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Paper

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Mental Health Commission vision statement

Our vision is for New Zealand to be a place where people with mental illness have personal power, full participation in their communities and access to a fully developed range of recovery-oriented services

Mental Health Commission mission statement

To take a lead, through advice, monitoring and promotion, to build a country where people with mental illness, the services they use and the communities they belong to, are able and willing to contribute to their recovery

ABSTRACT: Critical issues for workforce development and service delivery

This paper is a discussion about issues of power achieving recovery in mental health. There is an acknowledgement of the lack of overt discussions concerning power in the mental health sector. Power is defined; next there is a discussion of power from the vantage points of health practioner delivery, a systemic approach, and from a consumer perspective. The assumption here is that issues of power need to be overtly addressed in Mental Health in order for recovery outcomes to be achieved for consumers of mental health Services.

Acknowledgement: *To the people whose ancestral land this is, the Eora Nation on this Gadigal land, Aboriginal land.*

son of mine

*I could tell you of heartbreak, hatred blind
I could tell of armies that shame mankind,
Of brutal wrong and deeds malign,
Of rape and murder, son of mine;*

*But I'll tell instead of brave and fine
When lives of black and white entwine,
And men in brotherhood combine –
This would I tell you, son of mine.*

(by Oodgeroo Noonunccal)

INTRODUCTION

It is generally acknowledged personal empowerment is strongly correlated with recovery from mental illness (Meagher 1995,2002). The goal of recovery has been defined as people liberated to a self defined ability to live well in the presence or absence of symptoms (O'Hagan 2001). Recovery is therefore a radical shift from the present dehumanising

practice of mental health, which labels people from the DSM and treats people as a diagnosis (Deegan 1997). Therefore, if people discover effective processes to personal recovery, then a concomitant outcome will be the liberation of the mental health system. Psychiatrist Viktor Frankl expressed his dream of liberation as a 're-humanizing of psychiatry' (Frankl 1946 p156). And mental health sector staffs also call for their empowerment within the sector in order for them to take action in supporting consumer outcome (Wadsworth, & Epstein, 1996, P153). Therefore, mental health needs to acknowledge issues of power and find safe ways to discuss them in order for recovery of consumers to be an effective outcome.

Mental health sector does not overtly acknowledge issues of power

There are a range of issues regarding the development and delivery of Mental Health Services: an issue for services is that they have power to move from a culture of 'maintenance and risk averse' towards risking a recovery focus; for professional staff, that they claim and reclaim their efficacy in their personal practice; for the system, that it rewards individual leadership; for the consumer movement to claim our identity and take the power of citizenship to participate in the whole community and not just within the Mental Health sector. However, it is interesting to note there are very few references to power in mental health literature. The newly published "mental health in Australia" (Meadows & Singh 2001) mentions power issues only once, and that in reference to consumer participation. Consumers have attempted to be explicit about defining power dynamics (Meagher 1995,2002) (Head 1973) but have not been successful in capturing the discourse (Clinton, & Olsen, 1998). Those who perceive they do not have power are those who mostly raise issues with power. For example the first New Zealand Conference on Anxiety, Phobic and Compulsive Disorders named their conference "Powerlessness to Power" (Tiller & Kidd 1996) and they aimed amongst other things, to influence legitimate responses from the Mental Health sector for services for these diagnoses. For discussion on power we need to look outside Mental Health to feminism (Miller 1976, 1986), and politics (Brunton, 2000); and also to Sociology (Wilkinson et al. 1999) (Lukes, 1977).

1 DEFINITIONS

Power: Some working definitions of power include: "Power is the ability of people to effect change" (externally) and "Power is the ability to affect change" (internally). Power is 'the will to act' (Neitzhe, 1888), or 'the ability to influence others'. People have varying degrees of personal power. People may express power through others (ie/ getting others to take actions for us) which can be through 'power over' (positional, reward and punishment) or 'power with' (influence, expertise, leadership, mana).

Power works at the individual/community level and this is about personal/collective story. Power is also expressed at an organisational or systemic level. So power may reside in structure, position, and process and is about the legitimising of actions people may make.

Discourse: is a range of interlinked ideas saturated with power that determines what can and cannot be said. An essential element of the discourse is power. And power is constrained by the discourse. So discourse is the underlying network of ideas that may limit our reality and views of what is even possible.

Some examples of the discourse in mental health may include

- "The crisis in mental health is about staffing numbers and beds" ... and this discourse prevents anyone having a dissenting voice on this issue.

- “Mentally ill people in crisis must be treated in a hospital institution” ... and the discourse prevents anyone having a dissenting voice from contributing on this issue.
- “Mentally ill people must take medication” and the discourse constrains and marginalizes dissenting voices on this issue.
- “Mental health is about more and better mental illness services”.
- “Mental illness services are under funded and the issue of funding beds is central to the issue of mental health”.
- “The media story about mental health is about violence of patients and threat to society” ... and this discourse prevents anyone having a dissenting voice on this issue.

However within these limits (set by the powerful in our community) we have 'power within' which is our power to act and choose our actions (even if limited by discourse and legislation).

2 POWER ISSUES RELATING TO HEALTH PRACTITIONER DELIVERY

An outcome of onerous quality systems processes may be to hinder clinical efficacy
Consumers of services have long been arguing for the need of relationship as a central healing process. In an ideal world we would view individual clinicians as autonomous ethical people who we can be assured of and trust... with systemic 'quality system' supports to check their power. And these checks on clinical power are intended to ensure the safety of consumers who use these services. Ironically, it may appear the outcome of onerous compliance measures and standards reporting serves to limit the amount of quality clinician/client time. And quality time is one key to healing. Mental Health Services staff also experience personal silencing of their truth. This has been termed 'cork-in-the-mouth' by one research project (Wadsworth, & Epstein, 1996, P153)

Acknowledging Power involves truth telling

An effective and responsive mental health sector requires staff and systemic support to overtly acknowledge and effectively engage in a healing relationship. This necessarily invokes working with power. The (often unexplored) power issues for staff include:

- The arrogance of power about the ethics of doing something to people or for people for their own good.
- And the issue of power is the ethics of doing something to people for their own safety.

And part of the healing discourse includes health professionals acknowledging and discussing these truths and issues in supervision and with consumers. A leading consumer novelist wrote:

*People who have suffered from the cruelty of others prefer the truth
at all times, no matter what it might cost them*

(Bessie Head 1973)

And one of the overriding Mental Health power issues with service delivery from a consumer viewpoint relates to the increasing use of forced treatment. State sponsored legislated “Compulsory Treatment” acts are Government expressions of power. Mental health nurses are effectively acting as agents of the state with coercive powers similar to the police. Duly Authorized Officers have a mandate under this act to exercise powers greater

than that given to the justice system in relation to the curbing of the human rights of people who are patients under this legislation (and in New Zealand being a 'proposed patient' is enough to be detained against your will).

3 SECTOR PARTICIPATION: SYSTEMIC POWER ISSUES

Demand for entitlement against the need for economic growth

Perhaps Dahrendorf best describes the efforts of people who work for improvement in society for the mentally ill when he writes:

"Recent sociologists have argued that the politics of revolution or the framing of social issues as a class conflict is a dead issue. Rather, strategic political change must respond to the social conflict between, on the one hand, the demands for entitlement on the part of the disenfranchised, and, on the other, the need for economic growth in society" (Dahrendorf 1988)

Much of the effort in the past thirty years has been focussed on increasing state funding to dismantle the power of institutional hospital services and instead provide effective community based treatment. Mostly the increased funding in New Zealand has been achieved through reports of inquiry and in particular the "Mason Inquiry" (Mason, et al 1996).

Clearly Australasian nations have designed social and political systems based upon western democratic principles. Within these systems, all eligible adults exercise the power of democratic vote that elects leaders to the inner circle of public power. Over and beyond that, citizens have freedom to influence through lobbying and collective action. What needs to be understood regarding policies of state power, is "the machinery of government" has an 'inner circle' of the policy community made up of ministries, departments, and 'quangos' (of which the Mental Health Commission of New Zealand is one). And an 'outer circle' of interested parties and advocates. And the Mental Health provider sector along with various advocacy agencies is in the outer circle ... albeit "on the edge of the inner circle" (Brunton, 2000 P184). Once this is understood, next each one of us may decide how best to influence and where best to individually work for policy change (eg exercise power). Regarding systemic power, people need information about how systems work in order to work the system.

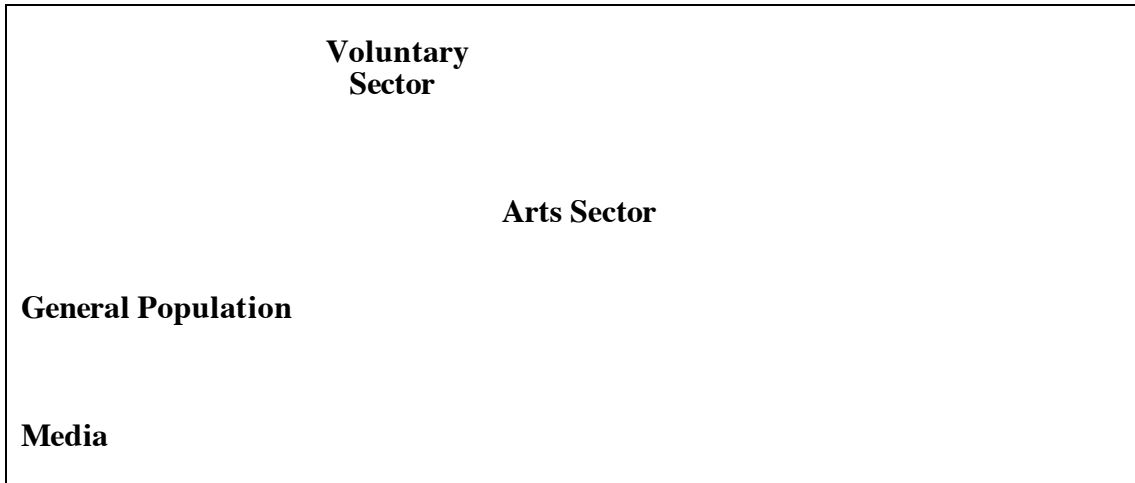
Participation outside government and health sectors

However, not all influence to act for better mental health lies within the government sector or the health sector. If we are holistic in approaching Mental Health, then services and people will connect across a range of sectors. Certainly employment issues for the mentally ill may be best solved within the private sector who employ, some effective personal supports may be accessed via the voluntary sector, and communication to the general public regarding mental health may be better expressed via the arts and media sectors rather than ministerial or medical reports. I have developed a "sector participation diagram" in order to better discuss these ideas. (See next page).

One of the unexpressed issues regarding power within this democratic and publicly funded mental health service is the responsibility of societal power. And the key issue here is the ethics of community deferring their responsibility to professionals. For how can we have community care if the community doesn't know how to care?

SECTOR PARTICIPATION DIAGRAM

Fourth Sector: Private (Business) Sector	Third Sector: Non-Government Organised Sector (NGO)	Second Sector: Public Mental Health Sector	First Sector: Government Commonwealth State
	Not for profit Sector		



**4. IF YOU TELL THE STORY, YOU HAVE THE POWER TO SHIFT IT:
CONSUMER POWER ISSUES**

The Panther

(In the Jardin des Plantes, Paris)

*His vision, from the constantly passing bars,
Has grown so weary that it cannot hold
Anything else. It seems to him there are
A thousand bars; and behind the bars, no world.*

*As he paces in cramped circles, over and over,
The movement of his powerful soft strides
Is like a ritual dance around a centre
In which a mighty will stands paralysed.*

*Only at times, the curtain of the pupils
Lifts, quietly -. An image enters in,
Rushes down through the tensed, arrested muscles,
Plunges down through the tensed, arrested muscles,
Plunges into the heart and is gone.*

Rilke (1907,1908)

Truth telling about the personal story

Finding a personal voice and your individual truth being heard is part of personal recovery. The poem above uses the image of a caged Panther; and it well describes some of the consumer sentiment and experience of containment under the power of Compulsory Treatment legislation with its concomitant of forced drugging. The need for consumers is to articulate their story about mental health services in relation to personal power and powerlessness. The Mental Health Commission's "Gift of Stories" is framed as a gift (Leibrich, 1999). And the content is about consumer story overthrowing a) the dominant medical story (about people described as chemicals who are out of balance) and b) overthrowing the pervasive community media story (about people objectified as violent time bombs ready to explode).

There is also a need for consumers to articulate their story about 'mental illness' in relation to personal power and powerlessness as part of a recovery process. The lived experience of survivors is not often acknowledged or heard. Too often the consumer experience in relation to trauma and abuse is not believed and even discredited for:

"The ordinary response to atrocities is to banish them from consciousness. Certain violations of the social compact are too terrible to utter aloud; this is the meaning of the word unspeakable.

(Judith, Lewis 1992)

We need more stories about individuals who take their empowerment and recovery out there in the discourse. These truths and stories help frame' or 're-frame' the mental health discourse.

Telling the collective consumer story

However, I am not just alluding to the telling of the personal individual story here. There is the collective consumer perspective that needs articulating and a call here for consumers with the skill to articulate it. And the Consumer movement needs to re-assess the paradigm which it has worked in, for after over one hundred years of mental health patients' rights and consumer rights activity (Tomes, 1998), the Mental Health Sector is still largely untouched in their understanding and attitudes towards people labelled with major mental illness. (Clinton, & Olsen, 1998).

Consumer movement abuses of power

Oppression by the oppressed has been explained as signs of the early stage of an oppressed group striving for liberation (Freire, Paulo 1970, 1973 p27).

*"Any situation in which "A" objectively exploits "B" or hinders his or
Her pursuit of self-affirmation as a responsible person is one of oppression"*
Freire, Paulo (1970, 1973 p37)

The oppressed resort to using the same instruments of oppression found in the oppressors (Ibid). Types of oppression within the psychiatric system maybe expressed as: 'Power over' through structure and role, occupied and pre-occupied with the correct labelling (diagnosing) of people, mandating through office and position, calling employee's to account to a role rather than connecting personally, calling for systems review and a public accountability of leaders, suspicious of people who don't appear to keep 'appropriate' boundaries and distance in dealing the 'the others' (eg between mental health professionals and consumers), and withholding of information.

One issue to demonstrate consumer oppression lies in the naming and labelling debates within the consumer movement: "who is a consumer and who is not?" These naming discussions can lead to issues of representation. This is sometimes expressed in power struggles of people and organisations to become mandated presenters or representers for the consumer perspective. This may lead to "who is in and who is out" oppression regarding participation choices of individuals within the movement.

Overt discourse regarding consumer uses of power may lead to new ways of being. The hope is the consumer movement will transcend psychiatry as it discovers new ways of expressing power. This would further the goal of liberating the mental health system.

Consumer participation across all sectors

So far, much of our Consumer effort has been located within participation initiatives in the public and mental health sector. This is good but hardly satisfactory. I believe a key issue in this area lies in consumer culture finding greater expression outside the mental health sector. And this may involve the Mental Health sector supporting consumer participation outside of mental health. As we enter a new century, it is clear that a shift in thinking has

occurred and this shift is summarised by Tessa Thompson (2000) when she writes: "work to promote social inclusion is fundamental to recovery ...(it) is not a sideline to mental health services - it is the heart". If this is representative of the emergent philosophical shift that has occurred, what can we say about ground level initiatives? There are glaring gaps in our participation within Australasia. This includes:

- The lack of meaningful political engagement with governments,
- Lack of consumer involvement in the NGO service sector;
- The largely unrecognised and unfocused voluntary sector requires engagement around consumer peer support and self help initiatives in furthering recovery in mental health
- More visible representation within the business sector
- More visible representation within the media sector
- It is evident that 'consumer culture' is filtering into the arts sector with movies, literature, visual and performing arts becoming avenues for expression, and this can be further developed.
- We do not see people with experience of Mental Illness as community opinion leaders
- We do not see people with experience of Mental Illness as key dissemination agents leading the discourse on recovery process and further articulating human potential for those experiencing mental illness.

(Pearson 2001)

CONCLUSION:

If power is defined as the ability to take action for one-self, or the ability to influence others, then there are critical issues in mental health service development and delivery. These issues are key to furthering better understanding to achieve recovery from mental illness. For our mental health services, they need the power to move from a risk averse maintenance focus to a dynamic recovery focus (which at present they do not). And attention needs to be paid to supports for staff and consumers to realistically and honestly work through and take personal power for achieving their goals. Key to achieving these outcomes, is that consumers capture part of the discourse and engage in transforming power structures in mental health and across the range of spaces within the democracy including: Government sector, Business sector, Arts and Media in addition to the traditional spaces of the Non-government and Public Health sector.

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