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# Can deinstitutionalisation work? Mental health reform from 1993 to 1998 in Victoria, Australia

## ABSTRACT

### KEY WORDS

psychiatric  
deinstitutionalisation;  
mental health  
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implementing  
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reform; community  
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in the community

From 1993 to 1998, mental health services underwent a major transformation in Victoria, Australia. The changes aimed to create a community-oriented service system under general health, instead of one based on psychiatric institutions. Community treatment was to be the first option, with hospitalisation as a backup. State psychiatric institutions were closed, and replaced by new area-based mental health services, providing local inpatient, residential and community-based care. This included mobile extended hours services, available seven days per week.

The article examines the rationale and nature of the changes. It argues that Victoria's reforms largely avoided problems usually attributed to deinstitutionalisation. This was because alternative services that were comprehensive and locally accessible were established before institutions were closed. Start-up funding from federal and state governments helped this transition, with institutional savings reinvested in new services. By 1998, the changes were substantial, although institutional practices were not transformed as thoroughly as the structures.

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care has been arranged. For reformers, deinstitutionalisation encompasses both the closure of state institutions and their replacement with a range of community-based alternative services, including residential and inpatient services as well as home treatment (Bachrach 1997:23; Hout 1986).

This conception is often broadened to cover the quality of the resulting treatment and care (Bachrach 1997:29-30), and the extent to which people with mental disorders regain their status and rights as citizens (Barham 1992: 98, 151). Both issues highlight the basic goal of deinstitutionalisation, which is the humanising of care for people with severe mental disorders (Bachrach & Lamb 1982:156). The politics of deinstitutionalisation can however, be read in different ways. It can be seen as a progressive

## Introduction

**D**einstitutionalisation is a fraught topic in the mental health field. Few issues of mental health reform are so contentious. The term itself is open to different interpretations. To the lay person for instance, deinstitutionalisation means shutting down psychiatric institutions, thereby releasing inmates (assumed to be permanent residents) into the community, irrespective of whether follow-up

and humane project which recognises the rights of patients to live as normal a life as possible, or as the triumph of neo-liberalism and its agenda of winding back state service provision in favour of the market (Barham 1992: 87-88).

Deinstitutionalisation has been blamed for a number of social ills, such as an increase in the number of homeless people with mental disorders (Lamb & Shaner 1993). Barham (1992: 143) argues that an emphasis on the homeless person with a mental illness distorts the outcomes of deinstitutionalisation. He notes that it is rare to hear from former institutional patients for whom living in community settings has worked well (Barham 1992: 143), yet such studies do exist, in Australia as well as the United States and Britain (Andrews et al. 1990; De Sisto et al. 1995; Harding et al. 1987; Leff et al. 1994).

Problems attributed to institutional closures often reflect flawed or incomplete implementation (Thorncroft & Bebbington 1989:749). In the US for example, community mental health centres were set up from 1963 to meet the service needs of previously institutionalised patients. Instead these centres turned to a new and less disabled group of clients (Turner-Crowson 1993:13-14). Former institutional patients were also given low priority in a new community mental health centre opened in 1975 in Melbourne, Australia (Lippmann 1982), and by new community mental health teams established in the 1980s in England (Patmore & Weaver 1991). Another example of flawed implementation is how, in Britain, money saved from reducing institutional populations was absorbed into general revenue. It is estimated that over the period 1985 to 1991 in England, two thousand million pounds were lost to the mental health budget, money which could have been used to fund new forms of community care (Shepherd 1998:166).

In the US (Turner-Crowson 1993:14-18), and until recently in England (Boardman 2005; Thorncroft & Bebbington 1989), the consequence of poorly managed deinstitutionalisation has been inadequate provision for the treatment and care of former institutional patients, and neglect of the service needs of those

who have never been institutionalised. Arguably this situation could have been predicted, given that changes to mental health services in most countries tend to be reactive rather than planned, and piecemeal not system-wide (Rosen 1999: 177). In Australia and overseas, governments rarely give mental health reform more than passing notice. As Ramon (1988:13) notes: 'the mentally distressed were, and are, neither vote-catchers nor a strong pressure group'.

Against this background, the way Victoria transformed its mental health service system in the 1990s warrants investigation. Victoria was the first Australian state to replace its institutional service system. The new service system was oriented to community care, in line with new national policy directions. Over the period from 1994 to 1998, the state's mental health service system underwent a major overhaul. The changes were striking in both pace and magnitude. By mid-1998, all of Victoria's fourteen separate psychiatric institutions either had been shut or were in the process of closure. To replace them, area-based service networks had been established across the state, providing locally-available inpatient and residential care, as well as treatment in community settings. Another major change was that, apart from the forensic mental health service, management of all public mental health services had been transferred to the general health system.

Clearly, Victoria's reforms comprised a large-scale program of deinstitutionalisation. Given the concerns already noted, it is therefore reasonable to ask about the results of this endeavour. Specifically, did Victoria's approach to transforming its mental health service system avoid the pitfalls encountered elsewhere? This paper seeks to answer that question. It has two main aims. Firstly, it documents the major features of Victoria's mental health reforms. The changes are outlined against the backdrop of how services operated in 1992-93, prior to the beginning of the reforms and before implementation of Australia's First National Mental Health Plan (henceforth called the First NMH Plan) (Australian Health Ministers 1992b).

Secondly, the paper reviews the impact of the changes, identifying what was achieved as well as what was flawed or left incomplete. It also considers what can be learnt about deinstitutionalisation from Victoria's approach. The focus is on the period 1993 to 1998, as this was the timeframe of the First NMH Plan, an important source of both ideas and money for Victoria's reform program (Australian Health Ministers 1992b). National reporting for this period provides comparative data on developments in other Australian states and territories (Commonwealth Department of Health and Aged Care 2000; Commonwealth Department of Health and Ageing 2002).

### **The background to Victoria's mental health reforms**

The overhaul from 1993 of Victoria's mental health services came after mental health reform in the state had lost some momentum. The inertia was all the more noticeable as it had followed landmark state developments from the mid 1980s, including the introduction of progressive mental health legislation (State of Victoria 1986) and the first complete closure in Australia of a psychiatric institution. This was Willsmere Psychiatric Hospital, a nineteenth century building in Melbourne's inner eastern suburbs. Opened in 1872 as the Kew Asylum, by 1986, three quarters of its 430 beds were for psychogeriatric patients, with the rest comprising beds for adult and psychogeriatric acute patients or those patients needing medical or surgical treatment (Grose 1986:17). Day program activities were run on site, largely for former patients bused in from the community (Grose 1986:17).

Over the two years of the Willsmere project, some nineteen replacement services were established, enabling Willsmere to shut in December 1988 (Rimmer, Buckingham & Farhall 1988:27). The Labor Government of the time allocated significant start-up funds to enable construction of new facilities and to provide transition or 'hump' funding whilst new community-based services got underway (Grose 1986: 6). The range of replacement services was

extensive. Long-term psychogeriatric patients were transferred to new psychogeriatric nursing homes in eastern, western and southern Melbourne suburbs, to a re-opened ward at Plenty Psychiatric Hospital in Bundoora or to other psychiatric institutions. Less disabled patients were placed in specially built cluster housing facilities in eastern and southern metropolitan suburbs.

For adults, three new acute psychiatric units were built at general hospitals such as Maroondah Hospital in the outer east, Monash Medical Centre in the south and Peninsula Hospital on the Mornington Peninsula, and a new acute ward at Heatherton institution in the south, previously for patients with alcohol and drug problems. In the eastern suburbs, two existing community mental health clinics gained extra staff and new premises, and a third clinic was also established. Other new community services set up in the east included a psychogeriatric day program, and a 10 bed adult continuing care unit, with 24 hour clinical staffing. Local housing was also purchased for residents moving on to more independent living.

The way the Willsmere closure was undertaken set a valuable precedent for the later reforms. For instance, the new service types trialed through this project, such as psychogeriatric nursing homes, acute units in general hospitals and a mobile psychiatric crisis and assessment team, acted as forerunners for services developed over the 1994 to 1998 period. Another critical implementation lesson was how the securing of substantial funding at the start of the project allowed replacement services to be set up before Willsmere closed. Extensive staff re-training was another important feature replicated in the later reform process. Lastly, the Willsmere project generated a network of clinicians, service managers and policy-makers who became advocates for reform and who were influential in the later reform process. Nonetheless, the Willsmere closure remained a one-off at the time, despite plans for it to be the first of further institutional closures across the state at that time (Rimmer, Buckingham & Farhall 1988:26-27).

By 1991, governmental reform malaise had set in. It is portrayed bleakly by Moynihan (1992: 143), a sociologist whose research encompassed the preceding reform period:

Victorian psychiatry's perestroika withered as it took back its old responsibility to incarcerate the 'mad' and provide them with custody and supervision.

Although new state policy directions were launched in January 1992 (Office of Psychiatric Services 1992a), implementation was hampered by the debt and division racking the incumbent Labor Government during its final months in office (Costar & Considine 1992: 7-10). Ironically, in 1991 this government had been successful in securing \$52m for institutional closure from the Commonwealth's Building Better Cities program (henceforth called Better Cities). This funding was for the building of thirteen new facilities in under-served areas to enable closure of a large mental health institutional complex at Bundoora, an outer Melbourne suburb (Psychiatric Services 1993b: 25). The complex comprised the three psychiatric institutions of Larundel, Plenty and Mont Park (recently amalgamated to form the North Eastern Metropolitan Psychiatric Services), and housed one third of the inpatient beds in the state, including separate acute and extended care wards for adult and psychogeriatric patients, as well as wards for forensic patients (Office of Psychiatric Services 1991:2). Despite the \$52m Better Cities windfall however, when the Labor Government lost the state election in October 1992, progress on establishing replacement facilities was still embryonic. The lack of political commitment to reform at that time made the speed and scope of the later changes even more striking.

### **Why was mental health reform overdue?**

By the time a new conservative state government was elected in October 1992, it was evident that Victoria's public mental health system was inadequate, if not detrimental to the wellbeing and recovery of patients. For instance, recent inquiries undertaken in two rural institutions had revealed unacceptable staff practices, including

a disregard for patient rights (Health Department Victoria 1991a, 1991b). These inquiries prompted a statewide clinical audit of all inpatient services, whether co-located with general hospitals or aged care facilities, or in separate psychiatric institutions. The audit report, published in March 1992, showed that the quality of inpatient treatment and care was unacceptably uneven, and fell below required standards in many adult extended care wards (Office of Psychiatric Services 1992b).

What follows is a brief description of the services in place when the government changed hands in 1992. The financial year 1992-93 is also taken as the baseline year before the National Mental Health Strategy (henceforth called the NMH Strategy) began to be implemented. By 1992 in Victoria many inpatient services were still remote from the communities they served, despite this having been noted as a major problem for service accessibility some four years earlier (Rimmer, Buckingham & Farhall 1988: 7-8). For instance, wards at the Bundoora complex provided acute inpatient care for people in suburbs up to 30 kilometres away. The distances involved made visiting inpatients very difficult for relatives and friends, particularly those reliant on public transport.

Problems with services went beyond geographical inaccessibility and included fragmentation and lack of continuity of care between inpatient and community services (Rimmer, Buckingham & Farhall 1988:4-9). Before the changes introduced from 1994, institutions operated largely in isolation from the community mental health services which covered the same geographical catchment area. As a result, a person could be admitted or discharged from a psychiatric institution without ever having had contact with the community mental health service in their local area, and without the latter being informed of the hospitalisation. Of first-time psychiatric inpatient admissions, 80 percent had no history of community treatment from public mental health services, indicating an over-reliance on hospital admission as a first line of treatment (Psychiatric Services 1993b:23).

Timely access was also a major issue. In most parts of the state, the sole public mental health service available on a seven day per week, 24 hour basis was the psychiatric institution or general hospital acute psychiatric inpatient unit. Although some 37 community mental health clinics operated across the state, the overwhelming majority kept business hours, and were not open during public holidays or at weekends (Health & Community Services 1996a: 3). Only a handful of fully-staffed mobile mental health teams operated on an extended hours basis, seven days per week, and all were in the metropolitan area (Health & Community Services 1996a: 3).

In Victoria, even by 1992, institutions continued to dominate the service system, although the incumbent Labor Government had pledged to bring the management of mental health services under the general health umbrella (Office of Psychiatric Services 1992a). The 1988 Willsmere Decommissioning Project had already generated three new acute inpatient units co-located with general hospitals. Nevertheless, to ensure union agreement to the Willsmere closure, institutional beds were re-opened, and a new acute ward built at Heatherton institution in the southern suburbs. In 1992, fourteen separate psychiatric institutions, seven metropolitan area and seven regional, housed most of the inpatient beds (Office of Psychiatric Services 1992b).

Although the service system was still based largely on separate psychiatric institutions, their use had changed. By 1992, inpatient beds for adults and older people totalled 2087, but only 51 percent of beds were for extended care patients (Psychiatric Services 1993b:21). The rest were used for admissions of three months or less for acute treatment or short term rehabilitation. This pattern of use contradicts the popular belief that, prior to deinstitutionalisation, most institutional patients were permanent or semi-permanent residents. Further, 61 percent of extended care patients were aged 65 years and over (Psychiatric Services 1993b:21). The long term institutional wards thus catered largely for an elderly group of patients. This had major implications for the type of replacement services needed.

The use of services had changed in other ways as well, although this was not reflected in how the mental health budget was distributed. By 1992, most clients of Victoria's public mental health services were receiving treatment in the community, not in institutions. For instance, over twelve months from 1991 to 1992, 68 percent of public mental health clients used only community mental health services (Psychiatric Services 1993b:15). Of the others, 22 percent used both hospital and community mental health services, with just 10 percent receiving inpatient services alone (Psychiatric Services 1993b:15). Nevertheless, whilst the institutions catered for only a small proportion of the total clientele of public mental health services, the cost of running the institutions absorbed most of the mental health budget. The distribution of funding did not reflect the new pattern of service use, as community mental health services received only 26 percent of the mental health budget (Psychiatric Services 1993b:27). Obviously this put major constraints on any expansion of community treatment.

### **What were the changes from 1994?**

By the end of the First NMH Plan in June 1998, Victoria's mental health service system had completely changed. A new service framework, launched in April 1994, was largely in place (Health & Community Services 1994). Its contents were familiar, being a continuation of policy directions first outlined in early 1992 (Office of Psychiatric Services 1992a), and further elaborated in a discussion paper circulated the following year (Psychiatric Services 1993b). The big difference this time around was that the policy directions were implemented.

The 1994 service framework set out a blueprint for the new service system. The focus was on providing community-based care as a first treatment option, with hospitalisation as a last resort (Health & Community Services 1994:14-17). To make this possible, services had to be both locally accessible and comprehensive. Under the new service framework, services were organised on a local area basis. First of all, 22 adult mental health services were established

across the state, each linked to a general hospital. All were to have a set of community-based, inpatient and residential services, designed to enable relative self-sufficiency in treating those with serious mental illness in their designated geographical catchment area (Health & Community Services 1994: 25-33). In addition, from 1994 to 1995, with the exception of the forensic mental health service, the general health system took over management of all government-run mental health services after a formal 'expression of interest' process. Called 'mainstreaming', this was a central plank of the National Mental Health Policy (Australian Health Ministers 1992a) and First NMH Plan (Australian Health Ministers 1992b).

Commonwealth funding played a pivotal role in Victoria's reforms. For instance, the First NMH Plan provided bridging finance to expand the number of mobile adult community teams. This so-called 'hump' or double funding is critical for closing institutions, as it keeps them operating whilst replacement services are being set up (Mahoney 1988: 82). In turn, the \$52m Better Cities funding, supplemented by state funding, enabled new inpatient units and residential facilities to be built to replace the institutional beds. As institutions were wound down, the resulting savings, secured for reinvestment in the mental health program, provided recurrent funding to run the new services. It is estimated that by 1997-1998, \$137.6m came from this source in Victoria (Meadows & Singh 2003: 65).

By mid-1998, all of the state's psychiatric institutions had been shut down or were in the process of closure. This has been described as 'an extraordinary feat by any modern international standard of mental health reform in the second half of the 20<sup>th</sup> century' (Meadows & Singh 2003: 65). The opening of local replacement facilities preceded the closing of each institution. For instance, the remaining institution to close, Royal Park Psychiatric Hospital in inner city Melbourne, only shut its doors in December 1999, after completion of the last of around fourteen facilities designed to replace it. This was the 50 bed acute psychiatric unit at the Alfred Hospital in inner Melbourne.

Additionally, new and expanded adult mobile community mental health teams were also set up prior to institutions closing. These teams worked on an extended hours basis, seven days per week. Specifically, from 1994 to 1996, extra staff positions were funded so that twenty more mental health crisis assessment and treatment teams, and twenty additional mobile mental health treatment and support teams, could be put in place across the state (Health & Community Services 1996a:3). In rural areas, rather than separate single-function teams, integrated satellite teams were set up with multiple functions, to take account of the more dispersed population and smaller client numbers. Lastly, six more staff positions were added to the existing homeless persons outreach teams in central Melbourne, so that all parts of the inner city could be covered.

Turning to the building program, the final list of new facilities was extensive. For adults, it included fifteen acute psychiatric inpatient units and two secure extended care units, all co-located with general hospitals, and fourteen community-based mental health continuing care units (Health & Community Services 1996a:22-25,39). Acute units varied in size, depending largely on morbidity rates in the local area, and ranging from 45 to 50 beds at two large city hospitals, both of which serviced inner suburbs with high admission rates (Office of Psychiatric Services 1992a:9), to 25 beds in hospitals in outlying suburbs. Continuing care units typically comprised 20 beds in four or five separate units on the same site. Fourteen new continuing care units were built, mostly in the metropolitan area, to add to the two already in place when the reforms began (Health & Community Services 1996a:22).

As well as expanding clinical mental health services, the reforms also included growth in psychiatric disability and rehabilitation support services run by the non-government sector. Unlike other Australian states and territories, this sector was already well-established in Victoria, providing psychosocial rehabilitation day programs, residential rehabilitation, outreach support, respite care and mutual aid services (Robson 2000). From 1993 to 1998, expenditure on these services rose

from \$2.24 to \$7.49 per capita in Victoria, against a national average of \$3.66 per capita (Commonwealth Department of Health and Aged Care 2000:59). Victoria's mental health reforms explicitly endorsed the integral role played by the non-government sector in the overall mental health service system. It was proposed that expenditure on this sector should grow to 12 percent of the adult clinical mental health service budget (Health & Community Services 1996d: 19). Increased Commonwealth funding through the new 1993-98 Commonwealth/State Disability Agreement, as well as extra state mental health funding, enabled an expansion of day programs, outreach support and respite care across the state. In 1995, a further Commonwealth windfall comprising \$1.8m Community Housing funding was secured by a non-government agency in the north eastern suburbs (Neami 2002: 11). This funding was used to expand that agency's supported housing program and to accommodate long term patients from the Bundoora institutional complex.

By June 1998, older people, children and adolescents also had access to a much wider range of mental health services. From 1995, general aged care facilities, such as Caulfield Aged Care, took over managing the mental health services for older people. Like services for adults, those for older people were significantly expanded across the state to enable a greater emphasis on community treatment. More mobile psychogeriatric assessment and treatment teams were added to the seven already in operation (Health & Community Services 1996a :22-25, 39). Capital works included new acute psychogeriatric assessment units usually co-located with general aged care services, psychogeriatric nursing homes based in community settings, and psychogeriatric hostel (Health & Community Services 1996a: 39). In the country, extended care psychogeriatric beds in institutions were re-located to local aged care facilities (Health & Community Services 1996b:69).

During 1995, public hospitals also took over the management of public mental health services for children and adolescents. Service expansion included a new twelve bed statewide child inpatient unit at the Austin Hospital to replace

one in Melbourne's inner west, and more adolescent inpatient beds for the southern metropolitan area, together with clinical staff for two extra community child and adolescent mental health assessment and treatment teams (Health & Community Services 1996c:51). In addition, by 1996, new mobile mental health outreach teams were in place to work with troubled teenagers with mental health problems. Lastly, funded as a suicide prevention initiative (Suicide Prevention Taskforce 1997), from 1998 sixteen new residential rehabilitation services were set up for young adults with mental disorders, and run by well-established non-government agencies such as the Richmond Fellowship Victoria and the Mental Illness Fellowship (formerly Schizophrenia Fellowship Victoria).

This snapshot shows that Victoria's mental health service system had undergone a revolution. It altered what was offered, where and to whom. With the exception of the forensic mental health service, the general health system now ran all public mental health services and employed the staff. This transfer of state employees had been sought by the government, in line with its goal of reducing the state-employed workforce, but was also welcomed by the general health system. All the changes were in line with the objectives of the overarching NMH Strategy, which included the National Mental Health Policy released in 1992 (Australian Health Ministers 1992a), and the First NMH Plan of 1993 to 1998 (Australian Health Ministers 1992b). The NMH Strategy had been introduced by a Commonwealth Labor Government, but had bipartisan support and continued after a conservative Liberal/National Coalition Government was elected in 1996.

Victoria's reforms drew on the model of comprehensive community-oriented care developed originally in Madison, Wisconsin, in the United States, designed to respond to the service needs of people with severely disabling mental illnesses living in the community (Stroul 1986:36-48). First trialled in the early 1970s, the Madison model comprised a range of clinical and support services, provided on an outreach basis in the community, seven days per week, with a 24 hour emergency response as needed

(Dixon & Goldman 2003; Thompson & Griffith 1990). The effectiveness of this approach for treating acute psychiatric conditions had already been shown by the 1979 Hout Project in Sydney's Lower North Shore (Hout 1983). This project had demonstrated that providing intensive community treatment available on a 24 hour outreach basis was superior on a number of measures to the standard care involving hospital admission and outpatient follow up (Hout et al. 1983). As noted by the sociologist Moynihan (1992: 251): 'Hout's research broke the link between being overtly psychotic and the necessity of being admitted to hospital'.

The principles of the Madison model also underpinned the Richmond Program in New South Wales, which drove the initial shift to a more community-oriented mental health system in that state (Richmond 1983b). Lastly, as we have seen, the Willsmere Project had set a local precedent for institutional closure in Victoria. It had also highlighted the importance of upfront funding for replacing institutions, and provided a range of service prototypes for the later developments (Rimmer, Buckingham & Farhall 1988).

The changes to Victoria's mental health service system also stood out in the national context. Under the First NMH Plan from 1993 to 1998, no other state or territory achieved a comparable level of service reform. The National Mental Health Report 2002 (Commonwealth Department of Health and Ageing 2002:58) captures the contrast as follows:

Victoria led the other Australian States and Territories during the 1993-98 period in the extent of its structural reforms and redistribution of resources from inpatient to community programs. Victoria's reduction in the funding base of freestanding psychiatric hospitals was four times greater than the combined efforts of other jurisdictions and accounted for approximately 80% of the national redistribution of resources to new service developments.

The Commonwealth clearly had an interest in promoting Victoria's reforms and the extent to which they met national policy directions, particularly given the slow progress elsewhere.

For instance, Victoria was the only state where savings matched inpatient bed reductions, whereas in four other jurisdictions, inpatient expenditure had risen as the number of inpatient beds fell (Commonwealth Department of Health and Ageing 2002: 33). Furthermore, from 1993 Victoria was alone in increasing the number of 24 hour-staffed community residential services (Commonwealth Department of Health and Ageing 2002: 34). These bed-based services catered for former patients of extended care wards in institutions. In contrast, other jurisdictions actually reduced their supply of beds of this type over the same period (Commonwealth Department of Health and Ageing 2002: 34). Lastly, by the end of 2004, Victoria was still the only mainland Australian state to have replaced all its psychiatric institutions (SANE 2004: 3).

How did Victoria manage to achieve such major service reform? A detailed analysis of the key factors is beyond the scope of this paper, but has been undertaken elsewhere (Gerrand 2005). In brief, the factors included an incoming neo-liberal government bent on radical reform; policy ideas already in good currency, in line with new national directions and supported by an active reform network; skilful policy entrepreneurship by a departmental secretary for whom mental health reform met multiple objectives; a minister ready to commit to the reform agenda; augmented bureaucratic capacity and decisive leadership; and Commonwealth start-up funding to help make the changes (Gerrand 2005: 224-244).

### **Taking stock of Victoria's mental health reforms**

How well was deinstitutionalisation undertaken in Victoria? Did the mental health reforms from 1993 to 1998 result in a better-service system? What criteria should be used to make this judgement? Further, did Victoria's approach provide any new lessons about how to undertake deinstitutionalisation? These questions will be addressed in turn.

How should Victoria's reforms be assessed in terms of deinstitutionalisation? There are two issues here: the criteria to be used; and the

availability of relevant data. Finding the criteria is not difficult. They have been identified in the US (Bachrach 1997; Talbott 1979: 624), the UK (Shepherd 1998; Thornicroft & Bebbington 1989) and Australia (Hoult 1992: 44-47; Rosen 1992). There is broad consensus on what constitutes effective deinstitutionalisation. Firstly, alternative services should be established *before* institutions close (Talbott 1979: 624), and priority should go to those with serious mental illness and the most disabling conditions (Shepherd 1998: 173). Services provided should include residential and inpatient care, as well as treatment in the community, although the latter should be the focus (Rosen 1992). Services should be accessible in terms of time and place, and treatment delivered in the client's own setting as appropriate (Hoult 1992: 44-47). Access to housing, social networks and paid work is also important (Shepherd 1998: 168-170). There must be an equitable spread of resources across continuing and acute care, and between inpatient and community-based services.

Selection and training of staff should ensure they have the right set of skills for a community-oriented service system, and in particular, the readiness to work in partnership with service users (Shepherd 1998: 174). Clients should receive individualised and culturally relevant treatment and care, which draws on the range of interventions known to be effective (Bachrach 1997: 29-31). Lastly, families should be consulted as part of the treatment process, and clients be actively involved in planning services (Bachrach 1997: 31).

What evidence is available to assess Victoria's reforms over the timeframe of 1993 to 1998? The data are surprisingly sparse given the magnitude of the reforms and the time that has elapsed. What data exist have largely emanated from national and state reports, rather than scholarly research, with some recent exceptions (Gerrand 2005; Lammers 2002). National reporting shows the changes in service mix and funding in the six Australian states and two territories (Commonwealth Department of Health and Aged Care 2000; Commonwealth Department of Health and Ageing 2002). These

reports focus on the extent to which the reforms met national objectives, particularly in providing a community-oriented system of care (Commonwealth Department of Health and Aged Care 2000: 58-64). As we have already seen, Victoria's progress far exceeded that of other states and territories in this regard. At a more local level, two senior public sector psychiatrists from Victoria provide an overview of the reform process up to the change of government in September 1999 (Meadows & Singh 2003). Lastly, state reports record changes to service use to 1997-98 (Metropolitan Health and Aged Care Services Division 2002: 6).

What do the existing data tell us about how well the reforms met criteria for successful deinstitutionalisation? Firstly, before the psychiatric institutions were closed, they were replaced by a comprehensive range of inpatient, residential and community services across the state (Health & Community Services 1996a: 48-93). This sequence of establishing alternative services in anticipation of institutional closure has been identified as critical for deinstitutionalisation to work (Talbott 1979: 624). That these services were organised around geographical areas also took account of the importance of making services as local as possible (Talbott 1979: 624). Secondly, they were to give priority to those with the most distressing and disabling conditions (Health & Community Services 1994: 22, 36, 37), in line with the national policy (Australian Health Ministers 1992a: 13) and reflecting lessons from overseas (Bachrach 1982:50-51; Shepherd 1998: 173). Further, the new mobile adult community teams worked extended hours on an outreach basis, so were not confined to a particular building nor limited to business hours. These had been identified as important prerequisites for responsive community-based services firstly in Madison, Wisconsin (Stein 1992a, 1992b; Stein & Test 1980), then in Sydney (Hoult 1992: 44-47). The expansion of community-services for older people and adolescents also focused on mobile outreach.

Whilst the overall number of beds remained constant (Commonwealth Department of Health and Ageing 2002: 59), the replacement bed-

based services encompassed a much broader spectrum of acuity and disability, and thus responded to a more diverse range of client needs, especially for community-based care (Bachrach 1980). Furthermore, with the exception of regional secure extended care units, the clinical bed-based facilities were located in their particular catchment area, again meeting the requirement of local accessibility (Talbot 1979: 624). Bed-based services for people with ongoing psychiatric disabilities run by the non-government sector also grew in number over the reform period (Human Rights and Equal Opportunity Commission 1995: 9). The growth of community bed-based services for those with continuing disabilities began to redress an earlier preoccupation with acute hospital beds (Moynihan 1992: 216).

Overall, the re-designed service system clearly represented a concerted attempt to ensure replacement services provided for a variety of service needs. Data on service use by all age groups showed that by the end of June 1998, more people were using the public mental health service system and also receiving more community-based mental health services. The number of people registered as clients of public mental health services grew some 60 percent, from 28,000 in 1992-1993, to 40,400 by 1997-1998 (Metropolitan Health and Aged Care Services Division 2002: 6). The number of clinical community-based mental health interventions per annum almost doubled from 600,000 to 1,192,000 (Metropolitan Health and Aged Care Services Division 2002: 6).

How should these data be interpreted? Were the increases real or an artefact of service reporting procedures? A thorough analysis has yet to be undertaken. Nonetheless, we can speculate on what the reported growth might indicate. Some of the increase probably reflected services becoming more rigorous about registering clients and recording clinical contacts. Apart from artefact, what else might explain the increase? Was there an upsurge in mental disorders over this period, or did service use grow because there were more services available in previously under-resourced areas of the state?

Accessibility had increased as well as availability as it was largely the mobile community mental health teams that had been expanded. It is possible that both factors played a part. To test their relative explanatory value would be difficult however.

Obviously, it cannot be assumed that increased client numbers necessarily meant more people experienced mental disorder for the first time over this period. Instead, referrals to newly established mental health services could have included those whose mental disorders were longstanding, but untreated due to an earlier lack of services, especially in outer suburban and rural areas. Lastly, from 1995, the Commonwealth had funded an extensive community education campaign aimed at de-stigmatising mental illness and its treatment. This may have encouraged people with mental health problems to seek help, and general practitioners to be more prepared to refer their patients for specialist mental health care.

The reforms also held out the promise of more individualised treatment, with clinical case management identified as the core mechanism for its achievement (Psychiatric Services Branch 1994). Each client of a community mental health service was to have a clinical staff member designated as their case manager, usually a mental health nurse or allied health professional such as a social worker, and less likely a psychiatrist, due to cost and scarcity. The case manager was responsible for undertaking a comprehensive assessment, developing an individual service plan and coordinating its implementation, often as the primary therapist (Psychiatric Services Branch 1994: 17-22). Case management was controversial as some psychiatrists saw it as challenging their clinical authority. Nonetheless, its inclusion was a core requirement under the First NMH Plan (Australian Health Ministers 1992b: 8).

For those people using mental health services, the reform process generated new opportunities to contribute their views and experience. The mental health consumer movement was already active in Victoria, with a statewide body, the Victorian Mental Illness Awareness Council

(VMIAC) providing leadership, and hosting relevant research (Wadsworth & Epstein 2005: 49-50). National policy also gave new legitimacy to the rights and voice of mental health consumers (Australian Health Ministers 1991), with consultations held across Australia in 1994 to identify critical issues (National Community Advisory Group on Mental Health 1994). Apart from consumer representation on advisory groups, state policy guidelines encouraged consumer participation in service development (Aged Community and Mental Health Division 1996a). From 1996, part-time consumer consultant positions were funded in all adult services to assist this process (Meadows & Singh 2003: 66; Middleton, Stanton & Renouf 2004).

In its second term, the conservative state government sought to soften its radical cost-cutting image. One of the measures was a Victorian 'carer strategy', launched in June 1996. This enabled formal if belated recognition of the role of families and other carers in supporting people with a mental illness. Policy guidelines were launched (Aged Community and Mental Health Division 1996b), and extra funding committed for service initiatives designed to help those in the caring role. These initiatives included extra respite care, a carer support fund and a training program to improve the response of clinical staff to carer needs for information, education and support (Aged Community and Mental Health Division 1996b).

In summary, Victoria's mental health reforms met most of the criteria identified for deinstitutionalisation to be effective. The process was not without its flaws however, as we shall see in the next section.

### **The other side of reform**

Given the size and speed of the reform program, it is not surprising that mistakes were made, gaps left and planned changes unrealised. Given the scope of this article, only some of the more obvious problems will be noted here. Independent evaluation did not begin until some years after the initial reform period (Auditor General Victoria 2002). The paucity of scholarly research also means the range of data sources is slim.

The pace of change meant at times quality of care was compromised through the push to vacate institutional sites to accelerate land sales. A glaring example is the 'temporary accommodation' organised in 1999 for twenty extended care patients, to hasten closure of the Bundoora institutional complex. The temporary facility was a locked ward on the first floor of a former repatriation hospital building without ready access to outdoor space. It remained in use for six years, despite calls by the Public Advocate and concerned relatives for its replacement (Ellingsen 2004). It is now finally being replaced by a new special purpose facility, built with 2005-06 state budget funding.

Green (2002: 4-5) reports on the precipitate discharge of patients from institutional wards about to be closed:

The manager of an inner city community housing project .... received a call from the chaplain at a major mental hospital complex. One of the wards is to close on Friday next and five patients have nowhere to go. Can the project fit them in at short notice is the query. The situation is desperate, the ward has to close, and housing is needed in a few days time.

Successful deinstitutionalisation must also encompass quality care, in addition to provision of readily accessible services. In the 1994 national consultations, service users and family carers had reported encountering more stigma and discrimination from mental health professionals than from any other societal group (National Community Advisory Group on Mental Health 1994: 23-24). Institutions clearly do not have a monopoly on institutionalising attitudes and practices (Bachrach 1984: 171). Nonetheless, their closure opens up the possibility of change, particularly through staff training (Farhall & Love 1992). Over the first phase of reform from 1994 to 1996, statewide staff training had been a core tool in building the capacity of the workforce to meet the new service orientation. For example, providing community treatment as a first option relied on skills in engaging with consumers and their families. This was a particular challenge for staff used to working in institutions or in the older

clinics, and ongoing training was essential. To illustrate the size of the task, the 1992 statewide clinical audit of inpatient services noted that staff did not give patients' rights high priority:

This finding, together with the opinions expressed by patients, suggests that most hospitals do not strive to develop an atmosphere whereby the patients and their family and friend are encouraged and assisted to express their views about treatment and care. Many patients believe strongly that their views are not wanted (Office of Psychiatric Services 1992b: 84-85).

Once the institutions closed, many of these clinical staff would be those working in the new services, including inpatient and residential facilities. Nonetheless, despite the known importance of training for changing staff attitudes and practices, the government-run statewide staff training unit was disbanded in 1996. This was in line with the neo-liberal government's ethos of 'steering not rowing' (Osborne & Gaebler 1992: 34-37), but was arguably premature. The staff training funds were redistributed to services but in most, regular in-service training was not made available. A key opportunity was lost to promote and embed progressive approaches to client care, and to counter institutionalised practices.

The culture gap also applied to general hospital staff. After institutions closed, hospital emergency departments more often became the first port of call for people experiencing an acute psychiatric episode, yet staff were ill-prepared to respond appropriately. For instance, acutely disturbed people reportedly had to wait in an environment which exacerbated their distress, rather than receiving urgent assessment. In 1997, as a suicide prevention initiative (Suicide Prevention Taskforce 1997), an extra \$8.1m was committed to expand the mental health crisis assessment and treatment teams so that their staff could provide assessments in emergency departments in public hospitals. Training for general staff was not however included in this initiative.

The closure of rural psychiatric institutions also had a major impact on country towns. Tobin (1993: 337) highlights the dependence of the host community on the continuation of the institution,

noting that '... employment security of the staff, unions and local township businesses was dependent upon organisational survival in its traditional manner'. Rural psychiatric institutions were a key source of employment not just for clinical staff, but also for artisans and other non-clinical workers. For instance, in June 1991, non-direct care staff comprised 40 percent of the 455 staff employed at Aradale, an institution in western Victoria (Health Department Victoria 1991b: 9), a pattern common to all the psychiatric institutions. In contrast, replacement services employed largely clinical staff, and contracted out maintenance and 'hotel' services. Furthermore, the effect of cuts to institutional jobs was magnified due to the state government pursuing its neo-liberal agenda of privatising public utilities, and closing small country hospitals and schools (Harkness 1999).

A different problem was ensuring that services were adequately funded to meet rising demand. After the conservative government's 1996 re-election, mental health reform lost priority and ways to match funding with service demand remained undeveloped. The impact was greatest for the community mental health clinics, which provided the continuing care that is the cornerstone of a community-oriented service system (Auditor General Victoria 2002: 8-9). These services became overwhelmed by the increase in client numbers, with unfortunate results (Auditor General Victoria 2002: 7). An example is over-reliance on medication as the primary and often sole method of treatment, without use of additional psychosocial interventions known to assist recovery (Healy & Renouf 2005: 45).

This brief overview indicates how insufficient attention to the details of implementation meant that, by 1998, Victoria's mental health reform process remained incomplete.

### Lessons learnt

What lessons can be learnt from Victoria's approach to deinstitutionalisation? One is that it is possible, indeed necessary, for all state psychiatric institutions to be closed if a community-oriented service system is to be established. There are those who argue that deinstitutionalisation remains incomplete whilst any institution remains

open (Bachrach 1982: 55). Apart from this philosophical stance, when institutions are shut, the resulting savings can fund new, locally accessible services. Reinvesting institutional savings was a requirement of the national strategy (Commonwealth Department of Health and Aged Care 2000: 19). Nevertheless, if some institutions remain open, their running costs severely constrain how mental health funds can be deployed. Put simply, by closing its institutions, Victoria was able to free up the maximum amount for reinvestment in new services, with institutional savings quarantined for this purpose.

A comparison with the neighbouring states of New South Wales and South Australia is instructive. By June 1998, neither had shut any of their psychiatric institutions, and 47 percent of the SA mental health budget and 32 percent of that in NSW still went to their separate psychiatric institutions, compared to 14 percent in Victoria (Commonwealth Department of Health and Aged Care 2000: 81, 52, 59). In 1997-98, reinvested institutional savings comprised 87 percent of Victoria's mental health funding, compared to 10 percent in SA and just 2 percent in NSW (Commonwealth Department of Health and Aged Care 2000: 62, 84, 55).

Victoria's reforms also show that with substantial upfront funding, it is possible to replace institutions with an adequate range of alternative services. In Victoria the institutions were replaced with a wide range of inpatient, residential and community-based mental health services, a key requirement for successful deinstitutionalisation. Start-up funding allowed new facilities to be built, and provided the bridging finance to establish mobile forms of community care before the institutions were closed. Moreover, the way the reforms were implemented made their achievement more likely. Firstly, the new blueprint was applied prescriptively across the service system, with area mental health services being directed about which new service components were to be put in place and when. Secondly, the mobile mental health teams were most likely to reduce new and repeated hospital admissions, so their expansion was given priority, together with the construction of new facilities.

Not surprisingly, both steps represented a major challenge to psychiatrists' authority as clinical directors. At least one objected publicly to the priority given to expanding community-based treatment rather than acute beds (Human Rights and Equal Opportunity Commission 1995). The trade-off for psychiatrists through the reforms was significant however. With mental health services now managed by the general health system, the continued primacy of the medical model was affirmed (Healy & Renouf 2005: 46), and psychiatrists got access to better employment conditions.

The prescriptive way the framework was implemented ensured for the first time that all services got the same suite of service components over a comparable timeframe. The system-wide introduction of the new service blueprint meant that all parts of the state benefited, not just those with entrepreneurial clinical leaders, or political appeal through being marginal seats. Lastly, most of the staff appointed to manage the new area-based mental health services were clinicians who understood and supported the changes, making a key contribution to the period of transition. The significance of their role was arguably underrated at the time, but is a particularly important lesson for reformers.

## Conclusion

Victoria's approach to deinstitutionalisation stands out in the uneven history of this movement in the mental health field. The traps have long been known, such as not securing the reinvestment of institutional savings, failing to establish an adequate range of replacement services or allowing those services to ignore the needs of the most disabled. Victoria's mental health reforms managed to avoid most of these pitfalls. Ten years on, the service framework is still firmly in place, with recent initiatives such as step-up/step-down acute services augmenting rather than replacing the core service elements (Metropolitan Health and Aged Care Services Division 2002). Despite its flaws, the redesigned service system has provided a solid basis for further reform, and fertile ground for sociological research.

## References

- Aged Community and Mental Health Division (1996a) *Victoria's Mental Health Service: Working with Consumers - Guidelines for Consumer Participation in Mental Health Services* Victorian Government Department of Human Services: Melbourne.
- Aged Community and Mental Health Division (1996b) *In Partnership: Families, Other Carers and Public Mental Health Services* Victorian Government Department of Human Services: Melbourne.
- Andrews, G. Teesson, M. Stewart, G. and Hoult, J. (1990) 'Follow-up of community placement of the chronic mentally ill in New South Wales' *Hospital and Community Psychiatry* 41 (2):184-188.
- Auditor General Victoria (2002) *Mental Health Services for People in Crisis* Auditor General Victoria Melbourne.
- Australian Health Ministers (1991) *Mental Health - Statement of Rights and Responsibilities: Report of the Mental Health Consumer Outcomes Task Force* Australian Health Ministers: Canberra.
- Australian Health Ministers (1992a) *National Mental Health Policy* Commonwealth of Australia: Canberra.
- Australian Health Ministers (1992b) *National Mental Health Plan* Australian Health Ministers: Canberra.
- Bachrach, L. (1980) 'Overview: model programs for chronic mental patients' *American Journal of Psychiatry* 137:1023-1031.
- Bachrach, L. (1997) 'Lessons from the American experience in providing community-based services' in J. Leff (ed) *Care in the Community: Illusion or Reality?* John Wiley and Sons: Chichester.
- Bachrach, L. (1982) 'Assessment of outcomes in community support systems: results problems and limitations' *Schizophrenia Bulletin* 8 (1): 39-61.
- Bachrach, L. (1984) 'Principles of planning for chronic psychiatric patients: a synthesis' in J. Talbott (ed) *The Chronic Mental Patient: Five Years Later* Grune and Stratton: Orlando Fla, pp.165-182.
- Bachrach, L. and Lamb R. (1982) 'Conceptual issues in the evaluation of deinstitutionalisation' in G. Stahler and W. Tash (eds) *Innovative Approaches to Mental Health Evaluation* Academic Press Inc: New York, pp.139-162.
- Barham, P. (1992) *Closing the Asylum: The Mental Patient in Modern Society* Penguin Books Ltd: London.
- Boardman, J. (2005) 'New services for old - an overview of mental health policy' in A. Bell and P. Lindley (eds) *Beyond the Water Towers - The Unfinished Revolution in Mental Health Services 1985-2005* Sainsbury Centre for Mental Health: London, pp.27-36.
- Commonwealth Department of Health and Aged Care (2000) *National Mental Health Report 2000: Sixth Annual Report. Changes in Australia's Mental Health Services under the First National Mental Health Plan of the National Mental Health Strategy 1993-98* Department of Health and Aged Care: Canberra.
- Commonwealth Department of Health and Ageing (2002) *National Mental Health Report 2002: Seventh Report. Changes in Australia's Mental Health Services under the First Two Years of the Second National Mental Health Plan 1998-2000*. Commonwealth of Australia: Canberra.
- Costar, B. and Considine, M. (1992) 'Introduction' in M. Considine and B. Costar (eds) *Trials in Power: Cain, Kirner, and Victoria 1982-1992* Melbourne University Press: Melbourne, pp.1-10.
- De Sisto, M. Harding, C. McCormick, R. et al. (1995) 'The Maine and Vermont three decade studies of serious mental illness. II longitudinal course comparisons' *British Journal of Psychiatry* 167: 338-342.
- Dixon, L. and Goldman, H. (2003) 'Forty years of progress in community mental health: the role of evidence-based practices' *Australian and New Zealand Journal of Psychiatry* 37: 668-673.
- Ellingsen, P. (2004) 'Home to 20 a house that's 'unfit' for care' *The Sunday Age* 26/12/04 p.10.
- Farhall, J. and Love, A. (1992) 'Delivering better mental health services: staff development as a strategy for change' in A. Venno and D. Thomas (eds) *Psychology and Social Change: Creating an International Agenda* Dunmore Press: Palmerston North NZ, pp.157-172.

- Gerrand, V. (2005) Transforming mental health services from 1993 to 1998 in Victoria Australia: a case study of policy implementation, PhD Thesis, University of Melbourne, Victoria, Australia.
- Green, D. (2002) 'Homelessness and mental illness' *New Paradigm* April: 3-9.
- Grose, R. (1986) *Project Manager's Report to the Minister for Health Willsmere Hospital - Proposed Decommissioning Strategy* Health Department Victoria: Melbourne.
- Harding, C. Brooks G. Ashikaga T. et al. (1987) 'The Vermont longitudinal study of persons with severe mental illness: long-term outcomes of subjects who retrospectively met DSM iii criteria for schizophrenia' *American Journal of Psychiatry* 144: 727-735.
- Harkness, A. (1999) 'Prognosis negative: health care economics and the Kennett government' in B. Costar and N. Economou (eds) *The Kennett Revolution - Victorian Politics in the 1990s* University of New South Wales Press: Sydney, pp.203-213.
- Health and Community Services (1994) *Victoria's Mental Health Service: The Framework for Service Delivery* Psychiatric Services Division, Victorian Government Department of Health and Community Services: Melbourne.
- Health and Community Services (1996a) *Victoria's Mental Health Service: The Framework for Service Delivery - Better Outcomes Through Area Mental Health Services* Victorian Government Department of Human Services: Melbourne.
- Health and Community Services (1996b) *Victoria's Mental Health Service: The Framework for Service Delivery: Aged Persons' Services* Victorian Government Department of Health and Community Services: Melbourne.
- Health and Community Services (1996c) *Victoria's Mental Health Service: The Framework for Service Delivery: Child and Adolescent Services* Victorian Government Department of Health and Community Services: Melbourne.
- Health and Community Services (1996d) *Purchasing Better Mental Health Services in Victoria: 1996-97* Victorian Government Department of Health and Community Services: Melbourne.
- Health Department Victoria (1991a) *Report of a Board of Investigation Appointed by Mr T.Daly, Chief General Manager Health Department Victoria to Enquire into Certain Clinical and Management Practices at Lakeside Hospital Ballarat With Specific Reference to the Death of Patient x and the Ward Twenty Two Outing of 30 August 1990* Health Department Victoria: Melbourne.
- Health Department Victoria (1991b) *The Investigative Task Force's Findings on the Aradale Psychiatric Hospital and Residential Institution* Community Services Victoria and Health Department Victoria: Melbourne.
- Healy, B. and Renouf N. (2005) 'Contextualised social policy: an Australian perspective' in S. Ramon and J.E. Willams (eds) *Mental Health at the Crossroads: The Promise of the Psychosocial Approach* Ashgate Aldershot, pp.39-50.
- Hoult, J. Reynolds I. Powis C. Weekes P. and Briggs J. (1983) 'Psychiatric hospital versus community treatment: the results of a randomised trial' *Australian and New Zealand Journal of Psychiatry* 17:160-167.
- Hoult, J. (1983) 'Psychiatric hospital versus community treatment' *Australian and New Zealand Journal of Psychiatry* 17:404-410.
- Hoult, J. (1986) 'Community care of the acutely mentally ill' *British Journal of Psychiatry* 149:137-144.
- Hoult, J. (1992) 'The Sydney experience' in C. Dean and H. Freeman (eds) *Community Mental Health Care: International Perspectives on Making it Happen* Gaskell and The Centre for Mental Health Service Development: London, pp.35-48.
- Human Rights and Equal Opportunity Commission (1995) *Human Rights and Mental Illness Victoria: Report of the Reconvened Inquiry into the Human Rights of People with Mental Illness (Victoria)* Human Rights and Equal Opportunity Commission: Canberra.
- Lamb, H. and Shaner, R. (1993) 'When there are almost no state hospital beds left' *Hospital and Community Psychiatry* 44 (10): 973-976.
- Lammers, A. (2002) The reforms to mental health and their impact on the empowerment of consumers and carers, PhD Thesis University of Melbourne, Victoria, Australia.

- Leff, J. Thornicroft, G. Coxhead, N. and Crawford, C. (1994) 'The TAPS project. 22: a five-year follow-up of long-stay psychiatric patients discharged to the community' *British Journal of Psychiatry* 165 (suppl.25):13-17.
- Lippmann, L. (1982) *Melville Evaluated: An Experiment in Community Mental Health Care* Special Publication No.11, Mental Health Research Institute: Health Commission of Victoria: Melbourne.
- Mahoney, J. (1988) Finance and government policy in A. Lavender and F. Holloway (eds) *Community Care in Practice: Services for the Continuing Care Client* John Wiley and Sons Ltd: Chichester, pp.75-90.
- Meadows, G. and Singh, B. (2003) "'Victoria on the move": mental health services in a decade of transition 1992-2002' *Australasian Psychiatry* 11(1): 62-65.
- Metropolitan Health and Aged Care Services Division (2002) *New Directions for Victoria's Mental Health Services - The Next Five Years* Victorian Government Department of Human Services: Melbourne.
- Middleton, P. Stanton, P. and Renouf, N. (2004) 'Consumer consultants in mental health services: addressing the challenges' *Journal of Mental Health* 13(5): 507-518.
- Moynihan, P. (1992) The fear effect: an exploration of attempts to introduce reform into public psychiatry PhD Thesis La Trobe University, Victoria, Australia.
- National Community Advisory Group on Mental Health (1994) *Let's Talk About Action: Redressing Human Rights Abuse Discrimination and Inequity in the Community's Response to the Plight of People with a Mental Illness or a Psychiatric Disability* National Community Advisory Group on Mental Health: Canberra.
- NEAMI, (2002) *Annual Report 2002* Melbourne.
- Office of Psychiatric Services (1991) *Continuing Victoria's Reform of Psychiatric Services General Information Sheet* Office of Psychiatric Services: Melbourne.
- Office of Psychiatric Services (1992a) *Policy and Strategic Directions for Public Psychiatric Services in Victoria* Health Department Victoria: Melbourne.
- Office of Psychiatric Services (1992b) *Audit of Standards of Treatment and Care in Psychiatric Hospitals in the State of Victoria* Health Department Victoria: Melbourne.
- Osborne, D. and Gaebler, T. (1992) *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector* Plume: New York.
- Patmore, C. and Weaver, T. (1991) *Community mental health teams: lessons for planners and managers* Good Practices in Mental Health London.
- Psychiatric Services (1993b) *Victoria's health reforms: psychiatric services - discussion paper* Victorian Government Department of Health and Community Services Melbourne.
- Psychiatric Services Branch (1994) *Victoria's Mental Health Services: Improved Access Through Coordinated Client Care* Health and Community Services: Melbourne.
- Ramon, S. (1988) 'Community care in Britain' in A. Lavender and F. Holloway (eds) *Community Care in Practice: Services for the Continuing Care Client* John Wiley and Sons Ltd: Chichester, pp.9-25.
- Richmond, D. (1983b) *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled Part 3 Mental Health Services and Services for the Mentally Ill* NSW Department of Health: Sydney.
- Rimmer, J. Buckingham, W. and Farhall, J. (1988) *Achieving Continuity of Care in Comprehensive Psychiatric Service Systems - Victoria's Approach* Office of Psychiatric Services Health Department Victoria: Melbourne.
- Robson, B. (2000) 'From philanthropy to profession - the evolving identity of psychiatric disability services' *New Paradigm* August: 8-14.
- Rosen, A. (1992) 'Community psychiatry services: will they endure?' *Current Opinion in Psychiatry* 5:257-265.
- Rosen, A. (1999) 'From colonial rivalries to a national mental health strategy' in G. Thornicroft and M. Tansella (eds) *The Mental Health Matrix: A Manual to Improve Services* Cambridge University Press: Cambridge. pp.177-200.
- SANE (2004) *Sane Mental Health Report 2004* SANE Australia: Melbourne.
- Shepherd, G. (1998) 'Models of community care' *Journal of Mental Health* 7(2): 165-177.
- Social Development Committee (1985) *Inquiry into the Future use of Willsmere Hospital* Social Development Committee Parliament of Victoria: Melbourne.

- State of Victoria (1986) *Mental Health Act 1986* Reprinted incorporating amendments as at 1 June 2000.
- Stein, L. and Test, M. (1980) 'Alternative to mental hospital treatment: 1. Conceptual model treatment program and clinical evaluation' *Archives of General Psychiatry* 37:392-397.
- Stein, L. (1992a) 'Creating change: a case study' in C. Dean and H. Freeman (eds) *Community Mental Health Care: International Perspectives on Making it Happen* Gaskell and the Centre for Mental Health Services Development: London, pp.18-34.
- Stein, L. (1992b) 'Innovating against the current' in L.I. Stein (ed) *Innovative Community Mental Health Programs* Jossey-Bass Publishers San Francisco vol. 56:5-22.
- Stroul, B. (1986) *Models of Community Support Services: Approaches to Helping Persons with long-term Mental Illness* National Institute of Mental Health: Boston.
- Suicide Prevention Taskforce (1997) *Report of the Taskforce on Suicide Prevention* Victorian Government Department of Human Services: Melbourne.
- Talbott, J. (1979) 'Deinstitutionalization: avoiding the disasters of the past' *Hospital and Community Psychiatry* 30 (9): 621-624.
- Thompson, K. and Griffith, E. (1990) 'A historical review of the Madison model of community care' *Hospital and Community Psychiatry* 41(6): 625-634.
- Thornicroft, G. and Bebbington, P. (1989) 'Deinstitutionalisation - from hospital closure to service development' *British Journal of Psychiatry* 155: 739-753.
- Tobin, M. (1993) 'Inquiries at Lakeside and Aradale hospitals: lessons and advances?' *ANZ Journal of Psychiatry* 27: 333-340.
- Turner-Crowson, J. (1993) *Reshaping Mental Health Services: Implications for Britain of US Experience* Research Report No.16, King's Fund Institute: London.
- Wadsworth, Y. and Epstein, M. (2005) Book review of *From signposts to pathfinders - consumer evaluation of consumer participation in mental health services in Victoria. Evidence-based strategies for the way ahead.* by Allan Pinches *New Paradigm* March: 48-55.

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