Key Concepts : Community-based mental health, Community mental health care

A Study for a Community-based Mental Health Model for House Bound Long-term Mentally Disabled

- focusing on the community residents of the Taegu-Kyungpuk area -*

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ABSTRACT

The purpose of this study was to investigate the residents' opinions about community mental health in the Taegu-Kyungpuk area for the future development of a community mental health program and model appropriate for Korea.

The subjects were 152 residents in the Taegu - Kyungpuk area.

In July 1999, the data was collected using a convenience sample technique.

Mental health status was significantly different for the level of occupational advantage($x^2=15.684$, $p<.05$) and physical health($x^2=39.262$, $p<.000$).

Factor structure for mental health problems with the percentage of variance was as follows: optimistic view(27.518), dark view(10.758), mastery(6.200), discomfiture(6.101) and life style(5.641). Most of the respondents(92.1%) took the mental health problems seriously. The serious aspects of the mental health problem were found to be epilepsy, mental retardation, neurosis and schizophrenia respectively.

Concerning about the view of community mental health, most of the respondents answered that the a C.M.H.C. was 'useful and urgent' concerning the need for C.M.H.(77.6%).

They answered positively on the utilization of C.M.H.C(75.7%) and preferred the separately new community mental heath center. A psychiatrist was preferred as the key person in charge(44.1%). If community mental health centers were established in a community health center, they answered that the expected major problem would be quality control of care(44.7%).

They preferred the psychiatrist's office as the recommended agency for the insane(44.7%). Opinions of the asylum system were found very negative in respect to psychiatric therapy and humanitarianism.

The results of this study will help establish a relevant model for this community as the primary site for a community-based mental health model.

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I. INTRODUCTION

In the Republic of Korea, the Mental Health Law of 1995 permits the qualitative development of community mental health care. Now, in the late 1990's, we live at a time when community-based mental health nursing is carried out.

We have to establish good standards of community-based mental health nursing. In mental health work, we have placed particular importance not only on community mental health professionals, but also on the agreement of community members to do this work.

We have thought that society's interest in mental health was an important component to establish effective countermeasures for early detection, treatment and social rehabilitaion of the mentally handicapped in the community.

To grasp latent mental health problems, the mental health levels of the community members and their opinions about community-based mental health were examined to propose concrete service practices.

The purpose of this study was to investigate the opinions of the community residents regarding mental health andwhat they thought about the present conditions of community mental health. My research explored what the community thought about the social recovery of the mentally disordered, their suggestions and how they corresponded with the today's changes. Ultimately, the findings in this study will be extremely useful for planning mental health services in the Taegu-Kyungpuk area.

II. LITERATURE REVIEW

The general relationship between social and economic conditions and mental health

Establishing the relationship between social class, social and economic conditions and poor mental health has been a dominant trend in both social psychiatry and sociology. There is also a greater emphasis on the relationship between the social structure and the human agency in gaining insights into the nature of health inequalities(Pilgrim & Rogers, 1999). A recent Korean study comparing urban samples and rural samples found a social structure gradient on a number of mental health indicators(Nam and Choi, 1993).

Lower SES(socio-economic status) is associated with each of the 14 major cause-of-death categories in the International Classification of Diseases as well as many other health outcomes including major mental disorders(Link & Phelan, 1995). Bartley et al.(1998) said that status more data such as education, level of income, and occupational advantages or acts as indicators of these past histories. Gender and age are another social variable which are implicated with mental health. Another study focusing on lower-class adolescents - 1000 young, unemployed people(15-21yrs) in Scotland - found that a third of the males and two-fifths of the females were exhibiting evidence of 'psychological morbidity' by 18 years of age (Sweating & West, 1995).

History and background of community-based mental health

In 1409 when Father Gilbert Jofre in Spain saw that mental patients were being teased and maltreated in the street, he decided to accomodate and care for them in a newly-built hospital in Valencia. The mental hospital in Valencia was hailed as the first mental hospital in recorded history(Chen, 1997). It is interesting to note that the historical event occurred during the Dark Ages when patients with mental diseases were widely regarded by the current day churches as people being possessed by demons and exorcised.

There are two competing accounts giving

differing interpretations of the events and policy leading to the establishment of the asylum system(Pilgrim & Rogers, 1999).

The first is a conventional account from a feminist perspective, a "great man" version of history. This type of history is usually written by and for the confident and successful and it emphasizes the valiant deeds, altruism, and humanitarianism of key agencies and individuals. From such a perspective the asylum is viewed as part and parcel of medical progress and an increasingly humane way of dealing with 'mentally ill' people(Jones, 1960; Donnelly, 1983). Contrast to this conventional explanation, critical historians explain that incarceration of mad people in asylums is seen as inextricably linked to the wider-scale containment of social deviancy: the poor in workhouses and criminals in prisons. Scull(Pilgrim & Rogers, 1999) suggested that mass confinement (of which the asylum system constituted an integral part) was a product of urbanization, industrialization, and professional forces during the first half of nineteenth century. At the time, ideas about madness were changing. It became recognized as a loss of self-control and not, as previously thought, a loss of humanity. These changing values were influenced by the exposure of the brutal treatment of those in madhouses. This encouraged the abandonment of mechanical restraints and it endorsed resimes, such as the York Retreat.

Indeed the changes were more profound in the United Kingdom than elsewhere in the world.

This prompted Jones(1962) to refer to them as 'the three revolutions',i.e. the legal, the administrative, and the pharmacological revolutions.

Therapeutic communities(TCs) - small units or wards designed to make the social environment the main therapeutic tool - were pioneered during the Second World War by psychotherapeutically oriented psychiatrists. The twofold objectives looked for in therapeutic communities were identified by Main(1946) as: the need to resocialize patients who had become dependent as a result of traditional hospital practices; and the use of the hospital environment as a therapeutic agent through establishing social participation.

The 'technology' for reaching the set goals of therapeutic communities was not enough to change custodial goals and existing structures(Pilgrim & Rogers, 1999), but perhaps this approach also creates the need for a multidisciplinary team in which all members with diverse professional backgrounds could contribute or take direct responsibility for the care and management of mental patients.

An alternative to trying to humanize the institution is the run-down and closure of hospitals. Community-based care refers to mentally disordered people receiving 'care' in non-asylum settings.

Model of community mental health services

Assertive Community Treatment(ACT) was created as a way of organizing outpatient mental health services for patients who were leaving large state mental hospitals and were at risk for rehospitalization. This model program provides a full range of medical, psychosocial, and rehabilitative services by a community-based team that operates 24 hours a day, 7 days a week. Treatment takes place in natural settings: patients' homes, neighborhoods, and places of work(Stein, 1985).

Multisystemic therapy(MST) is a highly flexible treatment approach that adresses the multiple, interrelated needs of touths with serious behavioral and emtional problems and their families(Henggeler & Borduin, 1990).

ACT and MST both use a social-ecological model of behavior applied to mental health patients. In addition, therapeutic principles emphasizing pragmatic (outcome-oriented)

treatment approaches, home-based interventions, and individualized treatment goals are key elements of their success(Worley, 1998).

Ⅲ. METHOD

Design

The cross-sectional survey was chosen to describe the mental health levels of the community residents and their opinions about community-based mental health.

Sample

The subjects who participated in this research were 152 community residents in the Taegu-Kyungpuk area.

Criterias for inclusion were: (a) ability to understand and complete the form structured by Nam and Choi(1993), and (b) willingness to participate in the study.

A survey questionnaire was used for this research to obtain information about

(a) general characteristics
(b) the opinions about his recent mental health
(c) the opinions about his physical health
(d) the opinions about the asylum system
(e) the opinions about the mental health problem and the policy.

Fixed-choice questions were asked. In July 1999, the data were collected.

The chronbach alphas were 0.86 for the level of mental health, 0.75 for the level of physical health, 0.77 for the opinions about the asylum system and 0.66 for the opinions about mental health problem and policy.

Data collection

All data was collected by public health nurses at two health centers in the Taegu-Kyungpuk area.

When the P.H.N visited a home, the community members was given the questionnaire to complete independently if he agreed to sign the consent form.

Limitations

The agencies were chosen for their convenience and for accessibility to obtain the data. This data cannot speak for the community members who did not participate in this study. The exclusion of those who did not complete the items skewed the sample in the direction of the less seriously impaired, a bias that may have been reinforced by the loss of those would be respondents who refused to participate.

Data analysis

The data was analyzed using the Statistical Package for Social Sciences version 9.0(SPSSPC Program 9.0).

The characteristics of the variables were analyzed using the actual number, percentage, Chi square, and factor analysis.

Ⅳ. RESULTS AND DISCUSSION

Characteristics of Subjects

The general characteristics showed that 28.3% of respondents were Buddhists. According to the level of income and occupational advantage or status, the level of vocation was classified to test for differences in three groups. The upper level of that included clerical work(i.e. teachers, journalists, officials, and bank clerks etc.) and professionals(i.e. accountants, attorneys, doctors, professors, and engineers etc.) The middle level of that included salesmen, drivers, farmers, and beauticians artists etc. The lower level included working classes, and the unemployed.

Approximately sixty five percent of the respondents were distributed in the upper level. In health status, 43.4% of the respondents answered moderate.

Differences of mental health status for the related variables

The variables related to mental health status included personal characteristics and physical health. The personal characteristics included religion, vocations, and educational levels. The Mental health status was classified into three classes according to the distribution of the total scores on the questionnaire. Differences of mental health status for personal characteristics and for the level of physical health status are presented in Table 1 and Table 2.

In Table 1, mental health status for the level of physical health revealed a significant difference. According to the level of physical health, a comparison of five groups Chi-square scores revealed a highly significant difference($x^2=39.262$, $p<.05$). The relationship between physical health and mental health was significant in these samples. This result was concurred with those of antecedent researches. The group with good physical health also showed good mental health.

The level of physical health had a significant influence upon mental health.

According to the vocation, a comparison of the three groups Chi-square scores revealed a highly significant difference($x^2=15.684$, $p<.05$) in Table 2. The relationship between social and economic conditions and mental health was significant in these samples, but the differences in mental health status for religion and educational levels were not significant. This result was more or less different from those of the antecedent research. Nam and Choi's study(1993) revealed that the differences of mental health status for vocation and educational level were significant.

Classification of Mental health Problems through Factor Analysis

A factor analysis of the 20 items resulted in the formulation of 5 factors(subscales). Theses 5 factors with their loadings and the percentages of variances are listed in Table 3.

As a result, the factor structure of mental health problems emerged as optimistic view, dark view,mastery, discomfiture and life style. The dark view of life and sense of discomfiture were classified as mental health problems.

Serious proportions of mental heath problems

In Table 4, 57.9% and 34.2% of the respondents rated mental health problems as "severe" and "very severe" on the serious proportions of the mental health problems. Therefore, most people took the mental health

<Table 1> Differences of mental health status for the level of physical health

M.H.S	N	Low	Medium	High	x^2	p
P.H					39.262	.000*
very well	7	1		6		
well	57	13	18	25		
moderate	66	26	24	15		
poor	19	15	4			
very poor	3	3				
Total	152					

* $p<.05$

problems seriously.

This results corresponded with those of the studies of Choi(1993) and Lee(1997).

In Table 5, the mental health problems which the respondents took seriously were epilepsy, followed by mental retardation, neurosis and schizophrenia. These results were more or less different with those of Nam & Choi's study(1993) and Lee's study(1997). They reported sexual violence was a first priority.

View of the Asylum System

In Table 6, the view of the asylum system was generally pessimistic. This result concurred with that of Nam and Choi's study(1993). Historically, the asylum system was problematic from its inception. Goffman(1961), in his seminal work 'asylums', considered the mental hospital to be a 'total institution'. The asylum was defined as a place of residence with an enclosed and formalized administrative regime where a large number of people are isolated from society for lengthy periods of time.

According to Goffman(1961), mental hospitals are the type of total institution which provides for those who are perceived as an unwanted threat to the community. Model total institutions possess a number of characteristics. All aspects of life are conducted in the same place. Activities always take place in the presence of others and follow a strict time table. They are geared towards fulfilling the official aims of the institution rather than the needs of individuals. A strict demarcation exists between 'inmates' and staff. Patients are viewed by the staff as bitter, secretive and conspirational, while staff are viewed by patients as harsh and authoritarian.

Wing(1978) drew attention to the social withdrawal and passivity of hospitalized patients, which could be correlated with length of stay and was independent of clinical conditions. Wing and Freudenberg(1961) demonstrated how such signs of institutionally induced apathy could be quite rapidly reversed

<Table 2> Differences of mental health status for personal characteristics

M.H.S	N	Low	Medium	High	x^2	p
Religion					12.678	
Buddhist	43	14	14	15		
Christian	34	14	10	20		
Roman Catholic	32	12	10	8		
Others	5	4	0	1		
Noreligion	38	14	12	12		
Vocation					15.684	.016*
Upper	98	28	34	36		
Middle	15	7	4	4		
Lower	39	24	8	6		
Educational level					18.121	.112
Uneducated	31	16	5	10		
Primary	70	22	21	27		
Middle	24	9	11	3		
High school	26	11	9	5		
University	1	0	0	1		
Total	152					

* $p<.05$

<Table 3> Factor Structure for Mental Health Problem

Factor Structure with Loadings and % of Variance	(N =152)
Factor 1: Optimistic View	27.518
1. Able to concentrate on doing things well	.528
3. Felt certain regarding how to act appropriately	.683
4. Felt that you could make good decisions	.493
7. Able to enjoy your every day life	.601
12. Felt happy when all things were considered	.620
13. Spent your time working hard	.736
15. Felt your function well at work generally	.665
16. Satisfied with the method in which you do things	.669
Factor 2: Dark View	10.758
2. Unable to sleep well	.594
9. Felt depressed and unhappy	.602
11. Felt yourself insecure	.497
17. Felt nervous	.643
18. Felt overwhelmed by everything	.654
19. Felt anxious or tense	.583
20. Suffered a severe nervous breakdown	.689
Factor 3: Mastery	6.200
5. Felt tense continuously	.831
8. Able to face up to significant problems	.755
Factor 4: Discomfiture	6.101
6. Had difficulty conquering all difficulties	.762
10. Felt lose of self confidence	
Factor 5: Life style	5.646
14. Went out as much as before	.827

if chronic patients were placed in a stimulating work environment.

The View of Community Mental Health

For the development of a community mental health program and model appropriate for the Korean situation, the subjects were asked about the requirements of community mental health, whether the community mental health is utilized or not, the relevant location of community mental health, the key person in charge of problems when the community mental health is located in a community mental center, problems when the community mental health is located in the community mental center, and requested agencies recommended for the insane.

In Table 7, the view of community mental health was presented. According to these results, most of the subjects answered that the community mental health center was 'useful and urgent' concerning the need for community mental health(77.6%).

Most of the respondents thought positively about the utilization of the community mental health center(75.7%).

They preferred a separate new community

mental heath center.

With a psychiatrist preferred as the key person in charge(44.1%).

If the community mental health centers were established in a community health center, the expected major problems, was quality control of care(44.7%).

These result showed that the residents did not trust the quality of mental health services implemented by the community mental center. Most subjects answered they preferred a psychiatrist's office rather than a community mental health center. These results suggest that the residents didn't understand the concept of a community mental health center and they should be taught about the role of the community mental health center so they could become familiar with the community mental health to then utilize the community mental health positively.

They regarded psychiatrists as the key person in charge followed by nurses. These result showed that psychiatric nurses should assume the expanded role.

We have the challenge to establish good standards of community-based mental heath nursingalthough we have to face the stigma and prejudice still common among ordinary people.

The community mental health program which was being discussed here to establish community mental health systems in Korea was developed by repeated trial and error in western countries since 1950.

<Table 4> Severity of mental health problems

variables number		%
Very severely	52	34.2
Severely	88	57.9
Moderate	12	7.5
More or less	1	7.0
Total	152	100.0

<Table 5> The serious aspect of mental health problem

mental health problem	Mean	S.D	(Rank)
Schizophrenia	2.27	1.38	(4)
Neurosis	2.49	1.44	(3)
Mental Retardation	2.70	1.48	(2)
Epilepsy	2.92	1.45	(1)
Depression	2.22	1.21	(5)
Alcholism	2.14	1.22	(6)
Drug Dependence	2.00	1.26	(8)
Dementia	1.91	1.21	(10)
Sexual Abuse	1.96	1.28	(9)
Family Violence	2.09	1.31	(7)
Juvenile Deliquency	1.96	1.28	(8)

< Table 6> The View of Asylum System

Variables	N	%
Received psychiatric patients isolated from general population rather than treat them		
Yes	95	62.5
No	43	28.3
Missing	14	9.2
They were given treatment by a special medical team.		
Yes	52	34.2
No	87	57.2
Missing	13	8.6
Mental hospitals were run for profit.		
Yes	76	50.0
No	62	40.8
Missing	14	9.2
Mental hospitals were nonprofit-making organizations.		
Yes	30	19.7
No	109	71.7
Missing	13	8.6
Treated a psychiatric patient as an equal.		
Yes	42	27.6
No	94	61.8
Missing	16	10.5
Treated a psychiatric patient as unequal by verbal or nonverbal violence.		
Yes	64	42.1
No	73	48.0
Missing	15	9.9
total	152	100.0

When chronic patients were increased and the mental and emotional disturbance of ordinary people who faced rapid socioeconomic changes were increased, the introduction of the community mental health concept and system were necessary.

The results of this study would contribute to the establishment of a relevant model fit for this community as the primary study for the community-based mental health model.

V. CONCLUSION

The purpose of this study was to investigate the community residents' opinions about community mental health in the Taegu-Kyungpuk area.

The subjects were 152 residents in the Taegu - Kyungpuk area.

In July 1999, the data was collected using a convenience sampling.

<Table 7> The View of Community Mental Health

Variables	N	%
Requirements of community mental health		
Useful and urgent	118	77.6
Useful but premature	31	20.4
Not useful	1	0.7
Missing	2	1.3
Whether the C.M.H is utilized or not		
Yes	115	75.7
No	34	22.4
Missing	3	2.0
Relevant location of C.M.H		
Asylum	16	10.5
Sanatorium for the Insane	11	7.2
Social Welfare Facilities	36	23.7
Community Health Centers	28	18.4
Religious Organization	5	3.3
Separately new C.M.H	53	34.9
Others	3	2.0
Key Person in Charge		
Psychiatrist	67	44.1
Psychiatric Nurse	49	32.2
Psychiatric Social Worker	14	9.2
Clinical Psychologist	6	3.9
Health Practitioners	7	4.6
Others	4	2.6
Problems when the C.M.H. is located in the C.H.C.		
Physical Difficulty	22	14.5
Mistrust of quality of care	83	54.6
Bureaucratic and unkind	17	11.2
No problems	27	17.8
Missing value	3	2.0
Agencies Recommended for the Insane		
Asylum	51	33.6
Psychiatrist's office	68	47.0
Sanatorium for the insane	10	6.6
Police	3	2.0
Shaman's office	1	0.7
Religious organization	5	9.2
Community health center	14	9.2
Total	152	100.0

The data was analyzed using the SPSSPC program for the actual number, percentage, Chi square, and factor analysis.

The results was summarized as follows :

1) Mental health status was significantly different for the level of occupational advantage($x^2=15.684$, $p<.05$) and physical health($x^2=39.262$, $p<.05$).
2) Factor structure for mental health problems with the percentage of variance was found as the optimistic view(27.518), dark view(10.758), mastery(6.200), discomfiture(6.101) and life style(5.641).
3) Most of the respondents(92.1%) took the mental health problems seriously.
4) The most serious mental health problem was epilepsy followed by mental retardation, neurosis and schizophrenia.
5) For the view of community mental health,
   (1) most of the respondents answered that the C.M.H.C was 'useful and urgent' concerning the need for C.M.H.(77.6%).
   (2) most of the respondents thought positively about the utilization of C.M.H.C(75.7%).
   (3) they preferred a separate new community mental heath center.
   (4) a psychiatrist was preferred as the key person in charge(44.1%).
   (5) if the community mental health centers were established in a community health center, they answered that the major expected problem was quality control of care(44.7%).
   (6) they preferred a psychiatrist's office for the requested agencies recommended for the insane(44.7%).
6) Opinions of the asylum system were very negative when viewing psychiatric therapy and humanitarianism.

The findings of this study suggest that the community resident's opinions about the community mental health in other areas should be investigated to compare with that result. Present community mental health care needs to be re-evaluated comprehensively. The findings of this study also suggest a need for practical psychiatric mental health nursing research, specifically, to grasp latent mental health problems, and mental health levels of the residents. Their opinions about community-based mental health should be examined to propose the concrete service practices.

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