

2006

Social and Historical Power Plays: A Foucauldian Gaze on Mental Institutions

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Publication Details

This conference paper was originally published as Smark, CJ, & Deo, H, Social and Historical Power Plays: A Foucauldian Gaze on Mental Institutions, College of Business Symposium, UWS, 7-8th November, 2006.

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Keywords

Asylums, Foucault, Historical, Mental hospitals, accounting, budgets, deinstitutionalisation, NSW

Disciplines

Business | Social and Behavioral Sciences

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ABSTRACT

This research focuses on New South Wales' process of deinstitutionalisation using a Foucauldian lens. By using this filtering process, this research aims to highlight the interchange between the concepts of power and knowledge as two vital and interrelated forces. These forces are seen as dominant forces within the process of deinstitutionalisation in New South Wales.

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INTRODUCTION

Deinstitutionalisation from mental hospitals is a policy that has been adopted since the Second World War by several senior western economies. This policy, from a Foucauldian perspective is seen as driven by power and knowledge and has meant that 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 case study is located in the State of NSW (the most populous state in Australia) but illustrates well some of the problematic outcomes which can occur if accounting-related thinking is given too much emphasis in policy and funding decisions. 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 Foucauldian reality of "Community Care" as implemented in NSW 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).

The outcomes discussed in this case study from a Foucauldian perspective demonstrates the complicated nature of power and knowledge western economies where there is some question as to whether accounting-type information has been privileged above other forms of '*power reality*' in policy-making. The limited scope of this case study and this forum does 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 or capture from a power and knowledge dimension is a particular version of social 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) and Richardson (1987, 341-343). 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). This paper is divided into a number of sections, firstly, discussions about the Foucauldian theoretical framework secondly, a brief history of the mental case study settings, discourse between the state and the federal government, thirdly the evaluation of the mental care policy and finally conclusions.

THE RESEARCH THEORETICAL FRAMEWORK

The lens for this case study is the Foucauldian framework. Mental institutions from a Foucauldian framework are seen as power and knowledge interplays that have influenced accounting policy setting process in the mental institutions in NSW state. Furthermore, the historical processes of the mental institutions are documented well through the process of the Foucauldian archeology, which basically views events from a historical perspective and follows a particular timeline to explain events (Foucault, 1977, 1984). The events are further explained through the Foucauldian process of genealogy, which focus on certain key events from a particular historical time-line. Generally the writings of Michel Foucault's deals with issues of social behaviour in areas such as psychology, criminology, mental illness and medicine (Foucault, 1977, 1984), Furthermore, Foucault's studies were conducted in socially "abnormal" settings, such as a mental institution and a prison (Foucault, 1973), his explication of the relationship between power and knowledge (Foucault, 1984), provides a passage through the case study of the mental institutions in NSW. The mental institutions in NSW are seen from the Foucauldian perspective as structures that provide "disciplinary surveillance" and "disciplinary gaze" and controlled by State governments that finance and control the day to day running of these institutions which give tangible representation by his "panopticon eye", the instrument of ultimate surveillance (Foucault, 1973, 1977, 1984), furthermore, other studies that have incorporated power in accounting and organisations (Clegg, 1989; Armstrong, 1994, Grey, 1994).

THE ARCHEOLOGY & GENEALOGY OF MENTAL CONDITIONS IN NEW SOUTH WALES

From a Foucauldian perspective the archaeological foundations in NSW psychiatry (and in all of Australia) was often strongly influenced by psychiatric practices in Britain and the United States of America (USA) (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 syphilis. 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 and 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 NSW in 1949 (Kosky *et al.*, 1991, 7). In 1952, chlorpromazine, the first antipsychotic drug began to be used. Antidepressant drugs followed (Puckett, 1993, 398). 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 USA and the UK. Overcrowding and understaffing led to these institutions being custodial rather than therapeutic and there was a lack of differentiation between different categories of patients hampered treatment. The overall implications therefore were that people were admitted to mental hospitals with senility, mental retardation and alcoholism (Lewis, 1988, 77).

DISCOURSE BETWEEN THE STATE & FEDERAL GOVERNMENT

The overall discourse from the Foucauldian perspective outlined the power plays between the Federal and the State governments where 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. Furthermore, funding for psychiatric services remained substantially a state matter (Lewis, 1988, 33). The Australasian Association of Psychiatrists (formed in 1946) also reported on overcrowding and poor conditions in state mental hospitals in 1950 (Pargiter, 1991, 4-5) and 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 and 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). 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.

THE POWER OF DEINSTITUTIONALISATION POLICY IN NEW SOUTH WALES

The power and knowledge outlined from a Foucauldian perspective and supported by Puckett (1993, 398-399) placed the beginning of deinstitutionalisation in Australia in the mid-1940, although the policy was undeclared until much later. Furthermore, 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 USA. The "Leading the Way" Report (NSW Department of Health, 1993, 58), also suggests that (just four years later than in the USA) the total number of in-patients resident in

NSW's mental hospitals peaked in 1959 at 12,668 people. The number of patients (as a proportion of NSW's population) peaked in 1954. The average length of stay in NSW 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.

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 "*integrated community networks*"; that services allow people to live in their "normal community environment"; and those 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 case 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 and (iv) provisions for opportunities for training existing Fifth Schedule hospital staff for new roles in community and specialised hospital services.

THE POWERFUL SOCIAL POLICY FORMULATION

The first stage in Puckett's (1993, 415) framework involves examining social policy formulation. This includes from a Foucauldian perspective 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 and was published in March 1983. The Chairman of this Inquiry was D.T. Richmond and therefore 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 such as: (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 and (6) to identify a broad strategy and mechanisms for implementing recommendations arising from the terms of reference.'

In other words, the Richmond Report (1983) from a Foucauldian perspective is a power and knowledge structure which was a reasonably far-reaching report on practice. In summary, the broad strategy that it recommended was that there should be a change in emphasis in mental health in NSW. 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", (2nd May, 1996), Robert Manne was interviewed on the issue of deinstitutionalisation in Australia furthermore, Manne commented that the right wing (taxpayers revolt movement) and the left wing (institutionalisation is oppressive movement) of Australian politics united behind deinstitutionalisation. Also deinstitutionalisation (as was the case in the United States) took place without adequate community care facilities being provided. 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. 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 NSW. 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 while welfare and community services believe they are a health problem and the Commonwealth says they are a State responsibility and the State says the Commonwealth should share the load and finally, some community agencies accommodate them but feel that they shouldn't, and many of them end up in jail. These comments suggest that the NSW experience of deinstitutionalisation has been comparable to the USAs' experience and perhaps as an exercise in legitimisation, (as deinstitutionalisation was already well under way in NSW).

POWER & KNOWLEDGE IMPLICATIONS ON SOCIAL PROGRAMS POLICY

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 NSW 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 NSW to have been remedied and 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 and 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: inpatient facilities, outpatient treatment services, crisis teams, mobile teams, community mental health clinic staff, living skills centres, accommodation support staff, non-government organisations and 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: continuity of care, discharge planning, integration of hospital and community services and case management and (3) treatment also needs to be monitored which also requires treatment follow –

up, medication maintenance, access to alternative treatments if required and 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 were 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 that 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 (NSW Department of Health, 1993, 61-62), particularly inconvenient places in NSW to have a mental health crisis still included all of the following regions in 1991 for example, the 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 NSW and 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 NSW 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 in NSW (National Mental Health Report 2000, 52) registered only a total of 33.8 inpatient psychiatric beds per 100,000 populations by 1997-98. Furthermore, 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 societies 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 for example, in Wollongong 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 NSW 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 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 NSW in human terms. For a fuller account of the few community care programs recommended in the Richmond Report which were ever provided, 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.

THE INTERPLAY OF POWER & KNOWLEDGE ON ACCOUNTING

From a Foucauldian perspective the link between the power and knowledge 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 and the 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 NSW money? Well what also needs to be taken into consideration is answering the question of whether deinstitutionalisation saved the State Government as 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 NSW) leads to longer, more severe illnesses because of the lamentable treatments (not) available and because of this opportunity costs should be considered which includes 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 NSW 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. Having reviewed the evidence from NSW on the policy of deinstitutionalisation where evidence clearly suggests that in NSW rationalist forces drove deinstitutionalisation.

In NSW, it would seem that the number of people institutionalised peaked a few years later than in the USA, but it seems to have been pursued with equal gusto and 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 USA and UK’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 NSW 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.

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 and 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 cost 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 and 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 and budgets tend not to take account of such indirect increases in costs.

CONCLUSIONS

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” goes. The assumption that all things shall be put into dollar terms serves to either hide or at least to de-value those things that are difficult or impossible to quantify. The entity assumption obscures those costs borne by anyone outside the SGHB wall. What effect has this misuse or misunderstanding of the appropriate use of accounting had? 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”.

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