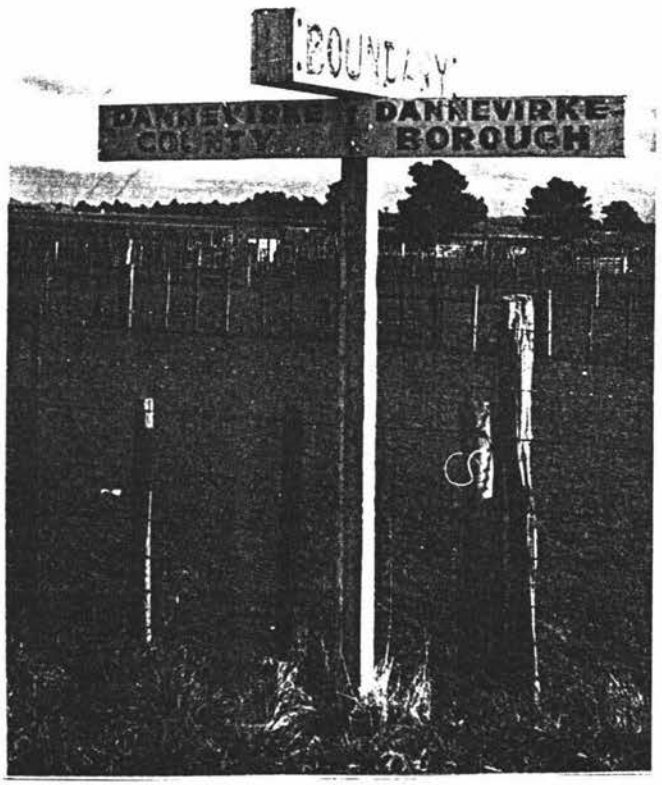
FORMAL AND INFORMAL SUPPORT SYSTEMS IN A RURAL TOWN AND COUNTY

REPORT OF THE RESEARCH ON MENTAL HEALTH IN DANNEVIRKE BOROUGH AND COUNTY



A thesis presented in
fulfilment of the requirements for the degree
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ERRATA

page 7, line 30: "Semmel" should read "Simmel".

page 9, line 19: "conflicts if" should read "conflicts of".

page 14, line 17: "wonder if" should read "wonder of".

page 24, line 12: "the Taranaki region" should read "the Wanganui and South Taranaki region".

page 42, line 16: "Ruatahura" should read "Ruatahuna".

ABSTRACT

The Dannevirke project was designed to provide a view into one rural borough and county in order to discern how that community provided services for those in need of emotional and psychological support. Professional human service providers and a representative sample of the general population were interviewed to identify the formal and informal supports that were available to the community and to define mental health and mental illness. This project was based on two assumptions: 1) rural and small town life in New Zealand had networks of self-help and support and these networks were different from those found in the urban environment; 2) clinical and professional practitioners adopted unique responses to practice in a rural area.

This study demonstrated that a rural community based on the romantic notion of a small homogenous, caring community was simplistic. Intrarural differences in the numerous settlements revealed a more complex fabric.

The data did reflect an intricate and caring network of informal supports but it was unclear as to how different (e.g. more supportive) these rural networks were to those in an urban/suburban community. Respondents with low group membership and low visitation from family and friends reported a statistically significant low sense of psychological well-being using the Bradburn Well-Being Scale (1969). The actual roles these networks played in caregiving and prevention needed further inquiry.

The pathways to service for people experiencing emotional/psychological problems were traced, including a ten year statistical analysis of inpatient psychiatric care. The general practitioner was identified by the respondents

in the community and by other professionals as the primary gatekeeper for services, underlining the medical bias in their definitions of mental illness.

Delivery of services by the professionals in the rural area was complicated by distance, minimal interprofessional coordination, shortage of specialist services, and a lack of ongoing professional education in the field of community mental health. Treatment in the community was favoured over sending the clients away for services and the local hospital was a unique resource for short-term respite care.

The findings brought forth numerous questions including: What models of practice are effective for mental health care in the rural context? How do geographical distance and isolation affect community mental health practice? Does the urban base of most professional training prepare formal caregivers for life and practice in the rural setting? Specific recommendations for policy development and for further research were discussed.

ACKNOWLEDGEMENTS

A transition occurred when I began to do research, during which I queried, "Why am I pursuing this particular topic of concern?" This was not an easy question to answer and in attempting to illuminate the reasons, personal biases, assumptions and life experiences came slowly to the foreground. In this specific research, why did I choose to query issues concerning the practice of rural social work in the field of mental health? The answers to this question certainly had a bearing on how the problem was perceived, defined and subsequently explored.

Developmentally, I am a product of an urban-suburban life-style. My education was in large urban schools and urban universities. Politically my secondary education was infused with the challenges of John F. Kennedy. His presidential endorsement of community responsibilities in mental health, racial equality, and social justice filled me and my peers with idealism and a powerful, albeit ill-defined, sense of commitment to structural change. There was complete certainty that all of us would work toward a just and caring community and that the federal government would be an interested partner in ensuring that this justice prevailed.

Graduate school at the University of Maryland School of Social Work and Community Planning in city centre Baltimore was focused on social change strategies for the numerous problems society was facing in twentieth century urban America. The structural deficiencies of the society and its economic systems were inextricably linked to the individual and familial struggles for survival and development. As a counterpoint to the stark realities of social work practice, my family became involved in a rural restaurant, a social hub of my mother's very small home town. Weeks were spent being challenged by peers, professors

and clients in the seemingly impossible urban mire of crime, unemployment, sexual and racial inequality.

Weekends were retreats into the sylvan countryside where urban anonymity was replaced by rural friendliness and clear networks of historical relationships. Rural life seemed simpler and safer - always in my mind the solace for my week's reality in urban stress, a symbol of the last place left where community spirit and individuality could be experienced.

But my training was urban based and I saw my role professionally remaining in the arenas of urban practice for the next six years. When an opportunity eventually surfaced to work in the field of mental health in a rural community mental health centre, it seemed a chance for a less complicated professional and personal life.

Yet the reality of rural practice was far from the expected ideal. Despite the seemingly friendly small town, feelings of estrangement were constantly surfacing. Advanced education, a "big city" orientation, and psychiatric expertise seemed to create barriers initially for me professionally. My romanticised picture of the sylvan rural life did not match the complicated and difficult problems facing the people served by our centre.

Practice expectations had to be altered to meet the unique demands on service delivery in a large geographical area with a sparsely scattered population. In my initial period of uncertainty a conflict resulted from the tendency to rely on "bringing in" professional skills instead of developing a new model of service delivery blending the professional expertise with the existing strengths of the community. To the people of Madera County and especially to the staff and clients of the mental health centre, I owe a great deal of gratitude for their patience and support in helping me resolve that conflict and for teaching me so much about rural life.

My practice experiences produced may questions about assumptions on community mental health and on urban and rural differences. I am grateful for Merv Hancock's early backing to continue my questioning through this research project. His continual excitement over learning has been an inspiration. Special thanks to the students (Barbara Scarfe, Wheturangi Walsh and Murray Walker) who stood by me in the early stages of the research and who, during the field survey, survived hundreds of cups of tea and biscuits. The support of numerous people in Dannevirke was instrumental in the research, including Cec Taylor, Grace Benson, Jennie Taylor and Edith Nicoliason who gave many hours on the survey and community feedback, as well as to Dr Mulvihill and the medical fraternity of Dannevirke who supported the project. Special thanks to John Robinson, the Department of Social Welfare social worker who opened so many doors for me and the research team and who cared so much for the community of Dannevirke. Also a note of appreciation is due to Dr Mason Durie for his statistical support from Manawaroa.

A special thanks to Graeme Fraser whose excellent supervision enabled this project to be finally completed. His occasional prodding kept me going when all seemed hopeless. Also a blanket thank you to my colleagues in the Social Work Unit who aided me throughout the project and knew the difficulty of doing research and working full-time. My wife, Angie, is also to be thanked for her caring and consistent belief in me, also for letting me use her superb typist, Jill Cheer, who understood my cryptic handwriting. Last but not least, thank you to the Mental Health Foundation for the financial support, without which this project could not have occurred.

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CHAPTER ONE: INTRODUCTION

Definition of the Problem: Community Mental Health in a Rural Context

Deinstitutionalisation, decentralization, and community control have been seen as basic to the development of community based mental health service. But these processes have assumed the existence of resources within the local community. Most of the research and practice models in community mental health have originated in an urban environment and concentrated on ensuring the availability of professional expertise, paraprofessional support and coordination of existing services on a local level. The question of what supports existed before the advent of community mental health has been often overlooked. The assumption has been made that certain basic services (inpatient, outpatient, day care, emergency services) were essential without first considering the possible differences that might have existed in rural and urban communities. A case could be made that the rural environment presents different challenges because of its unique characteristics: scattered population centres, extreme shortages of trained human service providers, difficulty in recruiting professionals, limited public transport in large geographic areas, and health care facilities which are scarce and widely dispersed. A vast proportion of New Zealand can be considered rural, even though the majority of the population now resides in urban areas.

There has been little research done in New Zealand on how people in a rural environment manage emotional and psychological problems. This brought forth two major concerns:

1. How do rural people experience, manage, and resolve their emotional and psychological problems; is it handled differently from those people residing in urban areas?

2. Does the rural context demand a different approach to mental health services? What are the differences and what are the implications in professionals practising in this rural context?

In addressing these two major areas of concern, the difficult task emerged of defining concepts like mental illness, mental health, community, networks of support; urban and rural. Each concept in its own right represents considerable research, thought, and disagreement - which made the task of describing mental health care in a rural community complex. Three different methods of investigation have been utilised to broaden the data base and aid in the exploration: a statistical analysis of the use of an inpatient psychiatric unit over ten years, a rural community household survey and personal interviews with a group of rural professionals.

The Goals of the Study

This study aimed to provide baseline data on the formal and informal supportive networks which existed in a rural borough and county in New Zealand, a county which does not have a formalised community mental health programme. This project was an exploration of the gaps in resources and the existing strengths of the rural community in dealing with personal and family problems. Therefore both the professional community and the population at large were queried as to their view of mental health and mental illness. This information would be essential before policy development could occur, service delivery planned, or any model of practice put into action.

Site Selection

The Dannevirke Borough and County was selected because it met certain key criteria for defining a rural environment.

The area was defined as rural because it covers a large geographic area (over 2245 sq.kilometres) with 10,413 people widely dispersed. Dannevirke County statistics reflected a depopulation trend since 1971, common in many rural areas.

The designation of rural by the New Zealand Census has been defined as less than 1000 people and in the U.S.A. less than 2500 people. But a rural environment based on low numbers of inhabitants has been challenged as simplistic. Pearson (1980) suggested that New Zealand has been characterised historically by small businesses and small enterprises and that even today much of New Zealand could be considered rural in context - if rural could be equated to small. Dannevirke Borough and County for the most part met this criteria. Positioned between two major metropolitan areas, Palmerston North and Hawkes Bay, Dannevirke demonstrated the "in between" status of many rural areas. This in between position has affected service development, service allocation, and service delivery.

The large geographic area contained a scattered population who depended on agriculture as their economic base. Numerous small settlements had been established, experienced growth and decline but continued to survive, despite the emergence of Dannevirke Borough as the main centre of many services. Because Dannevirke had its own hospital, numerous health care services were available locally which would not have been the case in other rural areas of New Zealand. However, there was no formalised community mental health service in Dannevirke. In fact, the following were <u>not</u> present in Dannevirke Borough and County:

1. An established centre of mental health professionals.
2. A coordinating committee of professionals concerned with mental health issues.
3. A community advisory council of citizens concerned with mental health.

4. An established community mental health education/ prevention programme.
5. Peripatetic or satellite centres from Hawkes Bay or Palmerston North Hospital Boards.
6. Inpatient psychiatric facilities (Manawaroa at the Palmerston North Hospital, and Lake Alice outside Marton, are the two closest available institutions).

There were numerous technical considerations supporting the choice of Dannevirke as a research site. It was an area which had not been investigated before and was accessible to the researcher and the research team. The small number of professionals in the community provided a realistic size group to be interviewed. Informal networks were highly visible and local contacts were enabling to the researcher in gaining access to the professionals and in facilitating the house-to-house survey in the community. The proximity to the University, the good roads, and the endorsement of major community leaders combined to make Dannevirke County and Borough an ideal area for surveying attitudes and discovering the ways in which people understood mental health and illness in a rural context.

Format of the Study

The report of the study is divided into six chapters. The present chapter states the problem, the goal of the study, the site selection and the format. The second chapter contains a selected review of the literature and examines the rural-urban debate, psychiatric impairment in rural and urban communities, networks of support, alternatives for rural based practice and the lack of theoretical background to the community mental health movement. The review includes an overview of literature concerning social life in rural New Zealand. The methodologies utilised, how the data was analysed, and how the community feedback process occurred are described in the

third chapter. Dilemmas which can occur for a rural researcher are also highlighted in this chapter.

The fourth chapter is divided into two sections: the researcher's impressions and a brief socio-cultural history of Dannevirke Borough and County. In the fifth chapter the findings are reported. Included is the 10 year statistical analysis of Dannevirke Borough and County's use of inpatient hospitalisation at Manawaroa, the interviews with the formal caregivers and the household survey. This chapter includes the interpretation of these findings. The last chapter covers the conclusions and implications of this project. Areas for further research are discussed and recommendations for practice are included.