impact of the contracts they were drafting, this adherence to minimum requirements was also very damaging.

Lack of information made it increasingly difficult to measure efficiency. The purchasers could not accurately predict their population's requirements and allocate budgets accordingly. This becomes even more relevant in NZ where purchasers are very prescriptive, or have been in the past. The whole concept of contracting is based on information. Providers must have a sense of cost of their services, and the task of the purchaser is even more difficult as it not only has to have a sense of cost information but also the information with which to monitor and assess services. In other words who gets what, where, for what time and with what provider at what cost. Lack of measurement regarding outcomes has been a major information deficit that has hamstrung purchase reform in NZ to date.

As mentioned earlier, the question of what to purchase was given to the National Advisory Committee on Core Health and Disability Support Services. The Core Health Committee, as it became known, was required to:

- identify current services in terms of cost, efficiency, range and utilization's
- assess relative benefits and potential impact of any recommended changes
- consult with the public and professions re current services and seek views on which core health services should be purchased by Government
- recommend annually to the Minister of Health which core services should be purchased, how distributed in terms of access
- They should periodically recommend any changes necessary in future processes or advising Government.

The Core Services Committee operated the principle that core services would not necessarily be free and immediate but there would be a commitment to ensure that any user charges would be affordable and waiting times reasonable and appropriate. The Committee in its report to the Government in 1991 identified four specific health gain areas: services for children; behavioral health care; services for Maori; and physical environmental health. The principles for purchase decisions would be made on the following pre-indicators:

- Equity
- Effectiveness
- Efficiency
- Safety
- Acceptability
- Effectiveness
- Efficiency
- Safety
- Acceptability
- Risk management.

Who provided health services under the new structure became largely immaterial. Whether one was a third sector provider, a Crown Health Enterprise, or a private provider, competition for contracts was supposedly a level playing field with each provider tendering or proposing to provide services. The Crown Health Enterprises (with their healthy Government stake holding) saw traditional hospital based services continuing with the CHEs, and private providers and third sector providers scurried around the edge for whatever other services fell outside this core business. Thus the playing field was far from level and relationships between providers in what was now a very competitive environment significantly deteriorated.

Purchase Design

The Regional Health Authorities purchased new health services by a variety of means. They used requests for proposals, requests for information and price volume tendering. They created a competitive market place with high-level service specifications as part of each contract that utilized fee for service and paid no attention at all to outcomes. The general philosophy behind this was that competition would reduce prices and so an artificial competitive environment was established which had profound results on health service delivery. As a result there was continued support for Crown stake-holding. Dis-aggregation of services occurred as the traditional links between services were broken down. There was multiple and disparate contracting, patch protection by organizations, proprietorialism and suspicion and hostility between providers.

The four Regional Health Authorities operated independently of each other. This meant significant confusion for organizations like the Richmond Fellowship that contracted across the country for services purchased by the different authorities. Each authority had its own particular and peculiar method of contracting, its own particular service specifications, and its own specific expectation of providers. In effect, it was like working in four quite separate countries. For the third sector, and to a lesser extent, for the Crown Health Enterprises, the biggest problem of all was contract specifications often designed in a bureaucratic environment by people who had no idea at all about organization culture or which particular method of operation led to any particular health gain. Consequently contracts focused on efficiency rather than effectiveness. There was a flattening of culture as all providers were forced, through the mechanism of contracts, into a particular narrow, ineffective way of operating. After three years it became apparent that this model was unworkable, especially in the area of mental health.

Mental health had traditionally relied upon good communication between providers and a co-operative approach to the many needs of people with psychiatric disability. There seemed to be a major dichotomy between treatment and management with the Crown Health Enterprises focusing on treatment and the third sector focusing on the long-term management of mental illness. Because all providers were conscious only of their own particular methods of working and area of operation, little information was communicated from one organization to another and the gaps between services continued to increase. The corporatisation of health had by and large been a disaster, and eventually enormous pressure from the sector, patients and opposition political parties led to another reform which endeavored to undo some of the structural imperatives of the first stage of health purchasing reform.

The Health Funding Authority

It had become apparent that the four Regional Health Authorities were cumbersome in administration and inept in terms of purchasing policy. The top down processing of service specifications was causing major problems for both patients and providers. Following a review of the manner in which health

coalition political partner, the four Regional Health Authorities were disbanded and replaced with a single authority, the Health Funding Authority. The Regional Health Authorities became 'locality teams' with specified duties. They continued to represent regional issues. RHA staffing dropped from 520 to 370 which reduced operating costs by approximately \$NZ20 million annually. They would consolidate contracting, so that national organizations would have national contracts and there would be a standardization of contract requirements so that a service specified in one area would be the same as a similar service specified in another area. In terms of the new purchase models there would be more consultation with providers, a reduction in price volume tendering, more purchasing by use of the RFP process, more innovative funding, and there would be integration of service provision.

NZ had discovered integrated or managed care.

Integrated care in NZ

Two years ago whilst the major changes were taking place and managed care was being debated, the following definitions were widely used to differentiate managed care from integrated care. Managed care is any system that manages the delivery of quality health care in such a way that cost was contained.

Integrated care, on the other hand, facilitates management of financial risk, within available resources, maximizes health gain by a process whereby clinical, financial and structural drivers are examined to identify barriers to best practice, and then to alter these barriers to improve health care.

Such definitions were obviously confusing, however it was encouraging to see health purchasers beginning to address the issue of reintegrating services which had been driven apart by the first stage of the health reforms. The focus was to be on integrated care, rather than introducing a full-blown managed care concept to NZ. In terms of structure, the Health Funding Authority would encourage a number of pilots involving community, consumers and providers in developing services which were integrated across client needs. It would involve partnership, risk sharing and most importantly shared ownership of the management or intake areas.

Integrated care crosses the boundaries that exist in current service provision. It has led to criticism such as that leveled by the

Association of Salaried Medical Specialists that bulk funding of doctors might be a Trojan Horse to privatize hospital services. In a sense, this criticism is partially correct since most general practitioners are in private practice there is already a sort of privatization of some activities. However, the New Zealand Government intends to retain ownership of the hospital services, and some GP's are in semi public organizations such as Iwi Health Services and Union Clinics. Integrated Care aims to break down barriers between occupational classes and between institutions, and to refocus attention on services provided, rather than which institution provides it. For example, whereas a psychiatric residential care provider can only currently provide services in residential places, after mid 99 such providers will be free to deliver other services including some now delivered by hospitals provided safety standards are met.

The focus under the new regulations will be on service systems. Nurses might, for example, form a company to contract their services. Over time hospitals might become contract holders owning plant and equipment, but contracting a wide variety of providers from GP's to Specialists, drug companies to surgeons, public to private, non-profit to profit. Also over time, and here is the bit that some politicians balk at most, GP's, Maori Health Groups, Specialists and others holding budgets that cross the primary/secondary boundary might work through private hospitals. All this describes a general and quite pervasive deregulation. However the one exception to this de-regulation is Pharmac. Pharmac, the company established by the Government to purchase and distribute drugs, is deemed too important a fiscal constraint to be deregulated and this will be especially so if the range of providers diversify. Pharmac's role as a single buyer charged with keeping the drug bill down will remain under whichever government holds office for the next few years. Irrespective of all the checks and balances, the current problem in NZ is that the Government still does not know precisely what it is buying. The new exercise is a much less ambitious process and substitutes a complex and disparate organization that existed previously with a fairly straight-forward centralized purchasing system. It is felt that this centralizing will allow policy makers to (at least in theory), explicitly set out the real cost of health care as it impacts on government spending to meet a demand that continually outstrips the rise of consumer prices and GDP growth. The move to centralized funding was described by the Minister of Health as to make it clearer what services are available to the community at large on a "disease state" basis rather than for individual people. He hopes then to get a dynamic debate. If people say we want to provide more, then this will be a process to say what the cost of that is. The Government is also interested in prioritizing which services to add at the margin. For example, if something needs to be added can the central process be used to decide how to pay for it, or do we cut something else, or do we have more tax or do we have a user charge. Prior to this last stage of reform these sorts of decisions had been internalized within the health system. The idea is that in future the people decide, and the Ministry sees as up for debate, not just the actual decisions but the process by which those decisions are made. Whatever happens in the future is to a large extent up for grabs. Certainly organizations such as the Richmond Fellowship are in a very strong position now as NZ moves towards case rate, case mix or capitation funding. We are not just the actual decisions but the process by which those decisions are made. Whatever happens in the future is to a large extent up for grabs. Certainly organizations such as the Richmond Fellowship are in a very strong position now as NZ moves towards case rate, case mix or capitation funding. We are extremely aware of the process which occurred in the United States and are working hard to ensure that funders and providers work in partnership to obtain the best health gains. The NZ experiment, for it can only be called that, has not been without its problems. But then all experiments are established to test ideas, not prove them. The test in NZ has been demanding and the casualties along the way significant. Nevertheless, we feel positive about the future structure of health funding and at least have generated an open and comprehensive debate about: how health services are purchased, the role of providers, and the role of funders to jointly develop a broad range of integrated services.

Integration in one sense is turning the full circle, once again we

en apart by a competitive health purchasing policy. On the other hand though, successful integration depends upon significant changes in funding streams. Organizations funded on a fee for service basis will not integrate irrespective of the structure that is established around them. Integration can only be driven by flexible funding and the ability of provider organizations to allocate resources where they are most effective.

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Traps for Young Players - Working With Indigenous Maori of New Zealand's North Island

by Gerry Walmisley PhD

Recent reforms in New Zealand to health purchase were guided by the need to contain costs yet maximize health gain. Initial ideas for funding were developed by the Core Services Committee which established health gain areas which included services for children, Maori and mental health. The Richmond Fellowship was contracted to provide mainstream residential psychiatric services in an area which had a high population of Maori (Whakatane in NZ's North Island). It was quickly realized however that irrespective of contract requirements and service specifications driven by the purchaser, the high number of Maori clientele and staff meant that a new paradigm needed to be developed.

Initial attempts to apply standard European care models to the service quickly foundered and led to a number of hui (meetings) with key members of local Iwi (tribes). These meetings allowed the development of a unique partnership between a mainstream mental health provider and local Maori. Iwi were involved in staff appointments and programme developments with the Richmond Fellowship retaining 'ownership' of the contract but Iwi guided and took a significant role in the delivery of the programme and models of care.

Background

New Zealand enjoys a unique relationship with its indigenous people, the Maori. The country was settled from Polynesia approximately 1000 years ago by Maori who by and large lived an agrarian lifestyle developing close affinity with the land and

Background
New Zealand enjoys a unique relationship with its indigenous people, the Maori. The country was settled from Polynesia approximately 1000 years ago by Maori who by and large lived an agrarian lifestyle developing close affinity with the land and its resources. Early Maori tribes occupied specific areas of New Zealand and these territorial boundaries are still very much a part of modern life.

The first European settlers arrived in the early part of the 19th Century and their lack of understanding of the Maori's sense of connection with the land led to the Maori Wars - a series of bloody conflicts between settlers, the British Army and Maori. The wars were eventually resolved and led to a formal treaty - the Treaty of Waitangi - that promised Maori protection by the Crown and British citizenship. This treaty remains one of the most important documents in New Zealand history and has led to gradual resolution of the many grievances that arose from colonization. Over the past twenty years enormous concessions and

Currently NZ Maori are enjoying a renaissance as the Waitangi settlements have increased resources to Iwi Authorities and given Maori significantly improved control over their traditional tribal areas and natural resources. Maori comprise 12% of the total NZ population and most Maori reside in the North Island. Some areas such as the East Cape and Northland have a very high percentage of Maori (up to 82%) compared to the general population.

Whakatane was originally settled in the early 15th century as part of the great Polynesian migration. The original migrants traveled to the Bay of Plenty in (large canoes) or Whaka which could carry up to 150 people. From the Bay of Plenty they continued their journey eastward and on landing at a seemingly hospitable part of the coast. The males did an inland excursion leaving the whaka in the care of the women. The whaka came adrift and were saved by one of the women after uttering the words "Kia Whakatane ahaou ia ahau" I will now become a man. And from this incident a thriving coastal settlement was developed.

Whakatane is a small city in the Bay of Plenty. It is surrounded by lush farmland on a volcanic littoral and is prone to earthquake and volcanism. The local Maori are represented by descendants of the original whaka but have split into two Iwi - the Tuhoe or Children of the Mist, and the Ngati Awa. The Tuhoe have a warrior tradition and have lived predominantly in the hill country of East Cape whereas the Ngati Awa have occupied the littoral being largely agrarian. In addition to the two main Iwi there are a significant number of Hapu or sub-tribes, each with their own particular affiliations and regions.
Richmond Fellowship Involvement

The region had not been well served by mental health services. The local Crown Health Enterprise (hospital) offered limited psychiatric services. Any patients with more serious disorders were treated at a large base psychiatric hospital in Hamilton - over 100 Ks away. There was little in the way of community care or residential support which increased the difficulty for local people to return to the area. CHE mental health services were overstretched and so appreciated the Richmond Fellowship gaining a contract to provide residential and home support serv-

Founded in London in 1958, the Fellowship had developed services in over forty countries and was a major provider in New Zealand. It had established such services throughout New Zealand and usually established good relationships with existing formal mental health services. The establishment of a small residential and home support service would follow a well-tested protocol whereby suitable properties would be purchased, staff appointed and referrals accepted.

The Richmond Fellowship was invited by the then Regional Health Authority to purchase a ten-bedded psychiatric recovery trust in Whakatane that was in difficulties. As part of the de-institutionalization of the regional psychiatric hospital, the Fellowship was contracted to provide an extra ten community beds in addition to those already provided by the trust. In the Midland Region the purchaser (Regional Health Authority) set up an Iwi Consultation arm. Unfortunately, proper consultation with Maori did not occur and instead a government appointed board offered their advice. Consequently when the Richmond Fellowship started developing its services they ran into resistance from community groups based on:

- Local groups believing ownership of resources coming into the region should be controlled by the local people. This was further exacerbated by the history of the New Zealand government acting paternally towards the Maori
- No recognition of the historical differences between Tuhoe and Ngati Awa in the consultation process.

The Richmond Fellowship also lacked understanding of this history and made some fundamental errors.

The first mistake in the current project was making the key appointment without extensive consultation with local Iwi. The first property was purchased and a Programme Manager was appointed who had previously worked for Richmond Fellowship services in the South Island. A pakeha (European), he had worked extensively with tribal groups in Australia and we felt he would understand the particular issues associated with programme development. This raised a particular dilemma for the Fellowship as we strongly believed in our right to employ whom we chose and that as long as skills were appropriate for the task in hand then as employers we had certain prerogatives. Nevertheless, such niceties had to be reviewed in the light of particular local demands if we were to expect to operate services in the region. we chose and that as long as skills were appropriate for the task in hand then as employers we had certain prerogatives. Nevertheless, such niceties had to be reviewed in the light of particular local demands if we were to expect to operate services in the region.

The second problem was our somewhat insular and top down approach to developing the new service. We were significantly taken to task by local Maori and several meetings were held in which we were reminded of our 'visitor' status to the region. That we had gained a legitimate contract made no difference and we became aware that our 'right' to operate the contract actually depended on cooperation from local Iwi irrespective of any legal right.

Liaison with Iwi

Initial liaison with Iwi was largely spent defending our position. At meetings on the local Marae, opinion among Maori was mixed about the role the Richmond Fellowship could play in

delivering services. In particular, our desire for partnership was rightly viewed with skepticism by a people who had had many similar offers in the past that had turned out to be insubstantial in practice. We had to, in the local vernacular, "walk the talk". The first step in what was a long healing process was the release of the original manager and the appointment of a kaumatua or elder from local Iwi. The kaumatua assisted with the appointment of a new manager, a Maori, and assisted the Fellowship in its consultation process. His role was both ceremonial and consultative. Ceremonial in that the kaumatua would represent the Fellowship at meetings with Maori, calling Richmond Fellowship management to speak at the appointed time in meetings. Consultative in that the kaumatua would advise and assist in appropriate protocol of kaupapa (philosophy) service. To further "walk the talk" we had to acknowledge that the majority of people in our programmes were Maori and as such required services that acknowledged their own special values rather than imposing a European mainstream clinical service.

The service underwent significant internal and external changes as Richmond Fellowship called several meetings with Iwi to seek guidance for the future direction of the programme. A new manager was appointed who was of the local Iwi. Similarly, many of the new staff appointed were also Maori who had links with Iwi or were part of the whanau (family group) of other staff. This sent a powerful message to local Iwi that the Fellowship was committed to an understanding of protocol and was endeavoring to create a service that was representative of the indigenous people. Fortunately, core Richmond Fellowship protocols were such that they were acceptable to Maori. Our approach was one of partnership with clientele and the Richmond Fellowship therapeutic community model had many similarities to the principles of kaupapa Maori. Currently the programme takes both Maori and European clientele. The latter integrate well into the programme and do not feel that the Maori kaupapa is materially different from their own. The kaupapa emphasizes the rights of the individual and their need to respect and assist one another as members of a whanau.

The differences between the two main Iwi, the Tuhoe and Ngati Awa, also had to be acknowledged. Although they had originally arrived in the Bay of Plenty together, time had led to significant differences between the two. These historical messages were important and frequently overlooked as few Europeans fully understood the importance Maori give to their whakapapa or genealogy. This genealogy encompassed not only the familial relationships, but also the relationships with the land, and has great significance in any negotiation. Eventually the Richmond Fellowship formed a partnership with Ngati Awa who were the Iwi more closely linked to the people in the service. The Tuhoe were acknowledged in an offer to work with them in any future mental health initiatives. Thus both Iwi were recognized and had a role and involvement in current and future developments.

Discussion

The process described in this paper demonstrates the problems that can arise when mainstream values are imposed on indigenous peoples. Irrespective of legitimate and contractual rights to operate in the region, no programme that treated a high percent-

age of Maori would be successful without the full cooperation of Iwi. To work with indigenous people successfully, mainstream providers must significantly modify existing protocols and adapt them to the special needs of the group with whom they are working. For example concessions must be made in staffing to ensure adequate and appropriate representation as well as internal service delivery protocols. The demography of mental illness in New Zealand demonstrates that major psychiatric illness is equally prevalent among Maori and Europeans yet only recently have mainstream providers made any particular effort to accommodate the special needs of Maori within their programmes.

The Mental Health Foundation (UK) (1997) in its Joint Policy Statement last year noted that "mainstream mental health services often failed to meet the needs of ... ethnic minorities because they are not sufficiently sensitive ... to (their) diversity." This is abundantly demonstrated in New Zealand and elsewhere by the large numbers of indigenous people who are institutionalized as a response to illness behavior. They are more likely to be given a diagnosis of severe mental illness and are over-represented among people compulsorily admitted under the mental health legislation. Similarly, once admitted this group tend to spend longer in hospital as often discharge failures occur due to lack of culturally safe community services. Interestingly the MHF Briefing Paper points out that deficiencies in access to and quality of mental health care services ... frequently reflect inadequate involvement of those communities in the planning and delivery of services.

In 1996 the US Congress also noted that ethnic minorities lacked access to mental health and support services and that mental health professionals often lacked the appropriate training. The problem of delivering culturally safe services is widespread and although New Zealand is pro-active in terms of race relations, services too often fail to take into account the needs of its indigenous people, the Maori.

For the Richmond Fellowship it quickly became apparent that we had to make major changes to our accepted manner of service delivery if we were going to offer effective care to Maori. Such changes were not easy to introduce, and were questioned by both Board and staff. Nevertheless, by working closely with Maori and developing a true partnership, many new doors opened to us that were formerly closed. It is too easy to assume that existing service protocols for the community care of people with mental ... Board and staff. Nevertheless, by working closely with Maori and developing a true partnership, many new doors opened to us that were formerly closed. It is too easy to assume that existing service protocols for the community care of people with mental illness will translate across cultural boundaries. We rediscovered that this is not so, and that it is important to recognize that all people, mainstream or minority, have special and individual needs.

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