Deinstitutionalisation and the construction of community care in Australian mental health policy

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Abstract  
While numbers of inpatients in psychiatric hospitals have been falling in Australia from 1955, the process of deinstitutionalisation accelerated from the mid 1980s. One of the catalysts for this has been the National Mental Health Strategy, first released in April 1992. The National Mental Health Strategy sought to replace stand-alone psychiatric hospitals with a range of community services offered by the public, private and non-governmental sectors. This resulted in a 68 per cent reduction in beds within stand-alone psychiatric hospitals between 1989 and 2000. This paper explores the impact of these changes upon the families of the mentally ill. It argues, through discourse analysis of policy documents from the National Mental Health Strategy, that the families of the mentally ill have been reconstructed as a source of informal care. This paper traces the development of the concepts of community and informal care in Australian policy documents arguing that they reflect a neo-liberal understanding of the individual and their family, one that views the family as an autonomous unit responsible for its own maintenance. This creates a moral imperative upon the families of the mentally ill to adopt to caring role but also allows for increasing regulation of the family by professional carers in the interests of monitoring the mentally ill.

Keywords: National Mental Health Strategy, neo-liberalism, informal care, community care, mental illness, governmentality

Introduction  
This paper examines Australian mental health policy from the 1970s, and in particular, the National Mental Health Strategy arguing that the documents forming the National Mental Health Strategy reflect a neo-liberal governmental rationality. This involves the state distancing itself from service delivery, leading to an increasing reliance upon non-governmental and private sources of care. This has implications for the families of the mentally ill who are increasingly asked to act as carers for family members.
The methodology adopted by this paper is discourse analysis. The underlying assumption of discourse analysis is that social reality is constituted in language: that language orders and shapes our social reality through providing us with representations of that social reality (Tonkiss 1998). Bacchi (2000) argues that a discourse approach to policy documents assumes that policy is not simply a response to existing social problems, but rather a means of identifying social problems and framing them in such a manner that the recommended interventions become self-evident. Policy creates the discursive framework for understanding a social problem through defining a social problem in a certain way, excluding alternate representations of the issue and limiting the range of possible interventions to those following from the framework. The goal of discourse analysis of policy documents therefore, is to examine the manner in which social issues are represented within policy; whose interests are represented and whose are excluded; and the power evident in these representations (Bacchi 2000; Silverman 2000).

This paper argues that mental health policy is framed by ideas arising from neo-liberalism. It commences with a discussion of neo-liberalism highlighting three features: the role of economics and the market in informing governance, the diminishing role of the state in the provision of health and welfare services, and a growing reliance upon self-governance and self-responsibility for health and well-being. The National Mental Health Strategy will then be examined to show how these ideas have been applied to the delivery of mental health care. The paper will conclude with a discussion of the changing construction of community care and of the family of the mentally ill as carers in policy documents.
Neo-liberalism

A neo-liberal model of governance emerged from the mid 1980s when the welfare state came under attack from both the left and right of politics. Left-wing critics expressed concern about the degree of social control exercised by the state through the social professions, while critics from the Right argued that the welfare state was maintained at the expense of the more productive private sector, and that current levels of public spending could not be sustained in light of increasing demands for services (Dean 1999; Rose 1996a). Dean (1999:149) argues that neo-liberalism reconstituted the social through “breaching older divisions between state and civil society, and...folding back the objectives of government upon themselves.” His term ‘reflexive government’ describes a form of government primarily concerned with identifying and moderating the detrimental effects of excessive governance. Gordon (1991:42) states that neo-liberalism is associated with a redefinition of the problem of government from the anti-social effects of the market to the anti-competitive effects of society. Economics becomes the defining discipline of effective governance and human behaviour is viewed as capable of being judged and understood within the context of economic theory. This reaffirms the separation of the market from the state. Modern forms of liberalism are concerned with the question of how to limit the government in relation to the market; how to create a state that protects the economic freedom of the market but which is also seen as legitimate by its citizens. The market is no longer viewed as a ‘natural’ entity to be protected and supervised by the state but becomes a function of the state. To govern in the modern liberal state involves creating the appropriate political, legal and institutional environment for the operation and existence of the market (Burchell 1993).
A separation between the state and the market effectively undermines the notion of society underlying the welfare state. Dean (1999) argues that one of the features of neoliberalism is the problematisation of ‘society’ where ‘society’ evokes a particular notion of citizenship and of the state’s responsibilities towards citizens. Society is no longer understood as individually distributed and collectively borne needs but as a source “of energies contained within individuals’ exercise of freedom and self-responsibility” (Dean 1999:152). The target of government becomes the responsible individual rather than the social citizen. Rose (1993) argues that the essence of neo-liberal government is self-governance; that is governance through personal choice. Personal autonomy is incorporated into the process of governance through encouraging individuals to take responsibility for making socially responsible choices. For Gordon (1991:44) this results in the idea of the “individual as enterprise”. The individual becomes responsible for preservation of their own human capital and as such, is responsible for undertaking activities to maintain and care for themselves. People are increasingly asked to become “experts of themselves.” They are required to adopt self-care in relation to their own bodies, minds and conduct and the conduct of their families (Rose 1996a:59). The role of the state is seen as establishing the requisite conditions for the exercise of personal choice and of personal responsibility (Rose & Miller 1992).

This results in a fundamental change in the conception of citizenship. Where previously citizenship was understood in terms of welfare, it is increasingly understood by the state as access to the potential to exercise free choice (Higgs 1998:187).
Programmes of government are to be evaluated in terms of the extent to which they enhance that choice. And the language of individual freedom, personal choice and self-fulfilment has come to underpin programmes of government articulated across the political spectrum, from politicians, pressure groups and civil libertarians alike (Miller & Rose 1990: 24).

This has resulted in a changing construction of rights from social rights guaranteed by the welfare system to procedural rights. For Higgs (1998) this is evident in the codification of the level of services that citizens can effectively expect from both public and private sector organisations, and of the obligations of people receiving welfare assistance. The disadvantaged person, no longer the passive recipient of welfare support, is reconstructed as an active agent who is required to take responsibility for seeking expert support (Rose 1996a). The dominant model of service delivery becomes one based upon contractual arrangements rather than one based upon entitlement.

Hancock (1999) argues that Australian health policy has been subject to a neo-liberal paradigm from the mid 1980s characterized by the application of market rationalities to the delivery of health care; a separation of health care professionals from the government; the subjection of professions to consumer demands and to standards and codes of practice; and individual and community responsibility for health (Rose 1996b). Pathology is seen as arising from exposure to a number of social and personal risks (Petersen and Lupton 1996). Lifestyle becomes the focus of health care and the individual takes a more active role in preserving their own health through management of lifestyle risks (Petersen 1996).
This paradigm became dominant in the 1990s, resulting in a shift in the model of governance from one “based on an administrative and regulating state [operating] through mechanisms of the bureaucracy to a minimalist state, working through the hidden hand of the market” (Hancock 1999:63). Demands on welfare spending lead to public services adopting managerial techniques from the private market; and for the tendering for service delivery on a competitive basis (Moon 1999). In this model of governance the role of government is limited to establishing the requisite legal and institutional setting for the operation of the market, as an unregulated market is believed to create the optimal conditions for the distribution of resources and for efficiency (Hancock 1999:57).

A neo-liberal approach to health care involves the devolution of state responsibility for the delivery of care. Responsibility is shifted away from core government institutions towards the private sector, leading to service provision by a mixed economy, consisting of governmental, informal, voluntary and commercial sectors (Dean & Thompson 1996). Where previously the state provided a number of social services to maintain family welfare, neo-liberalism is associated with the distancing of the state from welfare, making it the responsibility of the family. Professional intervention is critiqued on the grounds of authoritarianism and the undermining of parental responsibility (Bell 1993). Culpitt (1999) argues that services that were once viewed as social rights have been redefined as personal needs to be met by private rather than public means. This has contributed to a new normative discourse which problematises welfare dependence. Conservative governments have adopted a ‘pro-family’ stance which invokes an image of a stable nuclear family as a solution to welfare dependence. This not only creates a moral
imperative upon families to undertake a caring role but also ignores the diversity and fluidity of family structures (Morgan 1999; Rodger 1996).

This places a greater burden upon families, and in particular women, to provide for the well-being of individual family members and provides a rationale for informal care, defined as “support and guidance which is provided mainly, but not only by women to family members or others, such as neighbours, who are disabled, chronically sick or frail elders” (Offer 1999:469). The role of the families of the mentally ill is seen as that of “informal and voluntary sources of support and care” (Heaton 1999:761).

**British Mental Health Policy**

These changes are well documented in British sociological literature are they occurred in the early 1980s prior to similar changes in Australia. Heaton (1999) notes that community care was redefined as informal care in British policy documents in the 1980s. Professional carers were viewed as having a supervisory and respite role only leading to direct surveillance of carers in the interests of monitoring the mentally ill individual. Heaton (1999:761) associates this with the closure of hospitals and provision of “care by the community.” This process began with the increasing recognition of the family as an untapped source of care. A 1979 *Report of the National Commission of the National Health Services* stated that “community care is provided primarily by families and neighbours, with the support of the health and personal social services” (cited in Busfield, 1986:350). Two reports released in 1981, *Care in Action* and *Care in the Community* shifted the focus of community care towards the development of comprehensive services
providing a continuum of care for the severely mentally ill. This involved sheltered housing, outpatient care in clinics, domiciliary support, inpatient care within general hospitals and community education about mental illness to promote early treatment of mental health problems (Rose 1986a). *Care in the Community* also encouraged local authorities’ use of “what is already available, including the important contribution of the voluntary and private sectors” as a means of achieving greater value for money in mental health care provision (quoted in Busfield 1986:351). The 1983 *Mental Health Act* supported these goals through favouring entitlement to care in the least restrictive environment. This was ensured through access to frequent review of detention and treatment orders by an independent tribunal (Fennell 1999). The primary burden of care fell upon the families and carers of the mentally ill. The family was viewed as having a social obligation to provide care for family members (Dean & Thompson 1996).

By the end of the 1980s, caring for family members had become a moral obligation. Dean and Thompson (1996) argue that the ubiquity of informal care in policy documents normalised it, leading to a moral imperative upon families to undertake a caring role. *Community Care: Agenda for Action*, an influential report released in 1988 stated:

> Families, friends and neighbours and other local people provide the majority of care in response to needs which they are uniquely well placed to identify and respond to. This will continue to be the primary means by which people are enabled to live normal lives in the community setting. The proposals take as their starting point that this is as it should be (Griffith 1988:5).

The incorporation of a carer’s perspective into mental health policy resulted in the greater
visibility of carers (Heaton 1999). Formal mechanisms were developed to incorporate carers in the discharge planning process and to recognise the needs of care-givers as users of services. This culminated in 1995 in the Carers (Recognition and Services) Act 1995, which provides for the assessment of the needs of carers who “are either providing or intending to provide a substantial amount of care on a regular basis” (cited in Heaton 1998:767).

The National Mental Health Strategy

This was followed by similar trends in Australian mental health policy. It commenced with calls for an inter-sectoral approach to the delivery of mental health care. The Commonwealth government released A National Mental Health Services Policy: Summary of the Report of the Consultancy in March 1988. The key recommendations of this report were the adoption of a national mental health service policy, allowing for the development of a “balanced and collaborative inter-sectoral approach involving all relevant public, private and voluntary services” in delivering mental health care (42). This service was to have the dual goal of minimising the incidence of new disorders, and assisting those with existing disorders “to attain at least such a level of mental health, that they are capable of working productively and of participating in the social life of the community” (AHMAC Working Group on Mental Health 1988:42). A final policy statement was adopted by all Health Ministers and released in 1992.

The original National Mental Health Strategy was contained within four documents; the National Mental Health Policy released in April 1992, the Mental Health Statement of
Rights and Responsibilities released in 1991 and the National Mental Health Plan and Medicare agreements which established the roles of Commonwealth, States and Territory governments with regards to reforming mental health facilities (Mental Health Branch 1998). This was followed by a second National Mental Health Plan released in 1998, with a third plan released in 2003.

Table 1 summarises the goals established by the initial National Mental Health Strategy and later National Mental Health Plans, and outlines subsequent changes to mental health services as outlined in reviews undertaken in 1998 and 2003.

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<tr>
<th>Commonwealth intervention</th>
<th>Timeframe</th>
<th>Expressed goals/ Terms of reference</th>
<th>Structural changes</th>
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<tr>
<td>National Mental Health Strategy</td>
<td>1992-97</td>
<td>• Mainstreaming of psychiatric services</td>
<td>• Deinstitutionalisation of the chronic population</td>
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<td>• Mainstreaming of funding for psychiatric services</td>
<td>• Closure of stand alone psychiatric hospitals and greater use of services attached to general hospitals</td>
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<td>• Development of continuity of care between inpatient and community services</td>
<td>• Extension of community, particularly ambulatory services</td>
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<td>• Targeting of services towards those with severe mental health problems</td>
<td>• Greater use of non-governmental service providers</td>
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<td>• Increasing use of other social services including NGOs</td>
<td>• Establishment of the National Consumer Advisory Group</td>
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<td>• Consistency in mental health legislation</td>
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<td>• Greater evaluation of service delivery</td>
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<td>Second National Mental Health Plan</td>
<td>1997-2003</td>
<td>• Promotion/prevention</td>
<td>• Public education through the media</td>
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<td>• Development of partnerships in service reform</td>
<td>• Partnerships with general practitioners</td>
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<td>• Improving the quality and effectiveness of service delivery</td>
<td>• Consumer outcome measures</td>
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<td>• Development of a mental health casemix classification system</td>
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<td>• Development of national service quality indicators</td>
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<td>Third National Mental Health Plan</td>
<td>2003-2008</td>
<td>Have not been implemented and evaluated yet</td>
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<td>• Population mental health</td>
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<td>• Research and evaluation leading to greater accountability</td>
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The *National Mental Health Policy* (1992a) established a number of aims for Mental Health services throughout the country. These can be broadly summarised as the:

- mainstreaming of psychiatric services;
- mainstreaming of funding for psychiatric services;
- development of continuity of care between inpatient and community services;
- targeting of services towards those with severe mental health problems;
- increasing use of other social services;
- increasing recognition of carers and Non-Government Organisations;
- development of consistent mental health legislation across jurisdictions; and
- greater evaluation of service delivery

Fundamental to this policy was the replacement of stand-alone psychiatric hospitals with a variety of community-based facilities. The second *National Mental Health Plan*, released in 1998, established three further priority areas for mental health services: “promotion/prevention; the development of partnerships in service reform; and the quality and effectiveness of service delivery” (Australian Health Ministers 1998:6).
Promotion and prevention of mental illness remained an important goal of the third National Mental Health Plan with a shift to early identification and intervention to prevent mental health problems. The authors of this report also called for greater access to services through the development of integrated programs, and for mechanism for protection of consumers through greater participation in care, education of the workforce and the monitoring of standards of care (National Mental Health Steering Committee 2003).

**Deinstitutionalisation and Community Care**

One of the key goals of the National Mental Health Policy was the decentralisation and mainstreaming of mental health services. These goals translated in the first National Mental Health Plan into the mainstreaming of the management structures of mental health services; expanded community services; and provision of mental health care within either general community health services or general hospitals (1992b:7). The mainstreaming of services was largely justified by the belief that the community provides more humane and individualised care. According to the report “the former institutional approach enabled a person’s various needs to be met relatively conveniently in one place although at the cost of the quality of life of the person with the mental disorder” (Australian Health Minister, 1992a:8). The government viewed the mainstreaming of services as a means of increasing access to services, thereby allowing consumers to remain close to “family, community and cultural networks” (Australian Health Ministers, 1992a:2). It was also a means of reducing the stigma of mental illness through treatment in the community and general hospitals. “[I]ncreased access to mental health services...
[should] help to reduce the stigma attached to people with mental health problems and mental disorders" (Australian Health Ministers, 1992a2).

In practice this involved the closure of bed within stand-alone psychiatric hospitals and increasing use of a variety of public and non-governmental community services. There was a 63 percent reduction in inpatient bed numbers in stand-alone psychiatric hospitals between 1989/90 and 1997/98 (AIHW, 2000). Many of these beds were relocated into general hospitals. By June 30th 1997, 41.4 percent of psychiatric beds within the public sector were offered in general hospitals. This translated into a 35.8 percent reduction in psychiatric beds in stand-alone psychiatric hospitals across Australia from June 30th 1993 and a 20.8 percent increase in beds within general hospitals. There was a 20.3 percent reduction in all public inpatient beds within the same period (Mental Health Branch 1998).

The National Mental Health Policy also called for greater integration of services and for intersectoral links between health and other government agencies and between the private and public sectors.

Specialised mental health services can meet only some of the varied needs of people with severe mental health problems and mental disorders. Access to housing, accommodation support, social support, community and domiciliary care, income security and employment and training opportunities may have a significant impact on the capacity of a person... to manage in the community (Australian Health Ministers 1992a:19).

The existing system was identified as being separatist and discriminatory in so far as the mentally ill were often accorded low priority in the allocation of resources. The National
Mental Health Policy (1992a:3) argued that the needs of the mentally ill could best be met by “a complex array of other health and community services.” There was an increasing role for service provision by the non-governmental sector. The National Mental Health Policy called for greater support for the expansion and development of non-governmental service provision, and for consumer involvement in the mental health service decision-making processes (Australian Health Ministers 1992a:26). As a consequence, the first National Mental Health Plan set goals to establish joint projects with other government agencies; to review of these agencies procedures with regards to the mentally ill; and to establish communication networks with the non-governmental sector (1992b:9).

The construction of community care and carers

The integration of the public and private sectors had a number of implications for the understanding of, and delivery of, community care in Australia. The construction of community care within Australian mental health policy documents from the 1970s was one in which the state provided services. The National Mental Health Strategy reconstructed community care to incorporate provision of services across the public sector, non-government organisations and the family. This has contributed to a growing dependence upon families as a private source of care and in the emergence of carers as a political construct within mental health policy. The family was increasingly asked to asked to govern itself through managing the welfare of those members who are unable to manage themselves.
In the *Community Health Program for Australia* initiated by the Whitlam government in 1973, community care consisted of state provision of professional services within the local community. These services, while providing mechanisms for community involvement, sought to provide accessible, multi-disciplinary professional care with the goal of early detection and primary prevention of illness. The families of the mentally ill were viewed as a source of pathology, requiring professional intervention to allow them to care for mentally ill family members.

By the early 1980s community care was no longer viewed as the sole responsibility of the state. The Richmond report into mental health services in New South Wales states that community care is provided with the assistance of general practitioners; private psychiatrists and private hospitals; and voluntary agencies and groups (Department of Health, New South Wales 1983a). The Richmond report canvassed views from a variety of carer and self-help groups and recommended “making better use of family and home resources” through “increased involvement of family and friends...[and] placing more emphasis on self-help groups and self responsibility” (Department of Health, New South Wales 1983b:10-11). The 1983 *Inquiry into Mental Health Services in South Australia* not only develops mechanisms for user involvement in the delivery of care, but also recognises the role played by families as carers. In this report community care is viewed as the most appropriate service delivery option for most people with mental health problems. The authors call for the development of comprehensive, multi-disciplinary services that provide “readily accessible preventative heath services, promotion and maintenance of self-help, and the involvement of users in planning, organisation and
provision of health services” (Smith 1983:19). They note that “relatives are the real primary care agents of people suffering from schizophrenia” and as such they require further information about diagnosis and treatment options (Smith 1983:23).

By the time the National Mental Health Strategy was developed in the late 1980s the families of the mentally ill had been reconstructed as carers. The mental health working party (1989:7) argued, “the role of carers, the human and economic costs they bear and their need for support be recognised and dealt with in any national mental health strategies.” This report, while arguing for the dehumanising effects of long-term institutionalisation, notes that community care has come under critical scrutiny due to a failure to provide appropriate back-up services. This provided the impetus for the development of a comprehensive system of care, incorporating both hospital and community components, which allowed for continuity of care. The summary of the report of the Committee into the National Mental Health Service policy argued for the utilisation of all existing community services across the public, private and voluntary sectors (AHMAC 1988).

The National Mental Health Strategy is also premised upon the centrality of informal care. The Mental Health Policy statement asserts “many people with mental disorders are cared for in the community by ‘unpaid’ carers” (1992a:26). The National Mental Health Strategy defines a carer as “a person whose life is affected by virtue of his or her having close relationship with a consumer, or who has a chosen and contracted caring role with a consumer” (Australian Health Ministers 1995:23). The report argues that support services
for carers are undeveloped and that there is a need for the "expansion of non-
governmental organisations to assist carers and promote self-help" (Australian Health
Ministers 1995:26). The National Mental Health Plan identifies three strategies to
provide support for carers, namely education and training for those caring for people with
mental disorders; support services, such as respite care; and the establishment of
advocacy services. This contributed to the development of the Carers package in 1992/93
that provided funding for respite care, counselling and community support for carers, but
is only available for carers of people with dementia (Commonwealth of Australia 1994).
More recent documents adopt a more inclusive definition of carers. Carers are defined in
the Second Mental Health Plan (1998:25) as "a person whose life is affected by virtue of
a close relationship and a caring role with a consumer."

The role of family in governing the mentally ill is also evident in the Mental Health
Statement of Rights and Responsibilities which outlines carers and advocates’ rights and
responsibilities. It establishes a number of rights for carers, including the right of access
to the consumer; to be consulted by service providers; and to access respite care and
counselling (Australian Health Minister 1991:17). It also however, establishes a number
of responsibilities including "the responsibility to obtain appropriate professional
assistance"; "to consider the opinions of professional and other staff and recognise their
skills," and; to "co-operate, as far as possible, with reasonable programs of treatment and
care aimed at returning the consumer to optimal personal autonomy" (Australian Health
Ministers 1991:18). Neo-liberalism’s goal of self-governance holds for the family, which
is asked to manage the social and physical welfare of its members (Bell 1993). The
moral imperative for managing the health and well-being of the mentally ill falls upon informal carers, leading Dean and Thompson (1996) to conclude that while a neo-liberal approach is premised upon individual choice this choice does not extend to informal carers.

Conclusion

This paper argues that the National Mental Health Strategy is informed by a neo-liberal governmental rationality evident in the dominance of market principles in the delivery of health and welfare services; in the devolution of state responsibility for the provision of these services; and increasing family responsibility for welfare. Increasing family responsibility for welfare is seen as an example of self-governance that is evident in the emergence of carers as a political entity within recent mental health policy and in the codification of carers' rights and responsibilities in the Mental Health Statement of Rights and Responsibilities.

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