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## **Rationalism's irrationality - an example from Australian mental health policy**

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## Rationalism's irrationality - an example from Australian mental health policy

### Abstract

This article reflects on the way in which accounting-related thinking influenced one particular historical event: the process of deinstitutionalisation from mental hospitals in New South Wales. The article suggests that accounting (via economic rationalism and other allied philosophical lenses ) led to the under funding of the deinstitutionalisation process to the detriment of society as a whole. Some of the societal difficulties inherent in using such rationalist calculus (biased towards quantified, monetary, accounting entity assumptions) as a means of evaluating social policies are then considered.

### Keywords

Rationalism, Irrationality, Example, From, Australian, Mental, Health, Policy

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## ***Rationalism's Irrationality.***

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**Rationalism's Irrationality - An example from Australian Mental Health Policy.****ABSTRACT**

This article reflects on the way in which accounting-related thinking influenced one particular historical event: the process of deinstitutionalisation from mental hospitals in New South Wales. The article suggests that accounting (via economic rationalism and other allied philosophical lenses) led to the under funding of the deinstitutionalisation process to the detriment of society as a whole.

Some of the societal difficulties inherent in using such rationalist calculus (biased towards quantified, monetary, accounting entity assumptions) as a means of evaluating social policies are then considered.

## Rationalism's Irrationality - An example from Australian Mental Health Policy.

**Dr. Ciorstan Smark.**

*The honorary secretary of the Institute of Australasian Psychiatrists and former director of drug and alcohol services at Rozelle Hospital, Dr Jean Lennane, described assurances that community care would be upgraded to compensate for slashing bed numbers as "lies". "Ten years ago we had far more community services in Central Sydney than we have now," Dr Lennane said. "People have just been duded. The money has been syphoned off on the pretext of putting it into the community and then it goes into some black hole and it's never seen again." The Opposition Spokesman on health, Dr Andrew Refshauge, said "I think they have allowed the accountants to take over patient care. It's a nice theory but illness, particularly mental illness, doesn't strike that way." (Connell, 1994, 4.)*

Deinstitutionalisation from mental hospitals is a policy that has been adopted since the Second World War by several senior western economies. This policy has meant the replacement of a largely institutional model of caring for people with mental illness (whereby much of this care took place in large state-funded mental hospitals) with the "Community Care" model where far fewer institutional beds are provided. This shift towards "Community Care" has been accompanied by promotion of the new model as being more inclusive, tolerant and emancipating for people with mental illness (Scull, 1984; Johnson, 1990).

In many cases, the lived reality of "Community Care" as implemented in New South Wales (Australia's most populous state) has been one of isolation, homelessness and inadequate treatment for people with mental illness (St. Vincent De Paul et al, 1998) and extreme stress for their carers (Burdekin Report, 1993; Loney, 1986; Kinnear and Graycar, 1983).

This article looks at one particular policy process – that of deinstitutionalisation in New South Wales after World War II, however, it also illustrates some of the problematic outcomes which can occur if accounting-related thinking is given too much emphasis in policy and funding decisions. The outcomes discussed in this case study may well resonate in other western economies where there is some question as to whether accounting-type information has been privileged above other forms of reality in policy-making.

The limited scope of this article not allow for an extensive discussion of the literature of accounting links to economic rationalism or of the limitations which any quantified, accounting-based analysis brings to social policies if not balanced by broader considerations. Fortunately, these areas have been well covered elsewhere. Accounting's ability to emphasise a particular version of reality whilst obscuring other, alternative realities has been eloquently argued by such authors as Maunders and Burritt (1991, 15); Hines (1988, 256); Morgan and Willmott (1993, 8); Richardson (1987, 341-343) as well as many others. The way in which accounting abets and is implicated in economic rationalism has also been widely discussed. Some good examples of these discussions can be found in Rose (1991, 690); Boyce (1997, 10-13); Morgan and Willmott (1993, 10-16).

In order to evaluate the policy of deinstitutionalisation in New South Wales a framework for evaluation of Social Policy Process adapted by Puckett (1993, 415) from Rees (1985,25-28) has been chosen for this article:

**Figure 1**  
**Social Policy Process**

Social	policy	Social programs	Consumer impact	Evaluation	and
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<b>formulation</b>			<b>review</b>
Setting agenda for review, influenced by powerful lobbies, e.g. consumers, medical profession, public servants, legal profession	Professional planning phase	Consumer reaction	Forms of monitoring of service delivery
Setting of objectives and priorities	Implementation of policy goals	Level of satisfaction with new policy	Media representation
Options analysis	Publication of particular programs		
Commissioning cost-effectiveness studies			

The four stages of this process as applied to the case of deinstitutionalisation in New South Wales will be discussed in turn.

This paper will conclude by suggesting that whilst accounting can be a useful tool, it has been misused in the case of deinstitutionalisation in New South Wales. If accounting were to make a positive contribution to the debate surrounding the policy of deinstitutionalisation certain modifications would be beneficial. Knowledge of accounting's limitations would be beneficial for appropriate policy decisions.

### **Treatment of Mental Illness in New South Wales – a brief history**

Scull (1984) suggested the need for such policy analysis as this to be contextualised and historically informed. To this end, some brief comments about the conditions and available treatments in mental hospitals, about the funding arrangements for mental hospitals and about how deinstitutionalisation in New South Wales was pursued, now ensue.

#### **Treatments of mental illness prior to deinstitutionalisation**

Psychiatry in New South Wales (and in all of Australia) was often strongly influenced by psychiatric practices in Britain and the United States of America (Lewis, 1988, 49-52). The shift from the belief that moral failure caused insanity (held by the moral therapists to the mid nineteenth century) to belief in a physical cause for insanity (more prevalent from the late nineteenth century until the 1940's) was reflected in psychiatrists' methods of treatment. Despite the effectiveness of psychoanalysis in the First World War and a number of psychiatrists' adhering to this sort of "talking cure", the physical / hereditary model remained dominant. Whilst psychoanalysis was discussed in Australia and papers from both Jung and Freud were read at Australian conferences in the 1910's, there was a general scepticism about psychoanalysis from most Australian psychiatrists early in the twentieth century.

It should be noted, however, that while the debate about early treatment took place, the majority of mental patients in Australia were still in overcrowded mental hospitals where little "treatment" was ever received. It was not until the late 1920's that physical treatments began to be used in mental hospitals. At the time that these treatments were used, mental illness was (largely) believed to be the result of a physical injury, disease or malformation. It was reasonable, therefore, to hope that mental illnesses might be curable through purely physical treatments. (Lewis, 1988, 43). The first of these treatments was malarial therapy used in the 1920's on people suffering mental illness related to

sypilis. In the late 1930's insulin and cardiazol were used to treat schizophrenia and depressive psychosis. The 1940's brought electro-convulsive therapy and psychosurgery (Levine, 1981, 43).

These attempts at early treatments and physical treatment did represent a modification of the late nineteenth century view (still very prevalent until the 1930's and 1940's) that mental illness was hereditary and incurable (Lewis, 1988, 48; Garton, 1988, 57). In Australia, this change was brought about by psychiatrists and the mental hygiene movement arguing that mental illness could be cured or abated. This return to the belief (previously dominant during the "Moral Therapy" era of the early to mid nineteenth century) that mental illness could sometimes be cured was offset by government perceptions that there were few votes in funding expanded therapeutic or prevention programs. (Lewis, 1988, 48).

There were many developments in medical treatments for mental illness around the time of the Second World War. Electro-convulsive therapy (ECT) was used in Australia in the 1940s (Kosky et al, 1991,7). An earlier use of electrical treatments had been made in Australia from 1851 to 1876. At this time it was used for disciplinary purposes as well as for therapy. (Lewis, 1988,12). Lithium treatment for manias was introduced in New South Wales in 1949 (Kosky et al, 1991, 7). In 1952, chlorpromazine, the first antipsychotic drug began to be used. Antidepressant drugs followed. (Puckett, 1993, 398).

### **Conditions in New South Wales' Mental Hospitals**

A 1955 national survey of mental health facilities (headed by Stoller and Arscott) found that Australian psychiatric services were of a lower standard than those in the United States and the United Kingdom. Overcrowding and understaffing led to these institutions being custodial rather than therapeutic. Also, lack of differentiation between different categories of patients hampered treatment. People were admitted to mental hospitals with senility, mental retardation and alcoholism. (Lewis, 1988, 77).

Specifically referring to the state of New South Wales mental hospitals, Stoller and Arscott (1955) reported:

*The Mental Hygiene Department... has lagged behind world developments in psychiatry. It has been so starved of essential moneys, even for adequate maintenance over so many years, that its outlook has become somewhat restricted. Attempts have been made to raise standards, but these have invariably failed because of the lack of introduction to appropriate training programs.*

### **Fiscal Arrangements Between State and Federal Governments**

Despite the Federal Labor government's strenuous efforts in the 1940's to ensure limited universal health care, this did not include mental health care. Funding for psychiatric services remained substantially a state matter. (Lewis, 1988,33).

The Australasian Association of Psychiatrists (formed in 1946) reported on overcrowding and poor conditions in state mental hospitals in 1950 (Pargiter, 1991, 4-5). Cunningham Dax (chairman of the Mental Hygiene Authority of Victoria) described such appalling conditions at Kew Cottages (one of the largest mental hospitals in Victoria) that the Commonwealth Government took some uncharacteristic action. Commonwealth grants were given to the various states to improve the worst of their mental hospitals. However, although this States Grants (Mental Institutions) Act of 1955 offered states some help towards capital works on mental hospitals (a one pound Federal Government matching for every two pounds the states spent on capital expenditure in this area to a maximum of ten million pounds over the entire nation), it took away any payment from the Federal Government to the State Governments for the actual ongoing maintenance costs of mental patients.

(Lewis, 1988, 78). As this 1955 grant required states to spend money on capital works in mental hospitals in order to receive the grants, some of this grant money was still unspent as late as 1964. Also, states were now bearing the full costs of maintaining patients in mental hospitals.

The Commonwealth Government continued to place the responsibility for mental illness squarely in the hands of State Governments. 'The various Medicare systems have led to the anomalous situation where mentally ill people treated in general hospitals have health insurance status and those treated in State mental hospitals do not.' (Pargiter, 1991, 5).

The 1972 Federal election campaign saw "Community Care" becoming an issue. The Labor party was in favour of providing community-based services (Lewis, 1988, 78). In 1973, the 1955 Act was replaced with the Mental Health and Related Services Assistance Act under which seven and a half million dollars was provided nationally with the intention of providing community based services to people with mental illness, alcoholics and other drug dependent people. The Whitlam Labor government was also generous with ongoing costs of community care – funding 90 per cent of operating costs in 1974-75. The Liberal-Country Party Government of 1975 cut back funding for community care – only 75 per cent of operating costs in 1977-78 and only 50 per cent of operating costs in 1978-79. (Lewis, 1988, 79). Responding to the New South Wales State Government's (Labor) complaint regarding this diminution in federal funding, the Federal Minister for Health responded:

*we are concerned about the ever escalating costs in the public hospital sector...I reject the New South Wales Minister's blame for the difficulty that he finds himself in with the unions in New South Wales over rationalisation proposals for...psychiatric and geriatric homes.*

It can be inferred from this discussion that the question of "who pays for what?" in mental health funding had been a hotly contested issue between the New South Wales' State and the Australian Federal Government with both sides keenly interested in how the mental health bill was to be divided. It was clearly in the interests of the State Governments to move patients out of the State-funded mental hospitals and onto other (federally funded) benefit schemes such as the disability pension or unemployment benefit.



### Deinstitutionalisation in New South Wales

Puckett (1993, 398-399) placed the beginning of deinstitutionalisation in Australia in the mid-1940's, although the policy was undeclared until much later. Puckett also suggested that deinstitutionalisation was accelerated (not begun) in the mid 1950's with the development of psychotropic drugs. This is the same approximate time that Scull (1984) and Johnson (1990) give for deinstitutionalisation in the United States. The "Leading the Way" Report (N.S.W. Department of Health, 1993, 58), also suggests that (just four years later than in the United States) the total number of in-patients resident in New South Wales's mental hospitals peaked in 1959 at 12,668 people. The number of patients (as a proportion of New South Wales's population) peaked in 1954. The average length of stay in New South Wales's mental hospitals can also be seen to fall steeply from 1954 (average length of stay one and a half years) to an average length of stay of about three months between 1977 and 1986.

Lewis (1988, 205-207) and the "Leading the Way" Report (N.S.W. Department of Health, 1993) provide some information on how patient numbers in New South Wales' mental hospitals have fluctuated in the twentieth century:

Figure 2

#### New South Wales Mental Hospital Patient Numbers.

Year	Patients at End of year	Medical Staff	Nursing Staff	Insane (b) per 1,000	NSW (c) MHE .
*1901	4,423	n/a	n/a	3.23	230
*1918	7,581	21	1,111	3.94(d)	613
*1928	9,104	28	1,614	3.73(e)	1,234
*1938	11,678	36	2,127	4.2(f)	1,451
*1948	11,836	42	1,868	3.8(g)	2,570
*1958	13,761	65	2,160	3.7	8,762
*1968	11,558	231	3,523	n/a	23,232
^1978	6,172(h)			1.23(i)	
^1988	2,621			0.45(i)	

\* figures from Lewis (1988, 205-212)(a); ^figures from "Leading the Way" Report (N.S.W. Department of Health 1993, 58)

(a) Lewis' (1988, 205-212)

(b) Certified insane per 1,000 population. Lewis statistics show male and female. A simple average has been taken here

(c) State Government (Final Consumption) expenditure on mental health – inflation should be taken into account

(d) figure relates to 1917 as 1918 figure not available

(e) relates to 1929 as above

(f) relates to 1937 as above

(g) relates to 1949-1950 as above

(h) relates to number of inpatients in mental hospitals, Hospitals for developmentally disabled, admission centres and private psychiatric Hospitals

(i) rather than number of certified insane (as above) this relates to number of residents per 1,000 population.

From these sources, it seems clear that deinstitutionalisation was well under way in an unofficial capacity in New South Wales well before the Richmond Report (1983) ever recommended deinstitutionalisation as an official policy. A rather startling drop in the number of patients resident

in mental hospitals can be seen in the figures from 1968 and 1978. A substantial rise in the number of medical and nursing staff required to service the mental hospital population can also be seen by these years. Mental hospitals were becoming very expensive to run.

The next section of this case study applies an adaptation of Puckett's (1993, 415) Social Policy Process Framework (see Figure 1) to deinstitutionalisation in New South Wales.

### **An evaluation of the policy of deinstitutionalisation in New South Wales**

For the purposes of this evaluation, the Richmond Report (1983) will be taken as the (ostensible) social policy formation document. In this document, recommendations were made as to how community care was to be funded. The Richmond Report recommended that "Integrated community networks"; that services allow people to live in their "normal community environment"; and that services should provide "adequate follow up for mentally ill people in the community".

More specifically, The Richmond Report (1983, Part 1, 4-10) came down very much in favour of further deinstitutionalisation and community care. The following recommendations were made with regard to psychiatric care. (Those recommendations omitted are not directly relevant to this study):

1. *That services be delivered primarily on the basis of a system of integrated community based networks, backed up by specialist hospital or other services as required.*
2. *That the two prime operational objectives be to -*
  - i. *fund and/or provide services which maintain clients in their normal community environment; and*
  - ii. *progressively reduce the size and the number of existing Fifth Schedule (psychiatric) hospitals by decentralising the services they provide*
4. *That priorities for funding in mental health be-*
  - i. *provision of additional community based crises teams;*
  - ii. *provision of staffing to provide adequate follow up for mentally ill people in the community;*
  - iii. *provision of psychiatric staff for assessment services in general hospitals;*
  - iv. *provisions for opportunities for training existing Fifth Schedule hospital staff for new roles in community and specialised hospital services.*

### **Evaluation of Developments in Social Policy**

#### **A. Social Policy Formulation**

The first stage in Puckett's (1993, 415) Framework involves examining social policy formulation. This includes looking at the agenda for review in the policy area; the setting of objectives and priorities; options analysis and the commissioning of cost-effectiveness studies.

The 'Inquiry Into Health Services For The Psychiatrically Ill And Developmentally Disabled' was commissioned. It was published in March 1983. The Chairman of this Inquiry was D.T. Richmond. Thus this publication will hereinafter be referred to as the Richmond Report. The terms of reference of the Richmond Report (1983, Part 1, 4) included the following items:

- (1) *To determine the appropriate nature, extent and distribution of services for the psychiatrically ill, psycho-geriatrics and the developmentally disabled in New South Wales.*
- (2) *To review the appropriateness of the existing range of care and services for these groups and examine alternative methods of care and service delivery.*

- (3) *To identify priority areas for the development of new services*
- (4) *To assess resource requirements for the psychiatric system in the light of the findings in (1), (2) and (3)*
- (5) *To review the role of the non-government sector in these areas and to recommend future arrangements for co-operative planning, funding and co-ordination between government and non-government agencies.*
- (6) *To identify a broad strategy and mechanisms for implementing recommendations arising from the terms of reference.'*

In other words, the Richmond Report (1983) was a reasonably far-reaching report. In summary, the broad strategy that it recommended was that there should be a change in emphasis in mental health in New South Wales. The psychiatric hospitals should be closed, or at least much diminished, and money released from this sale of these hospitals and on the decreased running costs of these hospitals should be put towards more community based treatment for people with mental illness. (Puckett, 1993, 401-402).

Despite these recommendations, it appears that these recommendations were never funded in any meaningful way.

In the radio program "Life Matters", (2<sup>nd</sup> May, 1996), Robert Manne was interviewed on the issue of deinstitutionalisation in Australia. Manne commented that the right wing (taxpayers revolt movement) and the left wing (institutionalisation is oppressive movement) of Australian politics united behind deinstitutionalisation. Deinstitutionalisation also (as was the case in the United States) also took place without adequate community care facilities being provided:

*What is clear to me is that resources have been starved in this area... In the small government atmosphere in which we live, it is very easy for governments to very gradually cut back in certain areas. Now if you were going to deinstitutionalisation in a big way, you needed to put enormous resources into what happens after people are released from institutions. And I'm sure that that hasn't happened... This is one of the areas in which small government cannot work and is a disaster and a human disgrace if it takes place. (Manne, 1996).*

Webster (1987, 415) Professor of Community Medicine at the University of New South Wales shared Manne's (1996) view of the failure of deinstitutionalisation in New South Wales. He also commented on the extent of shifting and dodging surrounding the mental health issue:

*People with long-term mental illness are the victims of a pincer movement: Health wishes to deinstitutionalise them; Welfare and Community Services believe they are a health problem; the Commonwealth says they are a State responsibility and the State says the Commonwealth should share the load; some community agencies accommodate them but feel that they shouldn't, and many of them end up in jail.*

These comments suggest that the New South Wales experience of deinstitutionalisation has been comparable to the United States' experience. Perhaps as an exercise in legitimisation, (as deinstitutionalisation was already well under way in New South Wales, as has been discussed earlier).

## **B. Social Programs**

The Social Programs section of this analysis includes the phases of professional planning; the implementation of policy goals and the publication of particular programs.

One recurring theme that comes up in evaluating social programs and “community care” for people with mental illness in New South Wales is that the few programs that did exist were often difficult for people with mental illness to access. Also, there was a conspicuous lack of coordination and follow-up in mental health services.

Professor Webster (1987, 415) also commented on the recommendations of the Richmond Report not being backed by community care facilities. He noted that patients were often “discharged prematurely with inadequate follow up and support.” People with mental illness were also often unable to access support programs in areas such as health, living skills or counselling which were set up for the general population. Professor Webster noted that a stable address was vitally important for treatment and commented that “Government provision for their housing and accommodation is virtually zero. They frequently end up as rootless wanderers”.

More evidence of what social programs (if any) were provided after the Richmond Report can be gained by looking at information provided in the Burdekin Report (1993). In recognition of the fact that programs cannot be provided overnight, nor a creaking bureaucracy replaced in a week, please note that ten years elapsed between the Richmond Report (1983) and the Burdekin Report (1993). If this was not time enough for the realisation of the shortcomings of the social programs (not provided for deinstitutionalisation to be realised, the comments from other sources are from as late as 2002. Thus a further decade after the Burdekin Report have now elapsed to illustrate the (perhaps) unintended outcomes of the process of deinstitutionalisation in New South Wales to have been remedied. These outcomes have not been remedied.

Burdekin (1993) commented repeatedly on the dearth of community services that were ever provided following the cutting back of beds available in mental institutions. For example:

*Lack of resources has bedevilled community-based care in much the same way that inappropriately allocated resources contributed to the ineptly executed demise of the large institutions. Clearly, resources and effective coordination are imperative if mainstreaming is going to work. (Burdekin, 1993, 137).*

It is exactly these two imperatives – resources and effective coordination of community – based services that the Burdekin Report (1993) found to be lacking time and time again. In order for deinstitutionalisation to be an effective alternative to institutionalisation, Burdekin (1993, 300-318) identified the following social programs as having to be present:

1. *Adequate, accessible treatment, including:*
  - a. *Inpatient facilities*
  - b. *Outpatient treatment services*
  - c. *Crisis teams*
  - d. *Mobile teams*
  - e. *Community mental health clinic staff*
  - f. *Living skills centres*
  - g. *Accommodation support staff*
  - h. *Non-government organisations*
  - i. *General practitioners*
2. *There needs also to be coordination and communication between these services so that people with mental illness do not “fall through the gaps”. This includes:*
  - a. *Continuity of care*
  - b. *Discharge planning*
  - c. *Integration of hospital and community services*
  - d. *Case management*
3. *Treatment also needs to be monitored. This requires:*
  - a. *Treatment follow – up*
  - b. *Medication maintenance*
  - c. *Access to alternative treatments if required*

d. *Psychosocial rehabilitation*

At the time of the Burdekin Report (1993, 298), these social support systems, which might make deinstitutionalisation beneficial for people with mental illness, were found to be “abysmally inadequate”. Harris (1991, 7) also wrote that mental health services were inadequate to meet the needs of people with mental illness. She cited one case where a woman with schizophrenia sought urgent treatment at two hospitals because she felt a desire to kill herself. She was refused treatment at both hospitals. She then killed herself.

To give one example from the list of social program elements required for appropriate community care – crisis teams are supposed to be available around the clock and across the state to help in case of a sudden onset of mental illness. Early treatment can be vital to limiting the length and severity of an episode of illness. Are such crisis teams available around the clock and across the state? No. Burdekin (1993, 227) and Davis (1993, 228) commented on the lack of after-hours psychiatric help available. This lack of coverage was especially important because, as noted by both Harris (1991, 7) and Davis (1993, 228) most psychiatric crises occurred outside business hours.

As for mental health services in rural areas, people would be well advised not to develop any form of mental illness outside a major metropolitan area. Burdekin (1993, 678) writes of the “particular tension between effective recognition of the needs and rights of rural Australians affected by mental illness and the pressures of economic rationalism”. He noted that in small country communities mental health services were “almost entirely non-existent”.

Of the situation in New South Wales’s rural areas, the National Aboriginal Health Strategy Working Party (1993, 679) noted:

*In the Central West Health Region there are approximately three full-time equivalent psychiatrists in the public health system and one full-time equivalent in private practice. In Orana region [north-west] there is one psychiatrist in private practice. In the far-west I believe there is one at Broken Hill. I also contacted South West New England and South Eastern Regions, each of which have about four psychiatrists, some in private practice and some in the general health system. Needless to say, most of these are based in the major cities and services in the more remote areas are generally conducted by psychiatric nurses who are embattled.*

According to figures from the “Leading the Way” report (N.S.W. Department of Health, 1993, 61-62), particularly inconvenient places in New South Wales to have a mental health crisis still included all of the following regions in 1991: Hunter region; Central Coast region; North Coast region and Central West Region – these places had no crisis teams at all as late as 1991 which is the latest date for which figures were available in this report. This region represents a vast proportion of the State of New South Wales. Even in other regions of the state, there are few twenty-four hours services available.

Burdekin (1993, 281) was particularly scathing about the lack of “coordination and communication” between mental health services. Three factors are required for effective discharge planning: careful preparation of a plan well before a person is discharged; involvement by those (carers and agencies) intending to undertake care after the discharge; sufficient resources and expertise to carry out the plan. Apparently none of these was adequately present at the time of writing of the Burdekin Report (1993, 281-283). The Burdekin Report characterised the situation as follows: “Witnesses to the Inquiry repeatedly expressed dismay concerning the inadequacy of discharge planning”; “The Inquiry received a great deal of evidence about lack of continuity of care”; “Consumers, carers and support groups gave numerous examples of inadequate pre-discharge preparation and post-discharge support for families”. Indeed, Burdekin (1993, 283) went so far as to comment that the treatment of people with mental illness displayed:

*an astonishing lack of understanding, or indifference, about the consequences of ‘dumping’ vulnerable people without making adequate arrangements for their future*

*care.*

As for these situations (which “affect many people”) being directly reflected when the “costs” of the present policy choices are accounted for, they are not found directly stated and appropriately grouped on any Health Department Statement of Financial Performance. The National Mental Health Report 2000 (2000, 176) budgets for and reports such items as New South Wales’ Mental Health expenditure on insurance and superannuation for workers. But there are no items to reflect the cost of stress borne by a carer when a loved one is unexpectedly and inappropriately discharged whilst still suicidal with no support or advice furnished with them. As will be discussed further later in this paper, those costs are directly borne by an entity outside the one budgeted for and are ignored as “externalities”.

To substantiate the claim that the “integrated community networks” of services to allow people to live in their “normal community environment” and that such services should provide “adequate follow up for mentally ill people in the community” recommended by the Richmond Report (1983) never eventuated, please refer to the “National Mental Health Report 2000” (2000, 188). It will be noted that by 1993 (ten years after the Richmond Report) the total number of beds in community-based residential services offering 24 hour specialised mental health care in New South Wales had reached only 171. By 1998, this number had fallen to 147. Over the same period of time psychiatric beds available in Mental Hospitals and psychiatric beds in general hospitals (co-located units) had fallen from 2,652 in 1993 to 2,128 in 1998. In case there is any suggestion that the time between 1993 and 1998 might be an aberration, the Burdekin Report (1993, 166) points out that the overall trend in Australia (and New South Wales has followed this trend) has been that the number of psychiatric beds per 100,000 population had fallen from 281 beds in the early 1960’s to 40 beds in 1992. That represents an 86 per cent reduction. New South Wales (National Mental Health Report 2000, 52) registered only a total of 33.8 inpatient psychiatric beds per 100,000 population by 1997-98. Access Economics (2002, 1) noted that direct spending on schizophrenia took only 1.3 per cent of Australia’s national health spending. In comparable countries elsewhere, the average was 2.6 per cent.

Has there been a commensurate increase in “community care” half-way houses where appropriate, supported housing is available to people with mental illness? No. To refer to The National Mental Health Report, 2000 (2000, 52) again, the total number of non-inpatient (community) beds provided in New South Wales in 1997-98 is only 293. This is supported by the findings of the Burdekin Report that (1993, 341) there is a chronic shortage of housing available to the mentally ill. Not just supported, appropriate housing, any housing at all.

Is it possible that deinstitutionalisation had been so successful that people with mental illness were so empowered that they could take advantage of public housing along with other members of society’s poor? No. According to Burdekin (1993, 345) although most people with a mental illness are poor enough to qualify for public housing, only a small number are granted it (the example of Wollongong is cited, where only 7 per cent of people with a severe mental illness had been granted public housing).

Whilst the number of psychiatric beds available in New South Wales is by no means a comprehensive measure of services provided to people with mental illness, it is an indicator. This, along with the recurrent reporting of the chronic lack of any meaningful “community care” services (discussed in the next section), strongly suggests that services have been neglected. As the Burdekin Report suggests (1993,136), “the promise of more, and more effective community-based services is yet to be realised”. Now, almost ten years after the Burdekin Report and almost twenty years after the Richmond Report, it would seem that the term “community care” still has a hollow ring.

The numbers quoted above fail to convey the full failure of deinstitutionalisation in New South Wales in human terms. For a fuller account of the few community care programs recommended in the Richmond Report which were ever provided, the following section elaborates on the cost

(quantifiable and otherwise) and the extent of the failure of the social programs (not) provided to allow the community care recommended by the Richmond Report. Boson (1992, 17) noted that the government had “turned its back” on Richmond’s recommendations.

### **C & D. Consumer Impact, Evaluation and Review**

In applying Puckett’s (1993, 415) framework to the case of deinstitutionalisation policy in New South Wales, it was found that the two final stages (Consumer Impact and Evaluation And Review) were intertwined to the extent that separating the two strands was not appropriate. The Consumer Impact section involved examining consumer reactions to the new policy. The sources from which consumer impact was gauged in this case study overlapped substantially with the Evaluation And Review stage of analysis because it was largely through the forms of monitoring and service delivery and through media representation that people with mental illness, their carers and other consumers expressed their (dis) satisfaction with the policy.

The sources from which the following evaluation of the consumer impact of the process of deinstitutionalisation in New South Wales are drawn are: The Burdekin Report; The National Mental Health Report 2000; various reports put out by mental health support groups, charitable organisations, and newspaper reports. Because of this overlap between “Consumer impact” and “Evaluation and review” of the policies of deinstitutionalisation in New South Wales, parts (C) and (D) of the framework for evaluating developments in social policy will be discussed together.

As this paper will refer to a large quantity of material from the Burdekin Report (1993), some background on this report is appropriate. The Report of the National Inquiry into the Human Rights of People with Mental Illness 1993 (hereafter referred to as the Burdekin Report) was a National Report. It was commissioned after the Human Rights’ Commission report into “Our Homeless Children” suggested that a large number of homeless youths were affected by undiagnosed and untreated mental illnesses (Burdekin Report, 1993, 3-4). Another influence in its commissioning was the scandal involving Chelmsford Hospital and the “Deep Sleep” therapies practised therein. It was particularly noted that there had been no fewer than 40 enquiries into psychiatric facilities in New South Wales since 1861.

The terms of reference of the Burdekin Report (1993,5) which were relevant to this paper were:

- To inquire into the human rights and fundamental freedoms afforded persons who are or who have been or are alleged to be affected by mental illness, having due regard to the rights of their families and members of the general community.
- To examine the respective roles and responsibilities of Commonwealth, State and Territory Governments in these areas.

As was the case in evaluating deinstitutionalisation in the United States, a wide definition of “consumer” has been taken in this section to recognise the widespread impact of deinstitutionalisation policies in New South Wales. Groups substantially affected by the decision to curtail mental hospital places whilst at the same time providing very little by way of Community Support services were:

1. People with Mental Illness
2. Family and Other Carers of People with Mental Illness
3. Other (Non-Mental Hospital) Government Institutions
4. Other (Non-Government) Institutions
5. Society in General.

#### **1. People with Mental Illness**

The costs which have been most mentioned in the Burdekin Report; reports of support groups; and

media articles arising from deinstitutionalisation and resulting in burdens to people with mental illness were: premature death, inappropriate housing; lack of appropriate care, services and treatment; the prevalence of homelessness and incarceration of people with a mental illness.

According to SANE Australia (1998a, 5, 1) the risk of Australians with a mental illness killing themselves is much higher than in the general population. For example, the risk of someone with schizophrenia committing suicide (within 10 years of diagnosis) is 10 per cent, which is roughly 2,000 times more likely than someone in the general population. This leads to not only a loss of life of the people themselves, but also to distress for the families involved. A major cost, but one that is difficult to quantify.

Access Economics (2002, 29-31) put the social costs (direct and indirect) of schizophrenia alone (including costs of suicide and financial loss to carers, but excluding any "pain and suffering" amounts at \$A1,846,700 for Australia in the 2001 calendar year.

Under the heading of "inappropriate housing" come topics such as homelessness, boarding houses and supported accommodation. Another often inappropriate placement - that of people with a severe mental illness at home with relatives or other carers - will be considered from the person with mental illness's viewpoint in this section and from the carers' viewpoint in the next section. One of the reasons why the question of housing is vital in this area is because stable, appropriate housing is of such critical importance to the successful treatment or management of mental illness. Constant moving, uncertainty or housing conditions that are unsuitable are stressful and destabilising for anyone, but particularly for people dealing with a serious mental illness. (Burdekin, 1993, 339.)

The picture of an extreme paucity of anything vaguely resembling an "integrated community network" allowing people with mental illness a "normal community environment" and providing them with "adequate follow-up" makes the words "community care" a sick joke. Burdekin (1993,341) noted the bureaucratic shuffling between the Departments of Housing and the Departments of Health in Australia - each claiming that housing for people with mental illness was the other's problem. The result of each department denying responsibility was that people with mental illness wound up with very little by way of help in housing and (with that vital stability absent) often fell through the bureaucratic cracks into homelessness and marginal accommodation such as boarding houses.

The precise extent of homeless people in New South Wales who suffer from a mental illness is difficult to pinpoint as it is such a transitory and ignored population. St. Vincent de Paul (2001, 6) gave as their "guestimate" that between 25 per cent and 50 per cent of homeless people presenting themselves at the Matthew Talbot Hostel in Sydney had some form of mental illness. The Down and Out in Sydney Report (St. Vincent de Paul et al, 1998, 2) suggested that 75 per cent of homeless people had at least one mental disorder. Perhaps those with the organisational skills to actually present at a hostel are less likely to suffer severe mental illness. Other alarming statistics from Down and Out in Sydney (1998, 7) are that 58 per cent of homeless people in or contacting inner Sydney hostels and refuges run by St Vincent de Paul, Sydney City Mission, the Salvation Army, Wesley Mission and the Haymarket Foundation had been physically attacked or assaulted; 55 per cent had witnessed someone being badly injured or killed; 68 per cent of women admitted to having been indecently assaulted and 50 per cent raped.

Homeless shelters are not a great place to receive treatment for a mental illness. Being homeless and without a fixed, safe abode is an incredibly stressful mode of life and stress is extremely bad for people with a severe mental illness. Lack of treatment and the inappropriateness of hostels (when there is space and the hostel is willing to accept the person with severe mental illness) is a recurrent theme in the problem of homelessness. So is the extreme physical, sexual and financial abuse that many homeless people find themselves prey to. Another oft-repeated theme by charitable organisations is the "revolving door" syndrome whereby people with a mental illness are shuffled between hostel, hospital and homelessness with no long term coordination or plan for their future or



treatment.

One reason for the lack of treatment in hostels is that the staff seldom have any expertise in the area of mental health (Horin, 1997, 3). Another problem is the extreme lack of resources that these hostel staff can rely on when someone in the hostel does not take their medication and becomes difficult or bizarre to deal with:

*Witnesses representing homeless agencies and hostels repeatedly told the Inquiry of the difficulties they experience in attempting to obtain or sustain treatment for their clients who are mentally ill. One problem which arises frequently is that mentally ill residents in hostels or refuges refuse to take their prescribed medication. Staff with no mental health training are then forced to confront a person who is becoming psychotic... Sometimes, "if it is a real crisis", staff from the shelter take the mentally ill person to a hospital, only to find the hospital refuses to accept the person as a patient. An appalling shuttling process ensues. (Burdekin Report, 1993, 553-554).*

This refusal to take medications appears to be a pervasive problem. In the United States, it is estimated that some 40 per cent of people with a severe mental illness (Treatment Advocacy Centre, 2001) do not comply with the recommended taking of their prescribed medication. There are a variety of reasons for this – some of them are very understandable. The results are quite disastrous. The Treatment Advocacy Centre (2001) point out the high correlation between non-compliance with medication and suicide. They also note the higher than average correlation of non-treatment with violence (both against the person and by the person); with rape; with being robbed. Information about non-compliance with medication in New South Wales is not comprehensive, but there are certainly pointers to non-compliance being high. This is reflected by the difficulties experienced by carers and charity workers who very often struggle to deal with people not complying with their medication.

The Burdekin Report (1993, 238-248) mentioned several reasons for such non-compliance. These included extensive side-effects; non consultation or choice by patients as to which medications they should take and which side effects were likely with each; the high cost of certain drugs; the negative long-term effect of drugs and (Burdekin Report, 1993, 337-376) the lack of a stable living environment and continuity of care (both of which make taking medication far more likely).

Homelessness makes people with mental illness even less likely to take their medication (Burdekin, 1993, 554-555). The lack of routine in their lives, the lack of continuity of care and the instability that goes with homelessness makes the chances of remembering (or bothering) to take a particular dosage of a particular medication at a particular time even more unlikely than with a housed person having a mental illness.

Other people at homeless shelters (those without a severe mental illness) are also going through an extremely stressful time in their lives and bear costs associated with people with untreated mental illness being so prevalent in shelters:

*People with schizophrenia and manic depressive illness spend a great deal of time during the night walking. At present there is a lot of frustration experienced as some people are trying to sleep and others are in motion. (Hefferan, 1993, 559).*

This is also the case at women's shelters where the majority of women are fleeing domestic violence situations (Burdekin, 1993, 596; Wesley Mission, 2002, 5). The women are often separated from their children and do not need the extra stresses involved with dealing with people with mental illness as well. Felus (1993, 560), from her perspective as a worker in a women's shelter, commented that the staff in shelters face many calls on their time and on their limited resources. When there are a number of families experiencing severe distress staying in a shelter, the additional stresses and resources demanded by someone with a mental illness can make shelter staff's tasks (already difficult) even more difficult. Indeed, the situation at the shelters can be so distressing that some women will choose to return to an abusive situation rather than stay in a hostel. (Burdekin, 1993,

560).

The picture of physical, sexual and financial abuse (which all homeless people are prone to suffer, but to which homeless people with a mental illness are especially vulnerable) is distressing. According to a recent report in the Sydney Morning Herald (Macey, 1998, 5) half of all women and 10 per cent of men presenting at New South Wales hostels for food or shelter had been raped.

Hostels are inappropriate places for people with a severe mental illness, but are probably better than sleeping on the street. According to the Wesley Mission (2002, 11) more people were turned away from the Support Accommodation Assistance Program (SAAP) than were accommodated in 1997-1998 because of the growing number of homeless people and the static (or shrinking) numbers of hostel places available.

What price does one put on a compromised quality or length of life? What price on a rape or other assault? What price should be factored in for someone who has returned to an abusive relationship (possibly with children involved) because deinstitutionalisation without appropriate community care has made homeless or women's shelters potentially more threatening than the situation they left? None of these things were factored into costs in the Richmond Report.

Next in the category of inappropriate housing comes Boarding Houses. This sector houses quite a large number of people with mental illness, few of whom receive appropriate treatment:

*An expert witness to the NSW hearings estimated that of 1,300 people in boarding houses in central Sydney, 70-80 per cent are seriously mentally ill... However, these mentally ill people rarely if ever see a mental health worker – unless their illness escalates and they are hospitalised during an acute episode. (Burdekin Report, 1993, 387).*

Despite the sometimes insanitary conditions and lack of security of tenure (Burdekin, 1993, 386-389) it seems that many people with mental illness prefer life in a boarding house to that in hospital. Hoult, (1993, 389) reported that 80-90 per cent of people with mental illness preferred the liberty of boarding houses to staying in hospitals, even if conditions in boarding houses were fairly poor.

The main problem with living in boarding houses with a mental illness was the lack of treatment. Burdekin (1993, 391) wrote that there was little or no treatment or rehabilitation programs for people with mental illness living in boarding houses. This lack of treatment was found to be a contributing factor in mental illness.

Duke (1993, 396), commented on boarding houses being cut-price reinstitutionalisation:

*I think it's just horrendous that this group of terribly needy people is so poverty-stricken. The houses... take every penny they've got; and not because they're profiteering – that's what it costs... I don't think one should turn around and say that people who run [these] houses are monsters for taking all their money. They are providing an extraordinarily cheap service for the government.*

As in the United States, people with mental illness living in boarding houses were overwhelmingly recipients of federal government pensions, whereas the majority of costs in mental hospitals were still borne by state governments.

Despite occasional boarding house scandals (for example, Horin, 1996, 11) not all boarding house conditions were scandalous. Conditions were basic, perhaps, but given that homelessness was the realistic alternative for many patrons, to shut down boarding houses might be to do a grave disservice to people with mental illness (Porteous, 1996, 11; Long and Phelan, 1992, 1). Porteous also pointed out that it would cost the Government \$A300 million in capital to fund alternative accommodation infrastructure and about \$A280 million a year in recurrent funding to run these centres.

The final type of accommodation to be considered in this section is supported housing. This accommodation is included under this general heading of "inappropriate housing" not because it is necessarily wrong for people with a mental illness, but rather because there is an extremely inappropriate lack of such accommodation. Supported accommodation is defined in the Burdekin Report (1993, 352) as being "secure, affordable housing and having reliable support from staff who have adequate training and resources". Despite a few notes that not all supported housing was perfect, the general outcome for those suited to such housing who actually managed to get it was very good:

*the benefits of supported housing are amply demonstrated by the few mentally ill people lucky enough to have it. A number of witnesses told the enquiry that having adequate supported accommodation had allowed them to remain stable and out of hospital for years. (Burdekin Report, 1993, 352).*

The extreme scarcity of such placements is reflected in The National Mental Health Report 2000 (2000, 52) the total number of non-inpatient (community) beds provided in New South Wales in 1997-98 was only 293.

The next category of areas to which a burden of care appears to have been shifted from the State Government to another sector was families and other carers of people with mental illness who chose (often under considerable pressure - Burdekin Report, 1993, 476) to care for people with mental illness at home.

Life at home (generally with ageing parents, especially mothers - Burdekin, 1993, 476) could also be sub-optimal. The stresses and costs associated with caring for someone with mental illness will be discussed in the next section. For people with mental illness themselves, life at home was often far from perfect.

As far as treatment was concerned, there was often a lack of expertise at home. The carers were rarely expert in chronic mental illness (well, not at first, anyway) and were frequently denied even rudimentary information about medications and side effects on the grounds of doctor-patient confidentiality. (Burdekin, 1993, 456). The situation at home was also likely to be extremely tense (given the pressures which carers were under - Burdekin, 1993, 456). Support services which might ameliorate this lack of knowledge (such as discharge planning, crisis teams, available hospital beds during times of acute illness) were, as was discussed earlier, absent. Respite care which might lessen the tension in the home were almost uniformly absent. The Burdekin Report noted that carers were:

*walking a tightrope of fear and anxiety; stressful living 'day and night'; being robbed of peace and something to look forward to; of the home no longer being a place to relax; of being harassed and even assaulted, and being unable to get help...Physically, 24-hour nursing and sleepless nights impact drastically upon carers, as do the years of trauma and stress often associated with the carer role. (Burdekin Report, 1993, 471).*

Such intense stresses seemed to be involved in the role of carer without any support that it was not to be expected that carers could give the sort of calm, informed supervision that might be most helpful to a person with mental illness. Briggs (1993, 483) noted that despite the extreme stresses of being a carer, many people felt that there was nowhere other than home with them (or the horrors of homelessness) for their mentally ill relatives to go.

The importance of appropriate support and treatment given early in the illness is critical. Smith (1994, 11) cited a study of young Australians which found that delays in treatment were correlated with slower and less complete recovery. 25 per cent of people with schizophrenia would have only one episode in their lives and fully recover from this episode. Although there are many other factors, it seems that the earlier the treatment, the more likely was this positive result. Another factor in the likelihood of mental illness was stress and social support. A high level of stress, or stressful incidents, made the onset of mental illness more likely, whilst good social support made the onset of mental illness less likely. It can thus be seen just how costly the current, stressful, support-less

system of caring for people with mental illness could be.

## 2. Family and Other Carers of People with Mental Illness

As in the previous paper, the definition of “consumers” taken in this paper is broad. Appropriately broad considering the wide range of people and groups that have been directly affected by the deinstitutionalisation policy. People who are the primary carers of people with mental illness pay an incredibly high price (some would consider it an unconscionably high price) for deinstitutionalisation.

Amongst the categories of costs that carers have to bear, the following major cost categories have been gleaned from the Burdekin Report, (1993):

### ➤ *Exhaustion.*

Donelly (1993, 455) of the National Carers’ Association, explained the sheer weariness involved in being a carer. Carers could be called upon at any time, around the clock and around the calendar. Crises were frequent and generally extremely stressful. There was no time off and no respite for carers. They had huge responsibilities but often very little control over circumstances, which served to make the job even more tiring. They had served to save the government a huge sum of money. They got very little in return.

### ➤ *Uncertainty and lack of information.*

ARAFMI (Association of Relatives and Friends of the Mentally Ill) made a submission to the Burdekin Report (1993, 462) noting that when people were discharged from hospital (often still quite ill) carers were “left in the dark, expected to pick up the pieces” whilst often not being properly informed of the medication and treatment regime that the person discharged should be on. This lack of information made their job exceptionally difficult.

### ➤ *Lack of coordination and follow-up.*

A variety of carers (for example, Lanson, 1993, 462) commented on the dearth of follow up and discharge planning after an episode of hospitalisation for severe mental illness.

### ➤ *Stress.*

The stress and strain on the mental health carers and on anyone else living in the household was commented on by many carers. For example: Bacon (1993, 471); Ormorod (1993, 472) both reported the edginess and overwhelming stress and responsibility that came to a household caring for someone with a mental illness.

Spokespeople for a variety of carer support organisations also highlighted issues which increased stress to carers and their families. The Alliance for the Mentally Ill Australia (1993, 471) noted the unreasonableness and dangers inherent in expecting frail, elderly parents (generally mothers) to care for large (sometimes psychotic) adult children with no help. Lococo (Support Group for Relatives of People with a Psychiatric Disability) and Carberry (Association of Relatives and Friends of the Mentally Ill) made submissions to the Burdekin Report which spoke of the severe stress that becoming carers meant for the other children, marriages and mental health of carers. (Burdekin, 1993, 471). It was pointed out that the cost of family and other relationship breakdown and mental stress would (indirectly) cause an increase of costs to the government via health, social and legal services in the long run.

From the foregoing, it can be seen that the stress placed on carers and other family members are extreme. As in other areas of mental health, the lack of support services makes the task even more difficult.

➤ *Family finances.*

Carberry (1993) and Skews (1993) – both representatives of Association of Relatives and Friends of the Mentally Ill to the Burdekin Report (1993, 471-474) and also Donnelly - National Carers' Association, reported in Burdekin (1993, 455) mentioned the financial hardship that being a carer for someone with a mental illness could bring. Giving up work in order to be available for caring; moving to different (generally more expensive, urban) areas where psychiatric services were more accessible; spending on private treatment (when public treatment proved too inaccessible or inflexible); and paying for medications with fewer side effects than were allowed on the pharmaceutical benefit scheme were all mentioned as expensive aspects to being a carer.

The range of support services available to carers was fairly similar to the level of services provided to people with mental illness themselves. Almost none. Donnelly (National Carers' Association, 1993, 477) noted the large amounts of money generated by selling decommissioned mental hospitals and by shifting the responsibility for caring (previously held by governments) to families. Also noted was how very little support or money was ever shifted into the hands of carers along with the responsibility of care.

Very often the alternative to becoming a carer is homelessness for the person with mental illness. Few people would accept this as a "free choice" to take on an extremely costly role when the alternative may be to see your loved one (often your child) subjected to homelessness and the violence, sexual abuse and poverty that homelessness so often entails. The alternative is especially horrendous considering the nurturing, selfless, tireless role that parents - especially mothers- are expected to play in this society.

The role of carer seemed to fall particularly heavily on women. The "Mother and Son" situation where a son takes charge of a mother suffering from Alzheimer's is not unique, but it is not the norm. Women were far more likely than men to become carers. They were often expected to sell homes (because services were unavailable where they lived), give up jobs (because of the extreme time demands made by the role of carer), and provide care for relatives with physical or mental illness as a result of societal norms:

*Women are far more likely to become home carers, and to be expected to carry the responsibilities for the sick person... and be expected to also maintain high levels of care for the [rest of] the family at the same time... With the high level of socio-political push that home based care is best, they will be increasingly expected to provide it, feel guilty and be condemned as selfish if they do not. (The Burdekin Report, 1993, 136).*

An interesting (and rather galling in view of the difficulties inherent in the role of carer) sidelight is that women (especially mothers) are also often blamed for the mental illness of the person that they care for. The Burdekin Report (1993, 466) noted that GPs, nurses and other mental health professionals still sometimes encouraged feelings of self-blame in families even though the ideas of families being to blame for their member's mental illnesses was an outmoded psychiatric approach.

Consider, also, the extreme social pressures put on families of people with mental illness in Australia to take on the role of carers. Kinnear and Graycar (1983, 81-82) noted that "community care" should more accurately be named "family care". In order to "reprivatise" caring, the government regularly invoked the "moral duty" of the family to care for and provide for its dependant members. The family was thus manipulated into serving this caring function for the convenience of the state.

Kinnear and Graycar (1983, 81-83) reinforce that the burden of care falls disproportionately on women, and that the personal costs to these women was often very high. Many had to give up work to become carers and so often became dependent (either on a man or on the state) themselves. Such a decision was deemed in women to be no less than their duty. Men were seldom expected to make such sacrifices.

Kinnear and Graycar (1983, 85) also drew several conclusions about the outcomes of the onus of

care in Australia moving to the families of dependent relatives:

*The picture that emerges is of a caring situation which involves disruption and adjustment, often resulting in the isolation of the caring family from almost all other informal and formal networks. In turn, this isolation increases the pressures that result in cumulative social, emotional and financial costs. It is notable that family care entails these heavy costs because embodied in the current rhetoric is the belief that community care is a less costly form of care.*

Once again, as with most of the costs that fall on mentally ill people themselves, costs that fall on carers as a result of the policy of deinstitutionalisation were not directly accounted for in mental health budgets. They might show up indirectly in increased health care costs, in taxes lost because carers were unable to work outside the home, in the costs of divorce and counseling as the strain told on families. But the direct costs were "externalities" and would not be found accounted for in any State Government mental health budget. Access Economics (2002, 31) made what they considered to be a conservative estimate of "carer costs" for carers of people with schizophrenia only in Australia in the 2001 year to have been \$A111,500,000. This figure excluded such difficult-to-quantify costs as stress.

One category of people that seem to bear extensive costs when people with mental illness were not adequately treated was the dependent children of these people. Evidence presented to the Burdekin Report (1993, 366) suggested that there was a profound lack of appropriate accommodation for people with mental illness and dependent children. Being the dependent child of someone with an untreated mental illness often meant a child coping with continuous stress and chaos and sometimes having to assume responsibilities generally associated with adults. These children received little or no help, counseling or support.

Dependent children, therefore, tended to either lose their mentally ill parent or to take on a role of carer for them and for any other children. This, combined with the instability and uncertainty that children experience in an environment where proper support is not provided, led to extensive (but difficult to quantify) costs being borne by these children.

Guy (1996, 9) cited a recent Australian study of 300 people with mental illness who also had dependent children. This study found that any treatment the parent received tended to completely ignore the existence of the children. The children and the (often ex) partner who might assume control over the children if domiciliary care was provided to the parent with mental illness, were given no support, no information and no counseling. This report estimated that 27,000 children across Australia were living with a parent suffering severe mental illness. Perhaps many more. One of the researchers at the Early Psychosis Research Centre who carried out the study noted the following:

*We have found that while some children coped reasonably well, for many their parent's illness was, and remains, a terrible burden. Many adult offspring spend years feeling responsible for the illness their parent suffered; they worried about when the next episode may occur... (Cowling, 1996, 9).*

At least with the children of people with mental illness it cannot be rationally argued that they should have chosen their parents better.

### **3. Other (Non-Mental Hospital) Government Institutions**

As seemed to be the case in the United States, there was evidence in New South Wales of extensive "transinstitutionalisation". This could be argued to be taking place when people with severe mental illness go to boarding houses and hostels, but it also happened with other, directly government funded institutions. Particularly General Hospitals and Jails. The evidence and problems with each of these institutions as a place for treatment of people with mental illness will be discussed in turn.

### General Hospitals

Professor Vaughan Carr, of Newcastle University, (1993, 142) suggested a substantial crossover between physical and mental illness. He estimated that about 30 per cent of patients in general hospital beds also had psychiatric disorders and that between 30 and 50 per cent of psychiatric in patients also had a serious physical illness.

Storm (2002, 11) also stated that many people with mental illness had a co-existing physical illness or set of illnesses that would be best treated in a general hospital. The question arises, however, apart from those general hospitals with co-located psychiatric areas (at which a total of only 924 beds were available in New South Wales in June 1998 - National Mental Health Report 2000, 181), "how well set up are general hospitals to deal with the large amount of mentally ill patients they seem to have in their wards"?

Pakula (2001, 21), the recently-resigned Illawarra director of psychiatric services, was interviewed about the situation in Wollongong. The report he gave was not heartening. Pakula noted that "the necessary community mental health services just don't exist." Public hospitals in Wollongong were also not coping well with the number of mentally ill patients coming in. These units just weren't set up for the severity of mental illness that some of the patients displayed. Both Labor and Liberal governments were guilty of moving patients out of institutions without providing adequate support in terms of housing, health, general hospital psychiatric specialists and services like social workers and psychologists.

The shortage of beds and the sometimes overly brief stay in hospitals was also supported by the "revolving door" scenario explained by charitable workers. People noticed by hostel and shelter workers to be physically or mentally ill were frequently either unable to gain an admission to hospital, or are admitted, but let out so quickly that they had not been adequately stabilised - let alone any discharge planning done (Sydney City Mission et al, 1997).

### Jails

Because of the lack of psychiatric assessment of prisoners in New South Wales (Burdekin, 1993, 753-754) it was difficult for the Burdekin Report (1993) to estimate the number of prisoners with mental illnesses with any certainty. Professor Brent Waters (of the Prince of Wales Hospital estimated that between 30 per cent and 50 per cent of young people in Sydney's detention centres had a mental health problem. Whether the same percentage applied to adult facilities was not known. According to Burdekin, (1993, 754): "A startlingly high proportion of prisoners (82 per cent) had suffered at least one "mental disorder" at some point in their lives. However, in this case the term "mental disorder" included alcohol and drug abuse. Whilst drug abuse is positively correlated with mental illness (either as a causative factor or in an attempt to self-medicate) most people would not consider drug abuse to be a mental disorder.

Jacobsen (2001, 4) cited a Corrective Health Services survey that one fourth of female prisoners and one eighth of male prisoners were currently suffering from a severe mental illness and that half of all female prisoners and one third of male prisoners had a history of mental illness.

The Sydney Morning Herald (2001, 12) put the criminalisation of mental illness bluntly:

*Several recent studies show the State's prisons are, in part, last stop, old-style lunatic asylums. But politicians, in the senseless battle to outbid each other in law-and-order auctions, ignore these inescapable and shameful findings.*

What was clear to Burdekin was that conditions in jails were not therapeutic for people with mental

illness. Singling out New South Wales prisons for “especially severe condemnation”, Burdekin (1993, 761) cited a number of aspects of prison life as being particularly detrimental to inmates with mental illness. Conditions for both male and female prisoners with mental illness were extremely difficult. Jolly (1993, 771) consultant psychiatrist to the New South Wales Prison Medical Service commented that the system of segregating people having a psychotic episode would “almost inevitably predict a worsening of the psychotic condition”.

Conditions for female prisoners with mental illness were substantially worse. Burdekin, (1993, 771) wrote that in Mulawa Women’s Prison in Sydney, women thought to have suicidal tendencies (and this would include a fair proportion of people with untreated mental illness) are (sometimes stripped naked) locked into one of two “dry cells” with only a toilet (in one cell, not flushable) and a gym mat on the floor. Hardly conducive to treatment. Mulawa contained no psychiatric facilities and transfer to an external mental hospital could take up to 14 weeks (Burdekin, 1993, 778). The trauma and exacerbation of mental illness which could take place in such a long space of time would greatly add to the burden put upon the woman in question, her family, and quite possibly society in general.

Given the lack of facilities and support available outside prison, it was quite likely that people with an untreated mental illness would reoffend. Dr Ronald Barr, a forensic psychiatrist practicing in Sydney gave an example of this to the Burdekin Report:

*This was a young man serving a short prison sentence following a fairly trivial offence... and towards the end of the sentence, we became aware that he had nowhere to live on leaving prison – that he’d essentially been living on the streets prior to the offence, and unless something was done quickly he would return to living on the streets. We wrote to the community mental health clinic...they were not able to offer any help with accommodation. The man left prison, went back to the streets and...reoffended within a matter of weeks, and simply came back to prison again. (Barr, 1993, 794.)*

Dr Barr also told the Inquiry that the average cost (in 1993) to hold a prisoner in a cell was \$A50,000 per annum. This did not seem to him to be cheap housing.

The Inquiry (Burdekin, 1993, 756-760) also heard evidence that people with untreated mental illness were more likely to go to jail than others. Reasons given were the bizarre behaviour that untreated mental illness sometimes caused; the inability to pay fines because of poverty or mental disorganisation, thus leading to an unnecessary jail sentence; the difficulty that some lawyers had in communicating with or defending adequately their mentally ill clients.

Evidence was given to the Inquiry that not only were many prisoners denied treatment, but that when treatment was given, it tended to be in the form of drugs only. Counselling was seldom available. The drugs prescribed might or might not get to the prisoner for whom they were prescribed, as there were allegations of a thriving trade in medications in jail. (Burdekin, 1993, 772.)

Miller (1996, 1) also cited cases of neglect and lack of treatment within the New South Wales Jail System. Leonnie Manns, the executive officer of the Mental Health Coordinating Council, was quoted by Miller on the topic of the discrimination between physical and mental health issues in prison:

*A person (in jail) who has come from a psychiatric hospital and is not deemed to be a forensic patient (potentially suffering from a mental illness and assessed for treatment), that’s a criminal state of affairs. If you have any other illness in jail, your medical needs are met. I believe mental illness should be the same.*

#### **4. Other (Non-Government) Institutions**

Horin (1997, 3) wrote of the “dumping” of homeless mentally ill people on charitable shelters in



Sydney. Whereas once the ICMS (Inner City Mental Health Services) at least provided some health professional expertise and crisis services to homeless shelters, this service was now being cut back as homeless mentally ill people were being ignored in favour of people with acute mental illness (who had a better cure rate).

Two reports were recently written by a coalition of charities very concerned at the perceived shift in responsibility for homeless people with mental disorders. St Vincent de Paul, Sydney City Mission, the Salvation Army, Wesley Mission and the Haymarket Foundation jointly published 'Shifting the Deckchairs' (1997, 8) and 'Down and Out in Sydney' (1998, 12-14). In these reports they repeatedly stressed the insidious attempt by Government to shift responsibility for these people to the charitable sector and the withdrawal of what slight support was previously given by the government in this area:

*75 per cent of our time is spent with people suffering from mental illness. Two years ago I would have said 50 per cent. We're the biggest psych ward in NSW. (Sydney City Mission et al, 1997, 4.)*

The "Down and Out in Sydney" Report (St Vincent de Paul et al, 1998, 1) found that, of homeless people in or contacting inner Sydney hostels and refuges run by St Vincent de Paul, Sydney City Mission, the Salvation Army, Wesley Mission and the Haymarket Foundation, 75 per cent had at least one mental disorder. These charitable organisations were also very certain of the motivations of generations of governments in choosing to implement deinstitutionalisation as they did:

*There is no doubt, as far as we are concerned, that the root cause of these funding cutbacks is the imperfect execution of well intentioned health policies, such as the process of deinstitutionalisation, which successive governments have viewed as being primarily a way to save money. Money has been saved but at the cost of lives. (St Vincent de Paul et al, 1998,2)*

Whilst this paper argues that from some perspectives, money has not even been saved by the process of deinstitutionalisation in New South Wales, there is no disagreement on the charge that the way this policy has been pursued has cost lives.

This increase in responsibility for homeless people with mental illness came at a time when support services were being cut still further. Sydney City Mission et al (1997, 8-11) noted that ICMHS (Inner City Mental Health Services) were drastically cutting back on the clinics that used to be held at hostels for people with mental illness. This step had been taken with no discussion with the charitable organisations that ran the shelters. St Vincent de Paul et al (1997, 11) quoted one (unnamed) hostel worker as saying that the shifting of care for people with mental illness from government to other sectors was profound:

*Before you felt as if you were involved in important collaborative work. Now no-one seems to care. Homeless people are seen as being the hostel's problem not a shared responsibility.*

Once again, these charitable institutions were in little doubt of the motivation behind the cuts. The following quote is lengthy, but it raises issues that are at the heart of this paper:

*One document that has caused our (charitable) services considerable alarm is the Resource Management Plan for Mental Health (Boyd) distributed by SESAHS in April. There are a number of points made in this document that we wish to comment on...The options are based on "an extensive modelling exercise" aimed to 'move SEHAS towards equity of distribution of mental health dollars per weighted average head of population'. Firstly, we find the 'weighted head' exercise spurious to say the least. To use an economic model using supposedly 'acceptable indices' to determine the deployment of services to meet the needs of human beings is taking the economic rationalist paradigm to ridiculous and dangerous extremes...It also needs to be recognised that at no time were we consulted before the decision to opt for Option C was made. We were told this was the case and that \$100,000 would be disappearing*

*from the ICMHS budget in the coming twelve months. This \$100,000 is to be saved mainly by "efficiency measures". In our experience, "efficiency measures" is an economic rationalist euphemism for "cuts". (Sydney City Mission et al, 1997, 13-14.)*

From this it would seem that deinstitutionalisation has not merely been a process of cost shifting between state and federal governments, but also between government and other groups in society. Carers and charitable institutions in particular seem now to be expected to provide care for people with mental illness whether or not they are physically or financially able or have the expertise to do so.

Long and Phelan (1992, 1) also highlighted the shift of care from the state to charities. They commented that part of the recommendations of the Richmond Report (1983) was that there be a transfer of funds to charitable institutions to match this transfer of responsibility. Unfortunately, governments had "sought to cut corners" and the promised funding never eventuated.

A Sydney Morning Herald editorial (1997, 14) noted that governments had found it "preferable to dump" patients rather than to spend money on services such as finding appropriate accommodation, discharge planning, social workers and suchlike. This editorial also noted that in the 14 years (at the time the editorial was written) since the Richmond Report (1983) was published successive governments had been perfectly well aware that deinstitutionalisation would only succeed (from the patients' perspective) if proper support services were provided. Aware, yes; but wilfully and cynically deaf.

## 5. Society in General

According to Lennane (1994, 8), of the Institute of Australasian Psychiatrists, a study in Denmark (with a similar population and policies to New South Wales) indicated a 60 percent increase in suicide and a 50 percent increase in homicide over the past six years by people with a serious mental illness. No mental illness related homicide figures for New South Wales were being collected at the time that this article was written (1994). Winerip (1999, 3) also noted that whilst people with mental illness receiving treatment posed no additional risk to society than any average member of the community, the same was not true of people whose mental illness went untreated. People who added substance abuse to untreated mental illness added a significant risk to the community.

According to SANE Australia (1998b, 1) whilst people who were receiving treatment for mental illness are no more likely to be violent than anyone else, there was a relationship between untreated mental illness and violence. They also pointed out that this relationship is less strong than is the relationship between violence and alcohol abuse or violence and being a male between 15 and 25 years of age. However, fear is generally created in people approached by or witnessing people behaving in a bizarre fashion – whether this fear is justified or not, it is a cost to society. It is also extremely difficult to quantify – does it make people more likely to travel only in the perceived safety of their cars and forsake public transport? Does it make them worried and thus more prone to depression? Accountancy is not good at making such estimates.

Another group who were quite vocal about "the costs to society" were those property owners who had homeless people in their (often recently gentrified and very expensive) suburbs. For example Matheson (1996, 15) gave an example from the inner Sydney suburb of Surry Hills. A group based in that expensive inner-city locale began a campaign to shut down long-standing local hostels and providing busses to move homeless and mentally ill people to the (coincidentally less expensive) western suburbs of Sydney:

*The group's inaugural newsletter called the homeless "human scum", accused charities like the Salvation Army and St Vincent de Paul of competing for "the quite lucrative takings from the pension cheques of its clients" and warned, "the only shadow on our suburban idyll is the long one cast by those welfare joints and their clientele."...*

It is to be hoped that this group was not representative of the views of all home-owners in the area.

The losses of property owners in wealthy inner city suburbs might be calculated on the basis of what their properties would be worth if there were not large numbers of homeless people with mental illness and nowhere else to go nearby. More difficult to calculate is the cost of the "us" and "them" mentality that might grow out of such "gated" mentality on the part of our most affluent and eloquent citizens. Certainly alienation, class hatred and falling social services (as certain parts of society see public amenities as none of their concern because they neither use nor see them) are a foreseeable consequence. How can such costs be estimated?

### **Has Deinstitutionalisation Actually Reduced Costs?**

This is a difficult question to answer. It is too broad. This question will be broken down into a series of smaller questions. An answer to each of these is still tenuous, and a number of normative issues are raised, but the question seems to be worth addressing. First of all, a caveat on the figures used in the following discussions which come from official reports. Numbers in mental health and which cost is reported where and how estimates are formed are extremely fluid and definitions have changed over time.

Has deinstitutionalisation saved the State Government of New South Wales money? Well

What also needs to be taken into consideration is answering the question of whether deinstitutionalisation saved the State Government as a whole money is the question of transinstitutionalisation. Jails are state funded so the costs of incarceration fall to them. Also, the (difficult to quantify) costs imposed on people with mental illness and their families might lead to greater expenditures on, for example, physical health care in state funded hospitals because of stress. When these costs are considered, it is not at all clear that deinstitutionalisation saved the state government money.

How about Governments in general? A cost saving here is even less likely as deinstitutionalisation leads to an increase in the number of people (both with mental illness and their carers) requiring federal pensions. Deinstitutionalisation (as currently practiced in New South Wales) leads to longer, more severe illnesses because of the lamentable treatments (not) available. Because of this, opportunity costs should be considered. Both the people with mental illness and their carers have their ability to contribute to revenue severely diminished. It seems unlikely that deinstitutionalisation has led to a cost saving for government when State and Federal are considered together.

How about for New South Wales in total? When one calculates all the costs to all the people in New South Wales (both monetary and otherwise) enumerated in this paper, it would seem extremely unlikely that deinstitutionalisation has been anything but extremely costly in its effect.

In New South Wales, it would seem that the number of people institutionalised peaked a few years later than in the United States, but it seems to have been pursued with equal gusto. Also with the same lack of support services that would make "care in the community" anything other than a euphemism for shifting responsibility from the state budget to carers (generally families); to the federal government (generally disability support pensions); to charities; and to the people with mental illness themselves, in the form of shorter, more painful and more chaotic lives as well as inflicting various sorts of violence on these people by knowingly (or uncaringly) placing them in situations known to be dangerous and debilitating. The amenity and safety (real and perceived) of society at large could also be argued to be affected by the prevalence of homeless people as well as loss of taxation revenues from people with mental illness who (if appropriately treated) might pay tax and their carers (who would not be removed from the workforce by the pressures of being carers).

Could it be that the State Government was all unknowing of the fact that deinstitutionalising people without funding appropriate support facilities for “community care” would result in such huge burdens being dumped on certain sectors of the community? Even if the State Government was completely unaware (which stretches credulity) of similar findings in the United States’ and England’s experience of deinstitutionalisation, the Burdekin Report was published in 1983. After that time any possible excuse of ignorance ceases.

Since that time charitable groups such as St Vincent de Paul, Sydney City Mission and the Salvation Army have repeatedly warned of the increase in homeless people with mental illnesses. For example, the ‘Shifting the Deckchairs’ Report (St. Vincent de Paul et al, 1997) and ‘Down and Out in Sydney’ (St. Vincent de Paul et al, 1998). These suggested that government support services had worsened, not improved. Media comment since the release of the Burdekin Report (1993) such as Guy (1996, 9) also showed that the extreme dearth of government support services had continued long after the Burdekin Report (1993). The National Mental Health Report 2000 (2000, 181) again showed that the number of psychiatric beds in New South Wales had declined from 2,652 in 1993 to 2,128 in 1998 (the last year for which this report had data). Lack of knowledge is therefore not a valid excuse for this lack of services.

### **Where does accountancy play a role in this?**

It would seem incongruent that a state would choose to pursue a policy, which imposes far greater costs than it saves. That is, it would seem bizarre to any discipline other than accountancy. For a business, choosing to pursue methods that would enhance its own profitability at the expense of its rivals or of the community would make a degree of sense – maximising shareholder wealth. But the State? There are a variety of different views of what the role of the State should be (and here the term “State” is used in its wider meaning of Government, not the State Government in particular). But is it not a very unusual view of the role of the State that would applaud shifting costs from one particular budget to another budget and to other groups of the community? After all, the community is still a part of the total society of which the Government is supposed to enhance the well-being. This is especially incongruous if the total costs were made much larger by this shifting.

Only in accountancy-related thinking does such a decision make sense. Accountancy takes a very narrow perspective. If told to account for a policy change from the perspective of a state government, it will tend to do so only accounting for items directly impacting on that particular, narrow entity. “Externalities” (those costs falling elsewhere than on the narrow entity being accounted for) are ignored. This is the outcome of the entity assumption.

Many of the costs, too, shifted to carers and families; to charities; and costs borne by people with mental illness are difficult to quantify. Accountancy tends to disregard costs that it cannot state in monetary terms, this is known as the monetary assumption. Valuing the cost of a rape, a life cut short by violence, avoidable disease or by suicide is very difficult to quantify. The variation in damages awards of court cases dealing with such matters as the harm done by slander or physical injury offers evidence that society in general is not good at valuing such things. In the same line, it seems clear from this paper that the State and Federal Governments pay increased health care costs for carers with stress related illnesses. Budgets tend not to take account of such indirect increases in costs. No “account” is taken of them.

### **Accounting-related Thinking**

In order to see how accounting-type thinking might influence policy making, and to understand why this may be inappropriate in the case of mental health spending, it is necessary to return to accounting basics for a brief while. What is accounting? The traditional answer from a textbook runs

something like this:

*Accounting is a service activity. Its function is to provide financial information that is intended to be useful in making decisions about economic activity. Business entities, government departments... all engage in economic activity. Most economic activity involves decisions about how to allocate available resources effectively among alternate needs. – (Hoggett and Edwards, 1996, 5.)*

Whilst not denying that accounting is a service activity and that one of accounting's functions is to provide information on which to base economic decisions, some authors claim that the role of accounting in something wider than this:

*The systematic understatement of accounting's significance is reflected in the images of accountants in popular culture: as the technician, the innocuous bookkeeper, the "ink-stained wretch", the record keeper whose lack of creativity and imagination makes him trustworthy. (Tinker, 1985, xv.)*

### **Accounting-type Information and Public Policy**

The outcomes of policy decisions such as the ones made in New South Wales regarding mental health funding, however, suggests that knowing that accounting needs quantification and has an emphasis on "the bottom line" and changing one's evaluation strategies to take account of this knowledge are two very different things. It seems that we, as a society, acknowledge that some things are very difficult or impossible to quantify. We know that societal decisions should not be made purely (perhaps even substantially) on the basis of accounting – type figuring. But it seems to happen anyway. Johnson (1990, 249) suggested that "the bottom line" had become such a dominant concern in mental health programs that any other element in the equation seemed to have got lost.

Accounting, then, is not an objective, value-free, scientific undertaking. At least as far as the questionable assumptions we call "The Monetary Assumption" and "The Entity Assumption" go. The assumption that all things shall be put into dollar terms serves to either hide or at least to devalue those things that are difficult or impossible to quantify. The entity assumption obscures those costs borne by anyone outside the narrow fenced area that is called Health Budget. What effect has this misuse or misunderstanding of the appropriate use of accounting had? Johnson (1990, 105-106) stated the difficulties from a practitioner's viewpoint:

*The fact is that politically, it is extremely fortunate that so many of the costs of caring for chronically mentally ill people are hidden, because that fact covers up a lot of problems. For one thing, responsibility is diffuse and accountability even more... But as in three card monte, what you see is not necessarily what you get, and nowhere is that principle in operation to greater effect than in obscuring the whereabouts of the mentally ill, not to mention the costs of keeping them there. Strictly from the states' point of view, the mentally ill were and are better off living somewhere "in the community", where they are on somebody else's entitlement rolls and maybe even in someone else's catchment area. (Johnson, 1990, 105-106).*

The point is, then, that accounting functions here on a number of levels. It hides costs that fall afoul of either the entity or monetary assumptions. It also provides ammunition to defend decisions based on its (mis) use as well as giving an aura of sensible rationality to those who depend upon it. Morgan and Willmott (1993, 17) wrote of the "tendency to regard accounting techniques as a weapon that different groups seek to deploy to their advantage". On a similar theme, Boyce (1997, 14) pointed out the useful mystification accounting causes in other (non-accounting acolytes) as a reason for its defensibility. Accounting brought with it the "aura and social authority of expertise" and could be used to "validate the existing power-based normative order of society". In short, the way in which accounting abets and is implicated in economic rationalism has been widely discussed and elegantly argued by others (for example Rose, 1991, 690; Boyce, 1997, 10-13; Morgan and Willmott, 1993,

10-16). It is the contention of this article that the way in which accounting was (mis) used in mental health policy decisions in Deinstitutionalisation provides a good case in point of this.

In this article, the development and implementation of deinstitutionalisation in New South Wales were traced. An evaluation of the policy was carried out to see whether a pattern of cost shifting could be found. The outcomes of this evaluation strongly suggested rationalist forces were dominant rather than the humanist forces from which much of the rhetoric in the Richmond Report was drawn. The results of this examination of deinstitutionalisation suggests that many of the choices made in the way in which this policy was implemented had more to do with cost shifting and economic rationalism than to do with the care and inclusiveness of people with mental illness.

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