Reflections on the approach to social inclusion and community engagement of people using mental health services in New Zealand and England.

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Introduction

We were able to explore this subject through a series of seminars arranged by the Blueprint Centre for Learning that took place in Wellington and Auckland in March 2007. Ross attended several of these events and David and Peter were guest facilitators. The delegates comprised of a range of key leaders and clinicians from statutory and non-statutory mental health services and from mental health academic institutions. Our observations therefore consist in part of a series of comments on how policy *appears* to delegates*,* rather than a comprehensive comparison of documents. Discussion spread out from policy statements to implementation, governance and cultural issues both within the mental health community and beyond it.

As a convenient shorthand, except where indicated otherwise, we use the term ‘policy’ to refer to all government documents that impact on social inclusion and community engagement of people using mental health services.

Defining terms and understanding worldviews

This summary of our observations begins with a brief tour of the approach to mental health, social inclusion and community in both countries in order to learn how it might affect consumers, staff and communities.

Any review of policy in New Zealand needs to consider the implications the Te Tiriti o Waitangi (the 1840 Treaty of Waitangi) has had for Maori and non-Maori New Zealanders and for the State. There have been strong movements within New Zealand towards acknowledging and addressing the debilitating effects of colonialism and the consequences of past policies of assimilation and nationality. The Treaty, in many sectors, is identified as the framework for addressing this and also as the foundation document of citizenship in New Zealand. Arguments exist concerning the differing understandings from the two signatories of the Treaty. Nevertheless, this document (in its spirit and interpretation) is a primary source for understanding the relationship between citizens and the State and forms the basis upon which policy is developed and considered.

The current Government have stated in their Maori Health policy that the

> *The Treaty of Waitangi will continue to be seen by tangata whenua (1) as a suitable framework within which to consider health, especially in regard to the relationship between tangata whenua and the Crown as equal, sovereign signatories to the Treaty… [it] establishes aspects of how co-existence in Aotearoa (New Zealand) may be implemented" (National Health Committee, 2002:9).*

The Treaty principles of partnership, protection and participation are, then, mentioned and considered in all health policy development. All policy and contracting formats are required to demonstrate that their ambitions and actions are consistent with these treaty principles, although the extent of their impact is the subject of much discussion and debate.

Additionally, Maori thinking has favoured a long historical view, recognition of spirituality, a strong role for kinship and community networks, and cultural safety. Geographical isolation has perhaps encouraged the development of self-reliance while globalisation and a multicultural population has encouraged New Zealanders to look beyond their borders. Some delegates in our seminars observed a recent gradual loss of traditional NZ values, while others had noticed fewer references to the Treaty in recent policy documents, perhaps in line with a shift from a bicultural to a multicultural society.

In contrast, England has no equivalent to the Treaty more recent than the 1215 Magna Carta, and a less diverse society (67% of NZ population describe themselves as European, while 94% of the UK population consider themselves 'white') where the ideas and values of minority communities are generally unknown or devalued rather than prominent. Social policy takes an iterative approach to setting out what is meant by terms like 'community' and 'engagement' and sometimes avoids any attempt at codification.

In particular, the participation agenda arising from the Treaty of Waitangi aligns with England's concern with community engagement, and efforts are being made to provide protection to Maori who, like minorities in England, find themselves subject to institutional racism and substantial health inequalities (Ministry of Health 2002, Ministry of Social Development 2003).

In New Zealand the long historical view is seen in the fact that the Mental Health Commission has just been guaranteed another 10 years of life and the *Like Minds* media campaign is a long-term investment. Whilst this time frame is not common to English policy makers (indeed, quite the opposite), it is refreshing to see that *The Equalities Review* (Cabinet Office 2006a) looks back 60 years and forward 40 years.

In common with many other countries, the biomedical model has dominated mental health care in New Zealand until recently when the adoption of the Recovery movement has helpfully and comfortably linked with the tangata whenua understanding of wellness. This is expressed as Te Whare Tapa Wha – the four sided house - representing the four fundamental tenets of life: Te Taha

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1 Maori for "people of the land".

Hinengaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health) and Te Taha Whanau (family health). In addition to concerns about housing, work and health, social and kinship networks and the sense of connectedness (Whanaunagatanga) are recognised as essential by both policymakers (Mental Health Commission 2006) and citizens alike. There is also an emphasis on Maori health being determined by the concept of whanau ora (healthy, strong, developing and connected families). As a result, some delegates felt that care and recovery planning was more likely in NZ to pay attention to people's ordinary lives, relationships and connections to community, rather than focus too strongly on individual symptoms or experiences. Whist this focus is strongly expressed in policy development and within Recovery focused services there was a sense from delegates that it had not yet penetrated all parts of the NZ mental health community.

The Department of Health in England has similarly pressed for a focus on recovery (DH 2001) and this provides an opportunity to bring together the themes of recovery and risk management, but there is again a sense that the values underpinning a recovery approach have not penetrated all parts of the mental health community.

Delegates identified that NZ has some good success in recognising and incorporating cultural dimensions, however, there remains:

- lower levels of funding for culturally specific services
- lack of cultural competence in mainstream services and barriers to access for Maori consumers and families
- shortage of effective support to consumers from all cultural communities
- tokenistic involvement in decision-making by consumers from cultural minorities
- continued marked inequality in health outcomes.

There was a suggestion that the English use of the term 'inclusion' implies a generous gift from a benevolent and powerful community to a dependent and grateful underclass, rather than asserting the rights and equality of all. In contrast, the UK Secretary of State for Health, Rosie Winterton, at the launch of the SEU report in June 2004, described the need to promote social inclusion opportunities for people with mental health issues as a 'moral imperative' driven by the demand for social justice. In addition to its ethical underpinning, social inclusion rests on an understanding of individual and community identity that is multilayered and complex, and this is reinforced in the NZ adoption of the Maori view of society in which people embody a series of concentric identities – family / whanau (personal community of significant family, friends and associates), hapu (sub-tribe), iwi (tribe) and tangata whenua (Ministry of Health 2006 p41).

Community Engagement is an emerging blend of ideas in England that includes community cohesion and social capital, public accountability and community development.

> *'Community Engagement is the simultaneous and multi-faceted engagement of supported and adequately resourced communities and*

> *relevant agencies around an issue, or set of issues, in order to raise awareness, assess and articulate need, and achieve sustained and equitable provision of appropriate services.' (Winters and Patel UCLAN/DoH 2003).*

Social capital has been defined as, 'resources for collective action, such as contacts, friendships or the ability to ask favours of people, which citizens access through membership in particular types of social networks' (Skidmore et al 2006) Combining these themes suggests an approach to community engagement that promotes social capital for and by people with lived experience of mental health issues: In other words, community engagement means that those communities to which individuals with mental health problems currently or potentially belong utilise their social resources to combat the multiple forms of discrimination and exclusion experienced by those individuals to promote mental health at community level.

Leadership through Policy

Policy documents can set out an ambitious vision or endorse a consensus around current best practice. Both English and NZ policy are equally visionary about the creation of an inclusive, engaged community.

The New Zealand Context

The NZ government began by asserting a commitment to community-based services in 1994 (Ministry of Health 1994) and subsequent documents make it clear that:

1. Social inclusion and Recovery are core values for mental health services (Mental Health Commission 2005, p7; Reet & Mulligan 2006 p39; Minister of Health 2006 p13) and all government departments and Crown entities share responsibility (Minister of Health 2005 p2, 3). Some of the specific responsibilities of these government departments and Crown entities in relation to mental health have been identified in current documents, and there is an expectation that the number of these partners named in policy documents will grow over time (Mental Health Commission 2005 p7).

   In a similar vein, the UK mental health service has asserted that social inclusion and recovery are core values (ODPM 2004, Hope 2004). The ODPM report included a plan that committed over 20 government organisations to specified action (ODPM 2004, chapter 9) and included some duties laid on 'all departments' (page 97).

2. The capacity of society at large and government in particular to include people with experience of mental illness needs to be fostered (Mental Health Commission 2005 p10). This is required partly because previous policies of containment, segregation and institutionalisation have harmed the wider society.

The UK policy is not quite so definite about the harm caused by previous policies, but Standard 1 of the National Service Framework for Mental Health (Dept of Health 1999) requires mental health services to provide support for mental health promotion activities and there is government investment in an anti-stigma campaign.

3. Changes need to be made in policy areas beyond mental health services that lead to exclusion and inhibit recovery for people experiencing mental health problems - high unemployment, low benefit levels, expensive services and poor housing (Minister of Health 2005, p2). Primary care is not free at the point of use in NZ, and primary care organisations only have responsibility to their 'enrolled populations'. Mental health agencies need to work with the relevant community agencies to address these issues (Minister of Health 2006, p17).

   The UK government has taken action to improve employment prospects for people with direct experience of mental health issues (DH 2002, DH 2006b) as well as work on a range of other excluding factors, including access to post-compulsory education and civic participation. Primary care is free at the point of use, and efforts are being made to combat the comparatively poor physical health of people with mental health issues.

4. Experience of mental health problems can reduce an individual's sense of belonging and participation in society (Minister of Health 2005 p8) and service users must have the opportunity to lead their own recovery, have personal power and a valued place in their communities. (Minister of Health 2005 p1)

   UK Department of Health guidelines recognise the person as leader in their own recovery and as a potential contributor to the communities of their choice (DH 2001, Basset et al 2005)

5. Opportunities for full participation need to include the family and whanau of people who experience mental illness (Minister of Health 2006 p4, 17). Full participation means within all aspects of society and social life (Mental Health Commission 2005 p10).

   This theme is under-represented in English policy, although there are, of course, brief references to the role of family and friends.

6. Particular effort is needed to ensure full opportunities are afforded to groups of people at particular risk of exclusion: Maori, Pacific Islanders, those with addictions or in the justice system, and people detained or secluded within the mental health service (Ministry of Health 2002; Mental Health Commission 2005 p10, 17). Access to mental health services needs to be improved so that 'any door is the right door' (Ministry of Health 2006, p52), whilst people do not stay in hospital longer than necessary

   Recent mental health policy in England has included substantial investment in improving the experiences of people from minority ethnic communities through a community development approach.

The English context

In England, there has been a general shift in policy statements from a preoccupation with containing risk to the public to a recognition of social inclusion as a target alongside (but not yet integrated with) risk management. Consequently, risk continues to dominate many discussions about community participation for individuals. In contrast, NZ policy acknowledges that inclusion is a protective factor that reduces risk (Ministry of Health 2005 p8). In recent years, English mental health policy has emphasised:

1. The goal of improving public understanding and reducing discrimination while increasing the confidence of public and politicians (DH 1998)
2. The need for specialist teams to provide early intervention, home treatment, support for people in primary care settings and work with carers (DH 2000)
3. Recognition of the continuing need to combat exclusion (Cabinet Office 2006b) over the whole life-course (DH 2005).
4. The merits of self-directed services in which people are in control of their own health and care (DH 2005).
5. The role of commissioners in arranging services for their whole community through engaging with people as planning partners, including people with experience of mental health problems, in order to build sustainable communities and reduce health inequalities (DH 2005 page 164).
6. The Government encourages targeting of vulnerable groups as part of the challenge to inequality and to overcome the disengagement of these groups: [find quote for this bit...] ‘The proposal in this White Paper will give people more power over their own lives and the decisions that affect them. This will deliver more responsive and effective services for all communities … but will be particularly important for vulnerable people and those traditionally under-represented in decision making.’ (Local Government & Public Involvement Bill 2006)
7. Local Government as strategic leader and ‘place-shaper’ to form a cohesive and diverse community (Local Government & Public Involvement Bill 2006). ‘Rather than expect everyone to participate equally in formal governance, we should try to make more people’s everyday civic engagement count by designing the formal governance in a way that taps into the informal spaces of community life that they routinely inhabit…. The places with which people are already familiar – the school gate, their place of worship or their local newsagent or post office – hold the key to engaging them in governance activity. These places and the organisations that occupy them act as the everyday bridge between ordinary people and more formal governance activities. ’ Community Participation, Who benefits? (2006) Skidmore, P. Bound, K. Lownsbrough, H. Joseph Rowntree Foundation

Where caseloads are high, resources scarce and a risk-averse culture predominates, it is hard to promote inclusion as all effort is expended on responding to crises, ‘gatekeeping and protecting oneself from the attribution of blame or fault.’ Despite this, the NZ government envisages a role for non-mental health agencies in identifying early signs of mental health problems and alerting mental health services (Minister of Health 2005 p18). The mental health system will clearly need to change if it is to welcome and even seek out such relationships with organisations and individuals who will serve as flag raisers.

In England the vision of an inclusive society that includes people with experience of mental illness has penetrated a few policy statements written by non-mental health bodies, such as the Home Office document *Together we Can* (Civil Renewal Unit 2005), which explicitly refers to the engagement of citizens with mental health issues in working towards sustainable communities. ‘Together we can improve our health and well-being… What will be done: Tackle the social exclusion experienced by people with mental health problems *by bringing together local communities and citizens with mental health needs in partnership with the relevant public services*.’ Delegates felt that this cross-sectoral approach to mental health is lacking in current policy development in NZ.

The multiple or deep exclusion experienced by some groups subject to multiple exclusion, such as cultural minorities, people with problems with addiction, forensic history, lesbian, gay and bisexual people, older people and others can lead staff to adopt a defeatist attitude and they likely need support to maintain a positive attitude. This support can occur through policy leadership or collective mobilisation, such as that amongst older people in NZ, who have formed powerful political lobby groups to overcome their exclusion.

Leadership through implementation and accountability

This is how policy meets people. A NZ metaphor for ingenuity is that a farmhand can repair anything with a roll of No.8 wire, and seminar delegates felt that this approach in mental health services (i.e. ‘we can fix it’), especially amongst NGOs is a significant strength of the inclusion movement. One group of delegates said that a further ‘back the winners’ approach had contributed to NZ’s ability to develop world-leading innovations such as the *Like Minds Like Mine* anti-stigma programme (Ministry of Health 2005 p2; Mental Health Commission 2005, p9) and training on recovery competencies and human rights (Mental Health Commission 2005, p11,16).

Meanwhile, the strong culture of local problem-solving in NZ has perhaps led policy-makers to adopt a ‘hands-off’ approach to specifying the details of good practice, implementation and monitoring. Where local innovation is successful, it is quickly adopted by policy makers and prescribed for everyone, sometimes losing the very essence of what gave it impact in the first place. A second group of delegates felt that rigid contracts and outcome measures imposed by some contracting organisations is actually stifling creativity in some settings. A third group wanted to build social inclusion targets into contracts.

The competitive process for allocation of project funding erodes collaboration in some areas, especially where there is poor transparency or suspicion of low integrity in the selection of tenders. Where regional NGOs apply to several DHBs for funding or where NGOs receive funds from several places, they sometimes encounter different monitoring requirements from one contract to the next, and this may reduce commitment to the whole monitoring process.

In some areas of NZ, providers overcome these divisive forces by meeting together, sharing experiences (sometimes through secondments) and increasing mutual trust. Some shared outcomes and accountability frameworks have been agreed, and in one area, local departmental managers have agreed to change their practice in order to coordinate priorities and practice.

Seminar delegates felt that more mechanisms were in place in England to oversee the consistent implementation of policy, while in NZ, each of the 21 District Health Boards (DHBs) established under the New Zealand Public Health and Disability Act 2000 has more freedom to interpret the policy vision in its own way. So, for example, Direct Payments are available in one Auckland DHB but not in another. England also has variation between postcode areas, but the overall shape of provision is specified. For example, each area should have an Early Intervention Team, vocational expertise in each Community Team, a women-only day service and so on.

The NZ government has compensated for a history of under-funding in recent years and this has provided the impetus for a wide variety of new but ad-hoc, isolated and short-lived projects. Additional resources in England have been used to generate a range of increasingly standardised services since 1999. Alongside this, England has seen a focus on ensuring that services are based in evidence of positive outcome. As a result, there is a great deal of interest in England in measuring outcomes, but still a sense that commissioners lack the tools to effect sustained change; among managers that they have access to the infrastructure necessary to ensure conformity to progressive service delivery and among frontline staff, that cuts may be made randomly rather than rationally.

Delegates worried that while the NZ approach of blending clear values with few rules is effective in sponsoring innovation it may do little to incentivise services. Meanwhile, in England, there is a risk that careful specification of services could in some settings, compliance could eclipse creativity.

There was a general sense that commissioners in NZ need to better apply skills and knowledge in commissioning high quality, inclusion-focused mental health services.

Organisational culture, size, differentiation and fragmentation

Both governments pride themselves on being well ‘joined up’. However, delegates recognised that the exclusion of people with mental health issues is so deeply embedded that tenacious leadership at a high level is crucial to delivering sustainable change. Delegates were impressed by the cross-government network that in England, has successfully overseen the formal implementation of the actions set out in the report of the SEU (2004) *Mental Health and Social Exclusion*, and its affiliates network that brings diverse organisations together to share developments and take joint initiatives. England has combined policy statement, moral imperative and informal networking with practical assistance on workforce development, guidance and research. Success is illustrated in many places, including changes in welfare benefit administration, housing, further education and schools (*NSIP Annual Report 2006).* There was a general consensus across the seminars that effective action at this strategic, middle level between government policy and local implementation is crucial to progress.

One of the key aspects of NSIPs effectiveness has been a focus on both horizontal and vertical integration as a means of securing necessary cultural change in organisations. This approach generates a shared expectation that while policy can create favourable conditions for change, transforming services at a community level is ‘everybody’s business’.

We noted that Scotland has developed a framework (Scottish Executive, forthcoming) that will bring many sections of local government together in order to review the access opportunities available to people with mental health issues in relation to housing, leisure, economic development, civic participation and so forth. Leadership at this local level is needed to break out of the ‘silos’ and achieve coordinated implementation.

English policy is concerned to establish the primacy of commissioning as a means of both delivering services from multiple providers from statutory and non-statutory sectors and ensuring the relevance and quality of services to individual need. NZ already has perhaps one third of its mental health service provided by around 365 NGOs (Platform 2007) many of which are small and can tailor their work to specific sections of the population. As a result, DHB commissioners may have well over one thousand contracts to negotiate and oversee. Such small organisations may be closer to the communities they serve, but their small size may tempt them to over-bureaucratise or increase their vulnerability to being overlooked as the commissioner focuses on the larger contracts. The large number certainly complicates communication and coordination of the sector.

As a smaller country – the population is around 4 million compared to 56 million in England - achieving a shared set of values across the sector is made easier. It is incumbent upon mental health organisations to model effective communication with one another as a precursor to establishing such links with community organisations. The development of mental health networks in some places has led to an improvement in communication and collaboration. Some DHBs have brought together statutory agencies and NGOs to discuss needs and jointly agree who is best placed to meet them.

Consultation with consumers and the wider public

As well as being encouraged to outsource their work to NGOs, statutory mental health services in England are being reshaped as Foundation Trusts (*Health and Social Care Act 2003*). As part of this transposition, they are required to recruit Members from user and public constituencies, some of whom may be represented on governing Boards. This provides an opportunity for new forms of community accountability with these Trusts having significantly increased discretion as to how, within national service standards they respond to the view of their local public. While mental health trusts may be distinctively well positioned with regard to this change, it will have implications for their ability to promote inclusive opportunities for people with mental health issues within communities whose views may be diverse.

> ‘The sheer variety and volume of partnerships that make up mental health services means that mental health trusts can be more advanced than acute trusts in attracting local community membership although this can be counteracted by the stigma and lower profile of mental health.. *mental health trusts will need … to develop effective communication strategies and achieve good relationships with their local communities in order to try to reduce the levels of stigma and increase membership’ (* DH 2006a)

Similarly, while the NZ Ministry of Health and Mental Health Commission are expected to consult with local people, there is, in NZ, less formal obligation to shared accountability. The MH Commission is running a series of open space planning events called *The Way Forward* that involve consumers and other stakeholders. Many DHBs have advisory committees and networks that reflect diverse interests: consumer and family representation; Maori and Pacific Island communities.

Indeed, some delegates felt that the demands laid upon consumer representatives by an unfriendly process of involvement led to people burning out and withdrawing from the system within a year or so. This makes consumer involvement overly dependent on heroes, rather than building in opportunities for ordinary people to contribute too. Despite this, there is a strong history of the consumer movement in NZ and delegates said that consumer led work to promote social inclusion was needed and was increasing.

Rebuilding an inclusive lifestyle

Like many other countries in the world, NZ is struggling to respond to the widespread fracturing of traditional family structures and the resulting need to redesign the forms of community life. On the other hand, tightly knit societies can both narrow the norms of acceptable conduct and create and sustain individual reputations, making it more difficult for people with unusual or high profile behaviour to find a generous welcome or make a new start with a new group. Both countries have regions where tightly knit communities predominate, and neither country’s mental health service seems to be yet harnessing the potential of these networks to create advantage for people at risk of marginalisation. Informal community support in NZ, as in England, can range from very good to almost non-existent. Similarly, both countries have areas where the scarcity of community facilities (leisure centres, theatres and the like) and specialist organisations (clubs and societies) have led its citizens and mental health staff to find community through informal methods of association.

By and large, it might be argued that the skill to establish a rich and meaningful connection with local community organisations and networks remains scarce and undervalued (indeed it is seldom the subject of professional training programmes) and there are only a few examples of services where consumers consistently make the transition from formal to informal supports. As a result, there is a need for services to learn how to assist communities to be more inclusive and take responsibility.

When the broader concept of inclusion is broken down into some of its constituent parts, the need for action to improve employment opportunities is highlighted. In NZ there is a need to place 'immediate emphasis on how employers and others in frequent contact with people with mental illness and addiction can be more inclusive and supportive.' (Minister of Health 2006 p12). This is despite attempts to promote the IPS model (Grove et al 2005), and both countries suffer from patchy and short-term investment in this field. Consumers are often working in third sector mental health agencies, but in the DHBs their posts tend to be restricted to consumer advisor posts rather than spread throughout the organisation. There have been a number of initiatives to promote community volunteering by consumers In England but these are not matched by similar coordinated developments in NZ. A mark of success of the English national programme on social exclusion and mental health has been that the agenda has combined a focus on employment with a broader view, recognising that inclusion is about all aspects of citizenship and community.

Conclusion

Our reflections on the similarities and differences between our two countries are not based on an extensive anthropological or cross-cultural policy analysis. Instead, we have used the opportunity of a lecture tour to share impressions, gather observations, and reflect on what we have seen and heard. It seems to us that there are important similarities alongside distinct differences that form a creative matrix where there is a real potential to learn from each other and act together.

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