Primary Health Care as a Model for the Delivery of Mental Health Services to the Community

Cecil Deans, Associate Professor
Ballarat University College

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Cecil Deans
Associate Professor
Ballarat University College

This paper will firstly address the underlying principles of primary health care. It will then discuss the delivery of psychiatric services in Victoria, the nurse's role in primary health care and the evaluation of how the current delivery of psychiatric services measures up to the principles of primary health care. While the focus of this paper is on psychiatric services and nurses, I believe that all health professionals have a need to understand the concept of primary health care and how the application of its principles may be utilised to prevent mental illness and promote mental health. It is essential in any discussion on primary health care to establish some operational definitions of the key concepts. In her studies on the topic, Krebs (1983: 141) makes the following comment 'in the nursing literature we find, on the one hand, a number of articles where the term Primary Health Care is used, but when one reads these articles one finds out that the authors are talking about different things'.

For the purposes of this paper, I accept the term Primary Health Care as it is defined in the Alma-Ata Declaration (1978: 2):

*Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community can afford. It forms an integral part both of the country’s health system, of which it is the nucleus, and of the overall social and economic development of the community.*

It is clear from this definition that primary health care cannot be the exclusive domain of the health care sector but rather integrates the health care sector with local efforts in the promotion of health, the prevention of illness and community development.

The second concept requiring clarification is health. While some health providers tend to look upon health as the absence of disease, the World Health Organisation regards it as 'a state of physical, mental and social well-being'. It is clear that one's definition of health is a major determinant of how we consider health care should be delivered. If we accept the definition of health as the absence of disease, there is considerable justification for channelling services and resources, including research funding, into curing diseases and it is, therefore, not surprising that we continue to support government agencies who focus on tertiary risk groups.

It has been my experience, as a researcher and an applicant for research funding that the priorities for research granting bodies are for dramatic cures, while funding for research into practical areas such as more effective methods of health delivery are denied. In this paper health is defined by utilising the explanation provided by La Bonte (1989: 24).

*First, health is intrinsically a holistic concept; it cannot be reduced to simple measures of morbidity and mortality. Second, health is more than our notion of behaviour as inherently social. Third, health goes beyond the complex web of social conditions - income, employment, environment, housing - that we now look upon as the context in which health opportunities arise or are quashed. Essentially health exists in the dynamic moments of our social relationship.*
La Bonte stresses the importance of relationships between individuals and groups within society. While I agree with La Bonte's comment, there is still a need to eliminate factors which place obstacles in the individual's ability to have healthy relationships. How then can we evaluate the current delivery of psychiatric services throughout Victoria? This paper will utilise the concepts of accessibility, participation, equity and empowerment to analyse the existing services.

Access and Equity

The Office of Psychiatric Services, located within the Department of Health and Community Services, is one of the largest government-administered health services, with a budget which accounts for approximately ten percent of the Health Department's two billion dollar annual expenditure. Of the total days spent by Victorians in public and private hospitals, approximately 15% of hospital days are spent in Office of Psychiatric Services facilities (OPS 1992: 8). The services provided consist mostly of the treatment of acutely ill patients and long-term rehabilitation, predominantly within inpatient and outpatient hospital settings. The major hospitals that provide services to the mentally ill are located in sites which are geographically inappropriate to meet the current needs of rural communities, while voraciously consuming the major share of the health budget and simultaneously denying significant sections of rural communities access to psychiatric services. The Central Highlands/Wimmera region, with 4.1% of Victoria's population attracted 14.4% for the 1985/86 state psychiatric budget. In the past 5 years this has been reduced to 10.9%. This has resulted in a major distortion of funding for resources favouring inpatient units, thereby increasing response times to crises and follow up support to rural communities. The Health Department of Victoria Report (1987: 8) suggests that the annual admission rate is now seventy-five percent higher than in 1963. The same report also states that 'commencing in the 1970s there was considerable growth in the number of community mental health centres' (p.11).

However, these community health centres function primarily in a secondary and tertiary consultative role in relation to non-specialist agencies. The problem of looking after the mentally ill must address both the perceptions of the community within which the person lives, and health professions. Caplan, Engelhart and McCartney (1981: 353) state that:

_Mentally ill persons often are thought incapable of looking out for their own best interests and of participating fully in interpersonal relationships. Mental competency is often regarded as a prerequisite for maintaining moral and social status within a community. Those viewed as mentally ill are treated less as free moral agents and more as subjects in need of help and protection._

It is this public and professional attitude which inhibits the political changes required to ensure accessibility and equity of services.

From a primary health care perspective, there would appear to be a need to place greater emphasis in both changing public attitudes towards the mentally ill and encouraging the mentally ill to have a more significant say in the services which are provided for them. If the mentally ill are perceived by the public and health professionals as weak and unable to cope with the stress of life, they will never be given the opportunity to have a meaningful say in which services are required. When attempting to set up new psychiatric services in the Wimmera Region of Victoria, Hermans (1992) states that 'to ensure the new service was acceptable and relevant to the local population needs the community psychiatric nurses worked closely with the Mental Illness Support Group. The Victorian Mental Illness Awareness Council, (VMIAC 1990: 2) which is a statewide forum for consumers for the mental health system, claim that consumers have a vital contribution to make to the mental health system, 'It is our right to have a real say in issues which affect our lives'.

In a speech made by the then Minister of Health, Mr T. Roper (1983: 1) recognises this need for greater participation...
It is implicit in our approach...that people must be involved in the planning and delivery of health services most appropriate to their own needs and that they understand what these needs are and that they are community based.

Four years after the Minister's statements, the Health Department reported (p.7)

The distribution of psychiatric services is grossly inequitable, in terms of regional allocations, per capita expenditure, location of agencies and the balance of community based and hospital services. This problem has been recognised for many years as a major obstacle in the development of a modern service.

In 1986 the Office of Psychiatric Services in an attempt to rectify 'grossly inequitable services', launched a document entitled New Directions for Psychiatric Services in Victoria. This document included as the guiding philosophy for the Office of Psychiatric Services the Government's commitment to Social Justice,

The Office will plan to work towards social justice for people with mental illness or psychiatric disability. The principles of social justice will only make sense when they have been translated into concrete projects and services which implement them (p.3).

The priority for the Health Department was to provide a model, appropriate and locally-accessible system for psychiatric services in Victoria. While these initiatives are welcome and overdue, they do not comply with the principles of Primary Health Care as they appear to continue to concentrate on secondary and tertiary prevention. I believe this situation will continue with the current policy of integration and mainstreaming of psychiatric services into the general health system (Office of Psychiatric Services 1992). Psychiatric Services will now compete with the scarce general health dollar and as a member of a Public Hospital Board I believe that the demand for new technology, new services and the ever increasing pressure to reduce waiting lists in the general health field will overshadow the mental health needs of rural Victorians. I refer to Kingston who reported in The Age, 22 January 1993, that Mr Howe, the Federal Health Minister, threatened to withhold $7 million in funding for psychiatric beds, due to Victoria this financial year, because of 'concerns about whether Victoria is satisfying the requirements upon which the concession is based'.

The principles of Primary Health Care would focus on the causes of the problem. These causes may be seen according to Jackson (1985: 2) to belong to two sources:

Those who maintain that behaviour is the prime determinant of health and illness...and... those who argue that patterns of morbidity and mortality are not spread evenly across the population, ill health being correlated with low income, low education and social minority status.

While acknowledging the impact of lifestyles on health, this paper, however, accepts the view that socio-economic factors play a more significant causative influence on mental illness. This point of view is supported by the Health Department's own report which states that 'social disadvantage characterises the majority of clients treated by the Office (of Psychiatric Services) with more than half being unemployed or pensioners'. I would argue that there is sufficient evidence to add rural communities to the increasing list of disadvantaged citizens. There is little doubt that small rural communities in Central Victoria are suffering financial, social and psychological hardship, and perhaps ruin, with some communities crumbling before our eyes. In 1991, a total of 190 people in rural Victoria killed themselves.

Socio-economic environment has a pervasive influence on ill-health. The distribution of income and social power in a society, through housing standards, nutritional levels and sense of social worth and thus self-esteem, will advantage the health of some and compromise the health of others (Jackson 1985: 3).
In our society, to chronically and severely lack money is to be unable to adequately care for one’s children, to be powerless, to be considered a failure, to be an eternal outsider in relation to the very groups society at large so much admire, and to have little scope for participation in altruistic interchanges with either family or friends. This point is more adequately summed up by Wenegrat (1990: 3) when he states ‘therefore, poverty in our society is a psychological death sentence, an obstacle to all the activities from which distinctively human lives are made’.

The author suggests that the people most in need of health care are those with the least ability to influence the delivery of health care. Navarro in Hates (1978: 74) concludes that ‘the needs of the consumer are, in a capitalist form of economic organisation, subordinated to the needs of the system to make more profits by increasing consumption and creating insatiable wants’. Consumers of health learn that they have no control over the services they receive. The services are delivered to them at the discretion or convenience of the service deliverers. This factor combined with blaming the victim, results in what Seligman in Darly, Glucksberg and Kinchla (1988: 409) describes as ‘learned helplessness’. ‘Competence is a fundamental aspect of human nature. This becomes dramatically apparent when people are deprived of their feelings of competence’.

When the individual experiences a lack of control over their environment they become depressed, passive and unresponsive. The problem is often exacerbated with the mentally ill person who, on the one hand is being exhorted to get control of him/herself, while at the same time discovers that he/she has no or minimum control and feels incompetent and helpless.

The provision of a mental health service which is located in a site which was selected in the eighteenth century on the basis of its remoteness to the public, is not conducive to service delivery in the 1900s. For this reason the Health Department, Victoria, attempted to decentralise the delivery of psychiatric services. In their report, Pappa, Carter, Evans and Kopp (1986: 853) proposed a decentralised, administrative organisation based on regionalisation. Two important elements of government policy were thought most likely to be accomplished by mental health agencies being managed by Regional Directors:

- promotion of community-based rather than institutional care for psychiatric patients, and
- greater devolution of administrative responsibility to mental health agencies.

The rationale for these changes was to provide a modern, appropriate and locally accessible system of psychiatric services in Victoria. As yet, the Office of Psychiatric Services still retains a central administrative control over all government services for the mentally ill. The responsibility for the administration of these services has not yet been devolved to Regional Directors as have other health services.

A second major initiative for the regionalisation of health services was the establishment of District Health Councils. These were to be a formal mechanism for local communities to participate in decisions concerning circumstances which affect the health of people in their region.

The Regionalisation Task Force (1984: 2) commented that the creation of Councils should encourage a wider debate on important issues in the health field and foster the development of new perspectives and the expression of issues that are of vital concern to the community.

At the present time the Office of Psychiatric Services functions outside of the established District Health Councils. This means that there is no meaningful community input to decisions taken on their behalf by bureaucrats in Melbourne.

The Victorian Government’s Social Justice Strategy (Social Development Committee of Cabinet 1989: 6) is based on the four principles of Equity, Access, Participation and Rights.
While these principles are highly commendable, they once again do not address all the obstacles to good health presented to individuals. There is a need to reverse the multitude of negative discriminations that the mentally ill in rural communities currently experience, including the provision of public transport, building better roads, enhancing health and education services, improving telephone services, reducing the higher costs for supplies, such as petrol, and reducing rural unemployment. I would argue that these problems are significantly different from problems experienced by urban populations.

Would health professionals regard these problems to be within the ordinary sphere of health? If poverty is a major cause of psychological trauma, how does the Government plan to assist the eighteen per cent of families in Victoria living below the poverty line? If the principles of Primary Health Care are followed, the Government would attempt to identify the forces that maintain poverty and deny economic resources to large sections of the population. The result of inequity in resources is often reduced to a victim blaming argument about how the poor are mismanaging their finances.

**Empowerment**

Organisations and institutions don't give up power easily. Utilising the principles of Primary Health Care would require the convincing of the powerful to relinquish some of their power. This would include the doctors, social workers, nurses and psychologists who work with mentally ill people. VMIAC (1990: 2) claim that to date, 'the experience of consumers and service providers alike is that consumer participation hasn't worked'. Our lack of participation is explained away by service providers saying 'we're not up to it', rather than leading to a questioning of the structures that reinforce this. La Bonte (1989: 28) states that to be effective, resources for community health development, health professionals must learn to surrender our 'service provider label'. While the government can introduce legislation in the form of the Mental Health Act 1986 which increases the legal rights of mentally ill people, it still requires the community to ensure that these rights are honoured. Lack of equity and access marginalises and perpetuates the acceptance of the marginal status of mentally ill people.

In addition to changing public attitudes and new initiatives by governments and their agencies, the individual nurse can play a significant role in the delivery of psychiatric services. This may be achieved, according to Davidson, Chapman and Hull (1979: 2), in the following ways:

*Given that broad and sweeping social change conducive to improved community health is unlikely, national health promotion must concentrate on the most effective ways of motivating changes in these areas where individual choice finally determines behaviour.*

This would clearly give a mandate to nurses to assume different roles. In primary health, nurses are accountable to the community as advocates for self-determinism and empowerment. While nurses often bask in the warmth of personal job satisfaction, the service they provide contributes to the process of disadvantaging and disempowering people by fostering their clients' dependence and unwittingly undermining their self-reliance. Nurses will have to place a greater emphasis on health promotion and disease prevention with a focus on community participation and self-reliance. This will also require a major change in the attitude of psychiatrists who are the traditional leaders in psychiatry and who still emphasise the curative care, medically circumscribed, hospital-based approach.

Nurses will have to in the future approach their work from the widest possible base and to address the underlying causes of psychological suffering. This may mean that they need to become active within their local community by joining lobby groups, area health boards, committees and protest marches. Nurses may be in the unique situation whereby they can become the link between social justice strategies and the empowerment of the mentally ill. To some extent this would permit the individual to provide their own definition of health. With
the best intentions, nurses have applied their own value system to determine what is good for mentally ill people. They rob them of the ability and power to make major decisions and when they do not conform to what nurses want them to do we blame them for being uncooperative or non-compliant. Nurses should be assisting the mentally ill to overcome the barriers, including the barrier of professional health workers, bureaucratic barriers, economic barriers, attitudinal and prejudicial barriers and familial barriers. Minkler and Cox (1980: 312) provide us with an insight into how this may be achieved. They suggest that fundamental distinctions were drawn between the oppressors in society, with emphasis placed on the task of the oppressed to liberate themselves and their oppressors, both of whom were seen as manifestations of dehumanisations caused by an unjust social order. It may come as a shock to many nurses that they too require liberating. Storey, Romer, Maglacas and Riccard (1988: 5) state that:

*nurses can play a more dynamic role if the factors that impede them from making the most of their training, experience and potential are removed. Training geared more to curative rather than preventative services, and the lack of appropriate preparation...have among other things, prevented the integration of nurses into the primary health care effort.*

The integration and mainstreaming of psychiatric services into the general health system presents nurses with a new opportunity to advocate for rural Victorians. As already stated, this will not be easy in the context of a competitive health market. Maglacas (1988) provides us with two reasons why nursing's potential to help solve cost, equity and access is far from being realised. One is nursing lack of understanding and involvement in the social, economic and political realm and the other is the way in which nurses present what they had to offer.

One of the major exponents of assisting the oppressed to participate more fully in their health care is Friere. Friere in Wallenstein and Bernstein (1988: 381) states that 'the purpose of education should be human liberation so that learners can be subjects and actors in their own lives and in society'. In reality, this approach would have individuals and groups analyse the causes of their problems. There may be socio-economic, political, cultural and historical factors in which the group attempts to gain control. An important difference in Friere's method is that he places the expert in a minor role. Wallenstein and Bernstein (1988: 383) state that:

*While health education assumes that individuals can make health decisions with enough information, skills and reinforcement, Friere assumes that knowledge does not come from experts inculcating their information. His emphasis is on the collective knowledge that emerges from group shaping experiences and understanding the social influences that affect individual lives.*

This appears to be aligned with the World Health Organisation's perception of the role of health promotion as 'the process of enabling individuals and communities to increase control over the determinants of health'. While I agree with the principle of empowerment as expounded by Friere, there must first of all be a concerted effort to ensure nurses and other health professionals have an education that presents the philosophies of empowerment rather than philosophies of social control. This will be extremely difficult as the health professionals in Victoria with the most power and, therefore, the most to lose are doctors. Nurses and other health workers, although more powerful than the patient, remain relatively powerless to make the necessary changes that will assist the mentally ill to gain control. The mentally ill are frequently seen as socially unacceptable and to a large extent overlooked as a group with the potential to help themselves. However, nurses must learn to rely on the expertise of the patient as a person who has 'been there' or still is 'there'. The expertise of patients to help themselves must be recognised. Nurses must not use their position as professionals to dictate to the mentally ill what is in their best interests. They should not appeal to years of experience and their level of objectivity as parameters of skill. Frequently nurses use their position to maintain a separation and distancing from those they claim to care for. In summary I have attempted to outline the principles of Primary Health Care. The major thrust of these principles emphasises the accessibility, equity, participation and empowerment of people in health issues.
This paper outlines briefly the provision of psychiatric services in Victoria. In the 1900s it is still reasonably clear that the services exist without the degree of accessibility and equity that the Health Department would wish for and which the preliminary policies are attempting to rectify. Also examined was the inherent difficulty of delivering health care to a group of people, the mentally ill, who are perceived by the community to be different and, therefore, are in need of institutional care. I believe that although services to the mentally ill are inequitable, there would appear to be a genuine attempt by the Government through its social justice strategy to redress some of these inequities.

Finally, the paper examined the philosophy of empowerment and the role of nurses in the process of empowering mentally ill people to address the root causes of their problem. This would require a dramatic change in the attitudes of nurses and fundamental changes in their education. The major problem for the mentally ill and the potentially mentally ill is their socio-economic position in the community. This has an immediate and direct impact on the individual's ability to initiate, establish and maintain meaningful relationships. Nurses in the future should be willing to confront the challenges outlined in primary health care and diagnose community health problems as opposed to individual health problems. They then may perceive their role to include implementing strategies to protect, advance and monitor the health of populations. This would be a significant change from the present role of nurses which primarily is centred on secondary and tertiary prevention. Finally, the principles of Primary Health Care offer nurses an opportunity to develop a new and challenging role for themselves in society. They should become the activists which ensure the underlying causative factors of mental illness are addressed and, more importantly, changed. Then perhaps nurses with the alliance of mentally ill people can liberate themselves from being agents of social control.

References