5. Paradigm Shift in Mental Health Care: An Exploration of Mental Health Care Reform Objectives and Reform Processes

5.1. Central Features of Change from an International Perspective

From the middle of the 19th century onwards, institutional systems for the mentally ill had grown rapidly. As a consequence, large asylums with sometimes several thousand hospital beds dominated the psychiatric landscape (Goodwin 1997). With the exception of the Second World War-period where thousands of mentally ill people were killed or died due to starvation, growing institutionalisation lasted for around one century until the 1950s, when mental hospital bed space reached a peak in the majority of countries. Since the 1960s, across Western Europe and North America major changes in mental health services have taken place. The reforms have been characterised by two significant features of change. Firstly, there has been a shift from centralised care to decentralised service provision. Secondly, institutional and asylum-based care have been substituted by or have at least been supplemented with non-institutional services which has been termed deinstitutionalisation. These procedures can be summed up under the term 'community mental health care'. Put differently, the objective has been to provide acute and long-term care on the community level, preferably in non-institutional settings. As shown in the Austrian example in chapter 3, a variety of facilities such as residential homes, day structure centres, mobile treatment services and services to support employment have been established. Usually, these settings are run by multidisciplinary teams.

Overall, these processes had substantial consequences for patients. Lengths of hospital stays have decreased and treatment and/or care have partly been undertaken in non-hospital settings or in psychiatric wards in general hospitals. Although hospital beds have been reduced significantly, in many cases overall hospital admission rates have risen sharply due to higher turnover-rates and increased voluntary admissions (Goodwin 1997). Principally, decarceration has been a universal process, yet substantial variations within that process can be identified across countries which has resulted in different forms and characteristics of community care systems (Fakhoury and Priebe 2002). Thus, in several countries, such as the UK or Italy, the systematic establishment of community services has been paralleled by reducing the number of hospital beds considerably (Rothbard and Kuno 2000). There is some different evidence, for example from the Netherlands, that the shift to community care has been accompanied by a considerable expansion of mental health care, since community-based care
increased several times more than hospital-care was reduced. Empirical data have shown that the increase of services is mainly due to increased treatment of new and less severely ill persons (Pijl et al. 2000).

Despite numerous reform activities, deficiencies are still reported. In several countries, for example in Germany or in Austria, rather than deinstitutionalisation, transinstitutionalisation of former long-stay patients into nursing homes has taken place (Forster 2000). For example, it has already been shown in chapter 3 that mentally ill persons account for a high number of nursing home residents in Lower Austria. Equally, in Germany, especially until the 1990s, many discharged patients were transferred into nursing homes. According to Cooper and Bauer (1987), in the mid-1980s, there were around 50,000 to 60,000 people with mental problems to be found in nursing homes. A more recent survey has estimated that officially approximately 16% of places in nursing homes are occupied by mentally ill persons. Yet, in reality the figure is likely to be much higher (Von Cranach 2000). Additionally, people were transferred to other types of institutions. For example, Rössler et al. (1994) showed that parallel to the decrease of beds in mental hospitals, there was an increase in ‘drug abuse hospital beds’ which are predominately supplied by private and voluntary providers.

Additionally, evidence has shown that in some areas deinstitutionalisation has affected access to acute hospital care (Wilson 2000). Major deficiencies have, moreover, been reported with respect to co-ordination of services and services for people with multiple needs (Bundesministerium für Gesundheit 1996 and 1999).

In addition to broader structural changes, the new philosophy of care also implied a shift to a more individualised type of care. While at the beginning of the reform the focus was very much on providing alternative and different service elements, more recent discussions have stressed that rather than the service-structure, the individual person in need should be put at the centre of interest. This development can be described as a shift from supply-oriented to person-oriented or needs-based mental health care (Bundesministerium für Gesundheit 1999).

For explaining the policy shifts, different factors of explanation have been identified. According to Goodwin (1997), existing explanations can be classified into orthodox and radical accounts. The orthodox view, which stresses the positive and beneficial aspects of the reform process, explains the shift with pluralistic arguments. Common explanations are the developments of new types of treatments, the development of the sub-discipline of social psychiatry combined with the anti-psychiatric movement, poor conditions within old asylums and increasing community tolerance as well as institutional structures and funding arrangements which provided an incentive for community care. Radical writers have focused on a more general nature of social and economic arrangements and their possible implications for mental health policy. In their view, the emergence of community care is the result of measures to cut public costs and to reduce deficit spending. Additional attention has been paid to the relation between
unemployment and deinstitutionalisation where, for example, high demand for labour was found to correlate with early onset for deinstitutionalisation (Warner 1994).

These results indicate that there are no mono-causal explanations for reform processes and the related policy shift. Instead, we can identify complex transformation processes which have been influenced by dialectic interplays between structures and actors. In the following part, I will focus on the Austrian policy context where recent reform processes and main characteristics of the changes will be analysed. Rather than finding causal relationships and factors of explanation for why changes have taken place, the aim is to improve the understanding of the complexity of ongoing processes, patterns and trends and to draw a rich picture of the Austrian case, in particular of the reform objectives and their embedding in broader socio-economic transformation processes.

5.2. Mental Health Care Reform and Reform Discourse in Austria: A Critical Discourse Analysis

5.2.1. Rationale

Objectives and trends in Austrian mental health care reform initiatives have been similar to those in other countries. Hence, establishing a community mental health care system is the broad tenure within reform initiatives throughout the country. While core aims of the reform seem to be clear and identical in different Austrian provinces, a closer look at reform documents shows ambiguities and differences. This is particularly the case for key terms used where, at second glance, documents lack consensus and clarity concerning definitions of terms and concepts and, subsequently, concerning perceptions of the status of actors within the system. From a financing point of view, this raises difficulties for discussing financing questions. In other words, if it is not known exactly what various key concepts of mental health care mean, it will become a tricky task to discuss ways and modes of implementation and financing. This initial situation is one reason why it was found to be important to carry out an analysis of reform objectives. However, apart from this rather technical appearing problem, drawing attention to discourse was found to be important in another context. That is to say that controversies and ambiguities are not only mirroring a terminological dispute but that discourse in psychiatric reform has a deeper significance: Health or social care reforms are inevitably linked with structural and/or legislative changes which, in turn, have various implications on the individual and on the macro-level of a health care system. Not least they impact on the power and authority of institutions and individuals and their associated interests. Hence, those reforms are
political processes even if this is not always obviously observable. As the given case shows, although implementation of mental health reform goals are accompanied with substantial changes, the subject has hardly appeared on the social policy agenda in general, nor on the financing agenda. In that respect, reform documents and their inherent discourse as well as the overall reform discourse and the actors involved become a significant source for analysing the political dimension of the reform processes. Analysing mental health care reform through that lens means that various implicit links to financing questions will be identified, not least because any social-policy agenda is eventually a budgetary, hence a financing agenda. The underlying assumption is that reform aims and objectives as well as the discourses of actors is partly explicitly, but even more often implicitly linked with financing issues. It is assumed that through deconstructing the reform agenda, both, obvious and more subtle links between reform and financing aspects should become transparent. This is of even more interest, as mental health care plan development falls within the period of substantial restructuring processes in the Austrian welfare state and considerable changes in economic policy. Taking these considerations into account, it was decided to approach questions of mental health care financing with an in-depth analysis of the Austrian reform discourse and the recent reform processes.

The overall goal of this research design is twofold. Firstly, the research activity should enhance the understanding of mental health care reform processes and reform objectives within a broader historical and political-economic context. Herein, it should particularly make clearer the changing role and status of actors within the welfare state as reflected through discourse. Secondly, the analysis should make visible the contexts and modes of argumentation and its significance for issues of mental health care financing. This means that the focus of the analysis will continuously shift from the actual contents of empirical material to a broader socio-political and economic discussion aiming at eventually addressing relevant questions of mental health care financing.

**Excursus:**

**Theoretical and Methodological Considerations of a ‘Critical Discourse Analysis’**

The following analysis will be approached via a so-called ‘Critical Discourse Analysis’ (CDA). The method applied is based on the definition of CDA suggested by Fairclough (1995), who distinguishes sharply between CDA and ‘Critical Linguistics’. CDA, in a Faircloughian sense (1995), is an analysis of discourse from a sociological and philosophical perspective and as such, not only considers the actual language of discourse, but also text interpretation and text production processes as well as the overall context where the discourse is
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embedded. The approach seems to have some elements in common with the discourse theoretical strand defined by Laclau and Mouffe, who emphasise that discourse analysis goes beyond the linguistic level and who particularly address the socio-political level (Torfing 1999). On the whole, at the centre of interest are not only manifest contents as they appear in texts, but the analysis is also concerned with reality beyond language, in particular with the economic and political reality which is manifested in the texts. The central consideration underlying this approach is that texts are sensitive indicators of social processes and vice versa also shape social processes.

As Meyer (2001) points out, theoretical components of different origin have been adopted for CDA. In that respect, CDA works eclectically and is not based on a strict normative theoretical framework. Hence, prior to the empirical analysis it is required to outline the theoretical construct which will guide the analysis. Firstly, as ‘critical’ in ‘Critical Discourse Analysis’ suggests, the method implies a critical dimension. The critical approach can be traced back to influences of the Frankfurt School and Jürgen Habermas’s claim that language is a medium of domination and social force which serves to legitimise relations of organised power (Habermas in Wodak 2001). CDA is therefore based on the thoughts of ‘Critical Theory’. Weiss and Wodak (2003, 2) have put it this way: “This approach [CDA] is essentially based on a critical-dialectic concept of theory that is not limited to formulating and examining general statements about the laws of social reality.” Critical evaluation in CDA focuses on how social identities, roles, attitudes and value systems are transported via discourse, whilst users of discourse are not necessarily conscious of those processes.

At the heart of the CDA-approach are the concepts of ‘power’, ‘history’ and ‘ideology’. Roughly speaking, CDA is conducted with the notion that “discourse is structured by dominance, that every discourse is historically produced and interpreted ... and that dominant structures are legitimated by ideologies and powerful groups” (Wodak 2001, 3).

Concerning the concept of ‘history’, CDA pays particular attention to social changes as triggers of discourse changes and vice versa. These changes are usually gradual processes. For example, people do not abruptly begin using certain terms but new terms slowly replace other terms, with replacement taking place consciously as well as unconsciously (Herles 1996). Of vital interest for the analysis is that any changes in discourse take place within existing power relations, be it within an institutional context or within a broader political or societal context.

The definition of the term ‘discourse’ in CDA is not to be understood in its broadly used meaning of ‘conversation’. Rather, the etymological origin of ‘discourse’ can be traced back to the Latin term ‘discursus’ meaning ‘moving away, moving back and forwards’ (Nünning in Bargetz 2002). In Habermas’s sense discourse can be illustrated as the locus of constructive and public debate.
and, in Foucauldian terms, as an element of power-relations and even as an instrument of repression (Foucault 1991; Habermas 1977). Jäger (2001, 34) has further exemplified discourse as “the flow of knowledge – and/or all societal knowledge stored – throughout all time, which determines individual and collective doing and/or formative action that shapes society, thus exercising power.” Although focusing on different levels, what these definitions have in common is that they indicate the mutual link between text, conversation or communication and the societal, the political or the cultural sphere. Thus, discourse is not only ‘talking about different issues’, but discourses also create and construct issues as much as these issues construct the discourse itself. Importantly, at this point the central concepts of ‘ideology’ and ‘power’ come into play.

The relationship between language and ideology can be traced back to thoughts by Althusser and Pecheux (Wodak 2001). However, while for Althusser and Pecheux discourses are the result of deterministic and separate elements of hegemonic formations within the public state (Hauck 1992), others have integrated the relationship between language, power and ideology within a more dialectic theoretical framework. This can also be regarded as an attempt to shift from structuralism to a more constructionist and relationist perspective (Torfing 1999). Fairclough (1995), whose approach is followed here, has incorporated the Gramscian concept of hegemony with its central characteristic of integrating economy, politics and ideology. Hegemony, in a Gramscian sense, is a mode where those who are in power gain common consent within society including suppressed or discriminated groups or individuals (Eagleton 2000). This is based on the consideration that specific ‘Weltanschauungen’ are becoming the collective will and are, thus legitimated within society as a whole. Thus, ideology works through becoming ‘naturalised’. It is, consequently, left increasingly unquestioned because it becomes invisible. Hegemony, therefore, extends structuralist concepts of ideology to the notion of ideology as collective habit of social practice (Eagleton 2000, 136). As Torfing (1999, 27) quotes Gramsci: “Hegemony is won, when the ruling class has succeeded in eliminating the oppositional forces, and in winning the active or passive consent of its allies, and thereby has managed to become a state.” Hegemony is sustained via culture, politics and economy including non-discursive and discursive practices. In that respect, the concept of hegemony is linked to the concept of discourse.

CDA investigates the mutual relationship between extra-discoursal structures and discourse, thereby aiming at dismantling taken-for-granted knowledge. It goes on the assumption that each discourse contains a specific knowledge base which in turn embodies certain ideologies. Concerning mental health care reform documents, for example, the reform objectives stated are based on certain assumptions about the nature of medicine, the social roles and identities of mentally ill persons, etc. However, rather than reading off ideologies from the text
directly, the emphasis is on evaluating the imprints that ideological processes have on texts. Nonetheless, as Fairclough (1995, 82) emphasises, “this does not...imply that all discourse is irredeemably ideological” which, firstly, means that ideological investment may vary across different types of discourse and, secondly, that individuals are capable of transcending ideology. As a practical consequence, constant reflection concerning this issue has to accompany the analysis.

In rejecting the perception that language simply reflects social structures and the related notion of a deterministic relation between language and the social, for CDA, language and the social are mutually determined. These processes necessarily include the acting individual. As Fairclough (1995, 65) puts it: “It is important...to be sensitive to how discourse is shaped by and helps to shape social structures and relations and...to be sensitive to how social structures and relations are instantiated in the fine detail of daily social practices, including discourse”. Language is regarded as a receptor for and constructor of social praxis. CDA is therefore interested in “the social processes and structures which give rise to the production of a text, and [in] the structures and processes within which individuals or groups as social historical subjects, create meanings in their interaction with texts” (Fairclough and Kress in Wodak 2001, 3). In doing so, the concept links action and structure by taking into account the subjects’ action, the social and physical structures as well as the interrelation between these dimensions. Put differently, the approach can be described as a dialectic relationship between a structuralist and individualist theoretical tradition. In the given case, this relationship is specifically reflected in the notion that documents represent a form of communication. The link between written documents and communication was established in the 1960s, when Garfinkel (1967) pointed out that documents are similar to conversation. Even if participants in this type of conversation do not know each other, they will mutually understand insinuations or intentions. Not least is every text written with a specific readership in mind. It follows from this theoretical assumption that the production of a document as well as its use (reading, quoting etc.) is a mode of social interaction. This interaction, on the one hand presupposes social structures, in particular language codes or norms of language use. On the other hand, these actions reproduce structure. This interconnectedness is usually not obviously visible. It is one central objective of CDA to make these relations visible.

The concept of power does, in context with CDA, not necessarily mean coercion, domination or control. According to one of the central assumptions of CDA, power can, just as much, be inherent in consensus. It can as well be expressed as the direction of the free will of individuals to act in someone’s interests (Foucault 1982), or, according to Weber (1980), as getting a person to do something or to accept the existing order of things through shaping a person’s wants. In ‘Orders of Discourse’ Foucault (1991) has linked the power-category with discourse. Foucault argues that the production of discourse is controlled,
selected, organised and canalised in every society. As such, discourse is the result of a social process and therefore the result of power relations. The most visible procedures are prohibition, confinements or explicit taboos in the sense that various norms officially restrict the use of language.

An additional procedure, which Foucault considers at least as significant, is the (linguistic) construction of boundaries. Mental illness is a good example of that. Since the middle ages the constructed demarcation between 'reason and madness' has discriminated against the discourse of the mentally ill. These specific demarcations may not be valid anymore but, according to Foucault, demarcations are still produced and they still exist, albeit in other forms. In that context it becomes clear that for CDA it is not only interesting what is said but also what is not said in a specific context and why.

The theoretical assumptions have been developed further by the Foucauldian concept of ‘Dispositive’. A dispositive is to be understood as an established discursive practice including various discourses which are in a certain way related to each other and, thereby result in an integrating order. For the genealogy of dispositives, scientific discourse plays a significant role, because the dispositive is a form of power relation which is sustained by knowledge and which, in turn, sustains knowledge (Weiβ 1995). Additionally, the mass media, the education system and think tanks are important factors within those processes (Novy 2002). Specific terms which are used in written and spoken texts are, in that respect, discursive categories within knowledge/power formations. CDA engages in ‘denaturalising’ ideologies and dispositives. It questions taken for granted knowledge-bases via integrating the dominant discourse into a broader historical and contextual analysis. It searches for the genealogy of terms and their demarcations and boundaries which are inherent in their definitions and it investigates their development and their contexts of use. It asks how terms shape discourse and on which immanent presuppositions they are founded on.

It follows from these theoretical assumptions that the analysis is not restricted to manifest text but, as Mautner (2000, 47) stresses, has to take into consideration “opaque intertextuality” which goes beyond the actual text and takes into account other texts as well as social structures of text production and consumption. In this respect, CDA typically follows an interdisciplinary approach. The aim in the given case is to go beyond the level of mental health care planning and to address the broader political economic level of reform processes which is manifested in discourse. In addition, it will be reflected whether the reform discourse reproduces or challenges and transforms existing orders of discourse practices. The focus of interest in that respect is to unveil ‘discourse struggles’ which may be observed between different interest groups. This underlines the process orientation of the method.

Having outlined the theoretical concepts of history, power and ideology underlying the method chosen, some final theoretical issues need to be addressed.
First of all, from a constructivist epistemological perspective, documents reflect constructed forms of social reality. "... all texts, e.g. physics textbooks, do-it-yourself manuals, novels, children’s books, biographies, histories, speeches and conversations ... are discursive constructions of some world" (Fowler 1991, 208; original emphasis). According to Wolff (2000), documents are products of human activity and thus can be defined as standardised artefacts with a certain format or outer appearance. Hence, as much as to text and context, attention needs also to be drawn to formal features, frames, schema or style of a text. Beyond their manifested form of appearance, documents express and indicate a social logic. They allow conclusions about their authors, their purposes and intentions and about the institutions or organisations they have been produced in. In other words, they are representatives of a broader social context, in particular of socially organised practices of producing and processing. As a practical consequence of this constructivist perspective, the analysis needs to focus on the original texts including the original language used in the text and, furthermore, content features as well as formal features need to be addressed.

If one takes a look beyond the recent past, it is noticeable that the interest in psychiatric discourse is not a novel issue. Critics of mental health care, such as Dörner (1969), Scull (1979) or Foucault (1973/1991) have particularly addressed, among other issues, the significance of discourse within context of discrimination of the mentally ill. Additionally, mental illness is one of the most striking examples of diachronic language transformation within medicine. In many cases, this has again happened in conjunction with increasing awareness of the discriminating or stigmatising effects of specific terms. Hughes (1988) has shown that the semantic field of synonyms for ‘mad’ is quite large. Figure 1 gives an overview of the multiple terms which have been used in that context.

Also more recently, the mental health discourse has been under scrutiny. For example, as Strouhal (1989) has shown in his hermeneutic analysis of a psychiatric report, discriminating processes within mental health care may be closely linked to the institutional language of bureaucracy. Similar forms of discrimination may still happen, albeit in different ways. Furthermore, feminist scholars have shown that psychiatric discourse has contributed to pathologise, individualise and medicalise women’s psychological and emotional suffering in various ways, thereby providing another example of the ambiguous relationship between discourse and mental health care (Stoppard 2000). A Swiss female psychiatrist has summarised the relationship of discourse and psychiatry in the following way: “With language we exercise enormous power. The secret nature of medical discourse has a particularly uncontrollable potential for the misuse of power.” (Der Standard 24-02-2003, 18; interview excerpt; I.Z. translation)

18 ‘Diachronic’ refers to the chronological change of language.
5.2.2. Empirical Data, Method and Analytical Framework

Researchers have drawn attention to the difficulties of applying discourse theory to an empirical analysis which is primarily due to the highly abstract level of the theory (Torfing 1999). Nevertheless, the theory has been used to guide analyses of different social phenomena (e.g. Atzmüller and Redak 2000; Bargetz 2002; Mautner 2000; Fairclough 1995; Reichert 2003; Wodak 1989). The specific design for the empirical analysis is usually characterised by a triangular interrelation between theory, data corpus and method (Mautner 2000; Meyer 2001). For the present study, the empirical data for the analysis are, first of all, the
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official mental health care reform plans of different Austrian provinces which have been published since 1990. The date has been chosen because it marks the beginning of intensified reform discussions in Austria and because prior to that date, reform documents of that type hardly existed.

In addition to reform documents, results of qualitative interviews supplement the empirical data sources. Different sources of empirical data are, not least, important for reliability purposes. Furthermore, while documents show products of (discursive) processes, interviews have been conducted to learn more about these processes themselves, in particular about perspectives and perceptions of the process among different interest groups. For that purpose, seven representatives of various groups of actors within mental health care, namely service-users, their relatives, providers of services and payers have been interviewed via semi-structured interviews using slightly varying open questions (Kvale 1996). Contacts from former projects have helped to select key-actors within every group of actors. The selection-criterion was that the person had to be involved in the mental health care reform process. Interviews were carried out in different provinces and interviewees were of different age and gender. The interviews were recorded and subsequently transcribed into texts. Overall, analytical tools according to Froschauer and Lueger (1992) have guided the interview analysis. Identified discursive categories and distinct discursive features should supplement and differentiate hypotheses and interpretation results from the reform-text analysis, thus adding another dimension of interpretation. In general, the paragraphs for the detailed analysis of documents and interview texts have not been translated prior to the analysis and where possible, the documents used have not been manipulated or transformed in their original appearance.

Following the method of Fairclough (1995), the analysis is employed on three dimensions. Firstly, properties of the text themselves are looked at. Secondly, from the perspective of processes, the practice of text production and interpretation is addressed. Finally, the socio-cultural practice within which the discourse is embedded in the immediate situation, at the wider institutional or organisational level and at the societal level is analysed. This corresponds to three practical procedures. First of all, a linguistic description, secondly, an interpretation of the relation between discursive processes and the text and, thirdly, an explanation of the relationship between discursive processes and social processes are required. It has to be noted that these three dimensions do not necessarily relate to a chronological order but they are addressed variably throughout the analysis.

For addressing this different dimension, several analytical categories and questions have been defined in order to guide the analysis (see table 15). For the text/language level, categories have been adopted from Mautner (2000). They can be divided into categories addressing a) the formal level and categories addressing b) the content level of the language. Concerning the formal language level,
categories for the analysis are, firstly, the text itself (e.g. definition of the type of text, structuring, themes, perspectives of the author) secondly, lexis\(^{19}\) (e.g. use of metaphors\(^{20}\), metonyms\(^{21}\) and synonyms\(^{22}\)) and, thirdly, non-verbal modes (e.g. emphases, graphical design, illustrations, symbols). Concerning the content level of language, the analytical categories are ‘strategies’ (subordinate discursive aims which are manifested in the text) and ‘motives’ (single content features which constitute strategies). For the dimension of ‘text production/interpretation’ questions cover the processes of producing and ‘consuming’ the texts, the actors involved and the immediate contexts of these processes. Concerning the third dimension which has been named ‘discourse-society relationship’, the focus of the questions shifts from mental health care texts and interview transcripts to broader political-economic and societal transformation processes. It particularly addresses how developments in the mental health care discourse are related to developments in the overall welfare state. At this point, the analysis particularly aims to identify implicit financing arguments in the discourse. Although the stated categories are not applied for every single feature, they represent the entire analytical pool which has been compiled for the analysis. Illustrated on a ‘language-societal continuum’, the overall analysis predominately focuses on the latter features.

For a qualitative analysis, the data-base is fairly huge. Hence, the material is not analysed to full extent, but selected topics have been defined for specific ‘case studies’. Features for the text analyses are selected according to the criterion of a) being particularly salient in one text by comparison with other texts and according to the criterion of b) appearing as a key term and/or dominant feature. Obviously, this selection is subjective because it is impossible to cover every single issue. This raises questions of reliability. In that respect, data triangulation and theoretical sampling (see also 1.3.) should guarantee serious results. Additionally, particular attention is paid to making the research process as transparent as possible. It needs, finally, to be noted that the discourse which is produced in this paper has the same attributes as the one which is analysed. It is, thus, in itself

\(^{19}\) Lexis means the vocabulary or total stock of words.
\(^{20}\) A metaphor is the use of a vehicle to describe a specific topic. Lakoff and Johnson (1980) have found that metaphors are not a pure characteristic of language alone, but they are pervasive in everyday life, that is in thought and action. As they remark, metaphors can create realities. Their significance lies in their manipulative power. “New metaphors, like conventional metaphors, can have the power to define reality. They do this through a coherent network of entailments that highlight some features of reality and hide others. The acceptance of the metaphor, which forces us to focus only on those aspects of our experience that it highlights, leads us to view the entailments of the metaphor as being true” (Lakoff and Johnson 1980, 157).
\(^{21}\) Metonymy is the replacement of an expression by a factually related term. The semantic connection is of causal, spatial, or temporal nature and is therefore narrower than metaphor (e.g. using ‘Napoleon instead of France’) (Bußman 1996 in Lerner 1999, 310).
\(^{22}\) A synonym is a word or phrase with a meaning similar to that of another in the same language (Pollard and Liebeck 1994, 814).
influenced and shaped by the personal physical and social environment. From a meta-level perspective, the results which are produced can be regarded as 'secondary-order discourse'.

After a brief summary of the Austrian mental health policy since the 1960s and an outline of the Austrian mental health care planning documents, in the subsequent parts the introduced analytical framework will be applied for the analysis of mental health care reform discourse in documents and interview texts.

### Analytical framework

<table>
<thead>
<tr>
<th>Level of analysis</th>
<th>Dimensions of analysis (adopted from Fairclough 1995)</th>
<th>Analytical categories (questions to be asked)</th>
</tr>
</thead>
</table>
| Language          | Text and language (adopted from Mautner 2000) (text analysis) | a) Formal features: Text, lexis, non-verbal modes  
b) Content features: motives, strategies |
|                   | Text production and interpretation processes (processing analysis) | How is discourse constructed and how is it constructive?  
Who produces the text? Who consumes the text?  
Immediate institutional, political, societal, economic context  
Issues of transparency |
| Society           | Relationship between discourse and societal context (social analysis) | Genealogy of terms, definitions (what, who)  
What is not said in the text?  
Broader societal, political, economic and historical context of discourse formations and terms;  
Tendencies of discourse developments in the light of welfare state transformation;  
Explicit and implicit financing arguments |

Table 15: Analytical framework; own table
5.2.3. Mental Health Care Policy in Austria since the 1960s: A Brief Historical Overview

Compared to other Western European countries (e.g. outlined in Bennett 1995; Goodwin 1997), in Austria mental health care reform initiatives started late. Around 1970, mental health care was characterised by a ‘two-component’ type of service provision. This included hospital care in mental hospitals and treatment by specialist doctors. Furthermore, the system around 1970 can be described as a two-tier system with better equipped or private service provision for affluent persons and stigmatised mental hospital care for less well-off persons (Forster 1994). As the author remarks, there were significant reasons for the time-lag, such as the slow process of appreciating the problem within the medical profession, the political arena and the overall climate within the Austrian society.

Nevertheless, since the 1970s, substantial changes have taken place within Austrian mental health care (e.g. Meise, Hafner and Hinterhuber 1991). This is most significantly apparent in decreasing numbers of hospital beds in mental hospitals and utilisation of hospital beds as has been outlined in chapter 3. At the same time, chapter 3 also demonstrated that outpatient and community services (particularly for accommodation, employment related services, mobile and ambulatory psychiatric services) have been increased, resulting in a rising number of occupational groups involved (Forster 1997). However, unlike other countries, within the first 20 years of reform initiatives, strategically planned reform measures have not taken place. According to Forster (1994), endeavours within that period of time can at best be described as the beginnings of a reform process and have more or less, been the product of single actor’s initiatives resulting in a kind of patchwork-scenery of various community mental health care services. The author has summarised this type of reform procedure as ‘micropolitics’. That apart, from around the 1970s, public awareness of the appalling psychiatric conditions rose and a critical civil movement named ‘Demokratische Psychiatrie’ emerged (Hermann 1979). Several activities such as under-cover journalism in psychiatric hospitals revealed bad conditions and discriminating effects of the legal system and made psychiatry a public issue. Yet the movement lost publicity during the 1980s.

Since the mid-80s, discussions about the future provision of mental health care services have once more been intensified on the professional and political level. In 1990, two legislative changes mark the beginning of a new era: firstly the law of ‘Civil Commitment Act’ (Unterbringungsgesetz) and secondly the ‘Psychotherapy Act’ (Psychotherapiegesetz) were formulated. Over the last ten years, reform initiatives broadly focussed on further decentralisation and de-institutionalisation. In the following chapters the latest reform era is addressed in further detail.
5.2.4. Mental Health Care Plans in Austria: Development and Contents

The first official document which was concerned with mental health care in Austria was the ‘Zielplan für die Krankenversorgung und Altenhilfe in Wien’. It was established by the City Councillor Alois Stacher in 1975 (Schmidl and Rudas 1999). The publication was followed by several discussions with respect to the reorganisation of mental health care in large cities resulting in some further planning documents in the late 1970s (Schmidl and Rudas 1999). The majority of documents were however only written from 1990 onwards. In 1992, the Ministry of Health (Bundesministerium für Gesundheit 1992) published the first federal mental health care planning document which has been written by a group of experts. Furthermore, in 1994, hospital mental health care was, for the first time, separately covered in the federal hospital plan (ÖBIG 1994) and in 1997, a federal document including suggestions for the overall Austrian mental health care service provision was published (ÖBIG 1997) with follow-ups in the years 1998 and 2000. Additionally, mental health care was addressed in all of the subsequently following hospital plans (Katschnig, Denk and Scherer 2004).

Apart from those federal activities, planning initiatives have mostly been undertaken on the provincial level. All of the provincial governments have commissioned mental health care reform projects and several reform documents have been produced. Meanwhile, all of the nine provinces have published at least one mental health care plan. In some provinces (e.g. Lower Austria, Styria) revisions and/or evaluations of the initial documents have been made. The first provincial plan was published in 1993 (Meise et al. 1993), the latest one is from 2003 and addresses the revision of mental health care in Lower Austria. Since these documents include reform objectives and priorities, they play a significant role for future mental health care provision.

From a CDA-perspective mental health care plans can be described as discursive occurrences and narratives, shaped by different social groups and interests and their different forms of practice and strategies. It is on the one hand of interest, to address the process of document development and the actors included. On the other hand, it will be intriguing, to see how reality is constructed by the plans through structuring complex situations in a specific way. Finally it is interesting how different actors might be constituted by the plan and how specific attributes and aspects of theses groups of actors are defined in that processes, while some actors may be neglected entirely. Not least, as stated earlier, reform documents are political documents and therefore reflect broader ongoing political-economic processes and dynamics. Although planning projects have not been carried out by politicians personally, they have been commissioned by public bodies and final responsibility for publication of the documents has rested with the according political actors. This is not always clearly visible. Thus, in some cases the researchers that have developed the plans are named as authors on the
front page, thereby transporting the impression of a research document whilst other examples state the authors as public and private organisations which were involved in producing the plans, herewith reflecting the notion of a policy document (table 16). In summary, reform documents reflect policy objectives, however precisely they are stated. As a member of a provincial government put it: “The mental health care plan defines the cornerstones for future policies” (Landesregierung Oberösterreich 2002, 3; I.Z. translation).

![Table 16: Mental Health Care Reform Documents since 1990](image)

* italics marks documents on the provincial level
The content of provincial documents which are now going to be analysed in detail shows several characteristics from a synchronic and diachronic perspective. Firstly, since the publication of the first document in 1993, the central reform aims have been deinstitutionalisation and decentralisation. Thus, providing mental health care outside (psychiatric) institutions and on the local level where people live and work appears to be the unchanged main objective of the reform texts. These core aims are linked to various sub-goals such as changing priorities treatment pathways which should render institutional care secondary to outpatient and mobile care ('ambulant vor stationär'). Additionally, since the first document it has been stressed to transform mental health care from supply-oriented to person-oriented and needs-based care. In other words, individual persons’ needs should be at the heart of any question of service supply and development. In that context, concepts of ‘normalisation’ and ‘individualisation’ are emphasised which, in turn, require that more attention is paid to integration and co-ordination of services as well as to establishing arrangements for continuing care. Finally, in most of the documents from 1995 onwards ‘participation’ of people with mental illnesses and their relatives in treatment and service planning appears as an aim.

From a diachronic perspective the core aims have remained unchanged since the beginning of the 1990s. In addition to structural changes in quantitative terms, the younger texts increasingly pay attention to quality of services and forms of measuring quality.

In summary, evaluations show that despite several changes in service structure and provision, the overall aims of mental health care reform have not been achieved so far (e.g. Landesregierung Steiermark 2001; ÖBIG 2002; Pühringer 2000), which is similar to the experiences of other countries (e.g. Bramesfeld 2003). Documents show that mental health care at present consists of various types of services and institutions which are still largely uncoordinated and geographically unequally distributed.

24 ‘Normalisation’ refers to providing services in a way which enables persons with a mental illness to live their lives as ‘normally’ as possible. Hence, to enable them to live a life which is not different from generally accepted ways of life of citizens (Land Oberösterreich 2002).
25 ‘Individualisation’ refers to the right of self-determination and individuality (Land Oberösterreich 2002).
5.2.5. Analysis of Reform Discourses and Processes

"It is a hopeless condition that – when using well-worn language for suggesting innovations - even the most honest reformer, via taking over an established apparatus of categories and the bad philosophy lying behind, enforces the power of the existing which he/she wants to brake." (Horkheimer and Adorno 2001, 4; I.Z. translation)

5.2.5.1. The Different Faces of Community Mental Health Care

When addressing not only manifest but also latent contents and formal features of the documents, several characteristics can be identified. First of all, the plans differ considerably in their outer appearance. Some of them are simple ‘Word-documents’ (e.g. Dantendorfer 2000), while others mirror a professional and graphic-design layout (e.g. Landesregierung Salzburg 2002). On the cover page, some plans show paintings by mentally ill artists. Documents also differ in their length, ranging from 39 pages up to 671 pages. The appearance gives an impression of a different significance or purpose of the documents. The cheaper and plain documents appear to have been written in order to fulfil an agreement or for internal administrative use only, whilst others seem to address a broader audience, showing greater effort with a sense of taking the issue more seriously. Although the reform plans are public documents, public knowledge of their existence and their contents seem to be low and access is often linked with bureaucratic obstacles. A social worker who has been working in the mental health field for years states:

"Schauen Sie, was geplant ist in Wien, weiß ich gar nicht. Es wird ja nirgendwo veröffentlicht. Man hat nirgendwo Einblick." (I1)

("Look, I don’t know what is planned in Vienna. It is nowhere published. One cannot gain insight.")

Similarly, a former user of psychiatric services notes:

"Das Problem ist einfach, dass die Öffentlichkeit nicht weiß, was der Psychiatriereinweiterungsplan ist." (I3)

("The problem is simply that there is no public awareness of the mental health care reform plan.")

Concerning overall strategies for changing the priority of care from inpatient to community and outpatient care, there are some subtle contradictions. Within plans
covering overall mental health care, inpatient hospital care still seems to be the primary issue or the norm. It is used as a standard against which other service elements are compared. On the one hand, this is apparent in the order of topics, where hospital care heads the table of contents and the related chapters of the documents but it is also apparent in several terms which reflect hospital care as the norm, whereas community services are ‘the other’, ‘the deviant’ or the ‘hospital’s complement’. Community services and related issues are summarised with terms like ‘außerstationäre Versorgung’ (service provision outside the hospital), ‘extramural’, ‘komplementäre Versorgung’ (complementary service provision), ‘nicht-stationäre Versorgung’ (non-inpatient care) (e.g. Dantendorfer 2000; Katschnig et al. 1996; Landesregierung Oberösterreich 2002). The hospital’s dominance also appears in the utterance of a member of the managerial board in a mental hospital. When he describes mental health care plans as

‘...Dokumente, die die Grundsatzposition einer gemeindenahen Psychiatrie beziehen, die in die Spitäler der somatischen Medizin integriert werden soll,’“ (I2)

(‘...documents that outline the core aims of community psychiatry, which is to be integrated in hospitals of somatic medicine’),

he restricts reformed mental health care to reformed hospital care. This is underpinned by the characteristically dominant feature in reform discussions which is numbers of hospital beds.

“Ich bin ja einer von denen, die nicht so furchtbar auf den Betten herumreiten, aber andererseits hab ich es natürlich leichter...weil wir eh genügend Betten da haben.” (I2)

(‘I am not one of those who only discuss numbers of beds; on the other hand it’s also easier for me because we have enough beds anyway.’)

“In Niederösterreich gehört noch allerhand umversorgt, da wird halt gestritten um Betten.” (I1)

(‘Lower Austria still needs a lot of restructuring, commonly it’s beds which are fought for.’)

“...im Bezug auf Experten – auf Chefarzte – spielt die Macht eine große Rolle und es ist halt von alters her so, dass der der Größte ist, der die meisten Betten hat.” (I4)

(‘...concerning experts – the heads of a clinic – power plays a significant role and it has traditionally been the case that those who have the highest number of beds are the most important ones.’)
The spatial metaphor of a hospital’s employee which symbolises hospital care as safe space in contrast to the demanding and threatening space ‘outside’ similarly underlines the picture of hospital dominance:

"... die absolute Narrenfreiheit, die so ein bisschen belächelt wird, die hab ich da herinnen schon ... ich weiß nicht, ob ich in einem Amtshaus draußen – sag ich jetzt auch draußen – irgendwie so lernen hätte können ... wir stehen hier nicht unter dem Druck, nämlich wie draußen, gemma, gemma, schnell, schnell."

(‘...inside I’ve got the freedom to do whatever I want, this kind of freedom which is sometimes a bit smiled at...I don’t know whether I would have been able to learn all this outside – now I also say outside – in an office...we are not under pressure like outside, hurry up, quick, quick.’)

The statements demonstrate that the self-perception of key actors, including that of decision-makers is not generally identical with the definition of ‘community care’ in reform plans. Some of them address decentralisation but neglect de-institutionalisation. Prior (1993) has made the point that a confusion between these two processes can be traced back to the first publications about community care in the 1950s. It may be linked to these inaccuracies that the movement from mental hospitals to community care can in Austria be described as trans-institutionalisation rather than a move into an independent world of community life (Forster 2000).

The discourse, additionally, mirrors hierarchical structure within mental health care. In overall listings the common custom is to use terms such as ‘ärztliches und nicht-ärztliches Personal’ (medical and non-medical personnel), ‘medizinische und außermedizinische Fachdisziplinen’ (medical and non-medical disciplines) which renders areas that are not part of the medical field subordinate (e.g. Arnold et al. 2002; Dantendorfer 2000; Katschnig et al. 1996; Meise et al. 1993; Landesregierung Salzburg 2002). This is similarly visible in descriptions and metaphors of organisational structures:

"Die nördlichen PSD-Beratungsstellen (psychosozialer Dienst) sollten fachlich der zukünftigen Abteilungsleitung [für Psychiatrie] in Eisenstadt unterstellt werden, die südlichen PSD-Beratungsstellen der zukünftigen Abteilungsleitung in Oberwart.” (Dantendorfer 2000, 17)

(‘The offices of ambulatory and mobile psychiatric services (Psychosozialer Dienst) of the northern area should be professionally subordinated to the head of the department of psychiatry in Eisenstadt and the offices of the southern area should be subordinated to the head of the department of psychiatry in Oberwart.’)
"Was ich in der Psychiatrie als starken Hemmschuh erlebe, ist die Schnittstelle zwischen stationärem und extramuralem Bereich und zwar aus dem Grund, weil es da um Machtpositionen geht. Da geht's um die Machtposition, dass der stationäre Bereich bestimmt, was außerhalb der Mauern passiert, also dass sozusagen die Fänge nach außen gehen." (I6)

("For me the separation between hospital and community care is one of the major obstacles because it's associated with power-relations. The power-relation is structured in that way that the hospital sector defines what should happen outside the walls, the [literally] tentacles go from the inside to the outside.")

"Ich glaube, dass die Entwicklung, so wie sie jetzt ist, dass die Intramuralen den extramuralen Bereich definieren, dass das ein Handicap darstellt." (17)

("I think that the current development, where the hospitals define what is outside the hospital, is a handicap.")

One gets a similar picture of the situation in another province, where various psychiatric social services are run like ambulatories, according to medical patterns (ÖBIG 2002). This indicates that 'the social' is rather inferior to 'the medical'.

5.2.5.2. Actor-relationships and Discourse Struggles

Taking the perspective that mental health care plans are political documents, they are the result of negotiation processes between different interest groups with varying degrees of power. From that point of view, the role of actors becomes significant, with some groups of actors having better opportunities to organise their interests in order to shape politics than others (Jessop 1999). The analysis of the given process shows that in terms of shaping policies the profession of psychiatrists is in a dominant position. Firstly, although expert involvement has been extended to different disciplines, there are a greater number of psychiatrists represented as authors in the documents than other occupational groups. The dominant position is additionally underpinned by more subtle features.

"Man muss schon sagen, der rechtliche Anspruch [des Psychiatrieplanes] ist bescheiden, aber trotzdem wird das ja doch – und das ist der wesentliche Teil – von einem Großteil der ... Psychiater schon auch gewollt und auch getragen." (12)

("It has to be noted that the legal power of the mental health care plan is minimal but it is supported – and this is most important – by the majority of psychiatrists.")
The significant issue in that statement is not that psychiatrists are involved in planning but that it is primarily the psychiatrists who are ascribed that role while other groups of interests are not mentioned at all. This is similar when controversies about existing plans are described:

“[Psychiatre] X hat kritisiert ...; [Psychiatre] Y hat sehr massiv die 'Z [Psychiatre]-Pläne' kritisiert.“ (I2)

(“[Psychiatre] X has criticised ...; [Psychiatre] Y has severely criticised the planning document of [Psychiatre] Z.”)

These prevailing patterns mirror a hierarchical stratification within occupational groups as well as between medical professionals and users or their relatives. The inherent logic is also noticeable in utterances of other interviewees. An involved relative states:

“Es wär ganz gut wenn wir mitreden könnten, jetzt nicht im Sinne von bestimmen, sondern einfach nur, ah, unsere Meinung zu den Dingen kundtun können, als Korrekturnmöglichkeit. Das ist aber nicht geschehen, und das war die Schwierigkeit. Es ist besser geworden im Lauf der 90er Jahre dann, aber so richtig einbezogen sind die Users eigentlich nie worden, ah, und das ist also schade.“ (I4)

(“It would have been nice if we had been able to join the discussion, not in the sense of making decisions but simply, ah, to state our opinion, as a way to correct things. This has not happened and this was the difficulty. It has improved over the 1990s but users have not been really involved, ah, and this is a pity.”)

When paralleled with sociological literature about the status of the medical profession, medical dominance has to be seen in the light of the history of medicine and its relation to the state (Annandale 1998; Elston 1991; Freidson 1970). With regard to mental health care planning in Austria, the phenomenon of psychiatrists’ dominance is not a new one. In fact, already the first major changes can be traced back to the initiative of single psychiatrists while politicians have played a secondary role.


(“A psychiatrist told me that, once, they were meeting in the back room of one of these beautiful old pubs next to the ‘Goldenen Dachl’ and were
almost allying themselves, almost swearing – we want to improve psychiatry in Austria.”

This role is still ascribed to them. As a politician states:

“... und da haben wir wirklich mit dem Prof. X. [Psychiater] – Sie werden ihn sicher kennen – einen herausragenden Experten, der hat uns den Psychiatrieplan gemacht, mit allen Vernetzungsansätzen.“ (I5)

(“...and with Prof. X [psychiatrist] – I'm sure you know him – we have really got an excellent expert who has produced the mental health care plan for us; including all aspects of co-ordination.”)

The war-metaphor in the following utterance seems to underpin the logic. The interviewee describes a situation in one province where hitherto no planning document has existed:

“...da ist der Prof. X [Psychiater] dann angesetzt worden, dann hat er das sozusagen mit einer Armee von Panzern in Ordnung gebracht.“ (I4)

(“...then they have put on Prof. X [psychiatrist] and he has put things in order with [literally] a division of tanks.”)

It seems very likely that the dominant position of psychiatrists impacts on the mental health care discourse. In fact, medical terminology dominates the rhetoric, yet discourse struggles which question prevailing concepts are clearly visible. Thus, a former user notes:

“Ich hab natürlich nicht gewußt, wenn ich sie [die Medikamente] jetzt absetze, dass es dann zu einem so genannten Rückfall kommen kann, was die Ärzte dann wieder als Psychose bezeichnen.” (I3)

(“Of course I didn’t know that I will get a so-called relapse if I stop taking the drugs, which doctors then call ‘psychosis’. ”)

Additionally, dissatisfaction and uncertainty with prevailing terms in psychiatry are apparent.

“Es wundert mich nicht, ahm, wie viele wirklich, ahm, irgend eine Störung – also ich habe noch kein passendes Wort für mich gefunden – aber wie viele Leute dann ausbrechen oder flüchten müssen.” (I3)

(“I am not surprised, ahm, how many people, ahm develop some kind of disorder – I haven’t found the right word for myself so far – I mean how many people finally have to escape.”)
It is, however, characteristic that discourse struggles are restricted to psychiatry in a narrow sense. They primarily concern concepts of mental illness, diagnoses or treatment while broader issues of mental health care such as the financing discourse are not contested. This suggests that addressing the discourse which is beyond medicine and the traditional realm of psychiatrists seems to be of even more interest.

5.2.5.3. Mental Health Care between Economisation and Changing Patterns of Governance

The previous statements are already associated with another central issue in the documents which is the emphasis on involving people who have experienced a mental disorder and/or their relatives in planning activities. From a diachronic perspective, user involvement appeared for the first time as a definite objective in the Lower Austrian planning document in 1996 (Katschnig et al. 1996). Since then, 'user involvement' or 'user participation' have been stressed in most of the following documents. Generally, however, the terms seem to be used as a catchphrase, rather than a clearly defined concept. Addressing the issue of 'participation' is usually restricted to single sentences like the following:

“In diese Evaluation und die aus ihr folgenden Entscheidungen sollen Patienten, Angehörige und/oder Patientenvertreter einbezogen werden.“
(Arnold et al. 2002, 24)

(“Patients, relatives and/or representatives of patients should be involved in evaluation of services and in subsequently following decision making.”)

In its original meaning, ‘participation’ is understood as a constitutive element of democratic or republican forms of societies. It can mean both, taking part in political processes and decision making (‘teilnehmen’) or taking part in the results of politics, for instance in national wealth (‘teilhaben’) with the current usage focussing on the former rather than on the latter (Schnurr 2001). In terms of social planning, user participation has developed from an approach of overall ‘citizen participation’ (Ortmann 1976) to an increasing focus on ‘user participation’. The rationale for participation is based on two rather different theoretical foundations. From a democracy-theoretical perspective the purpose of participation has on the one hand been defined as providing conditions for legitimised power and on the other hand – according to the so-called ‘participatory democracy theories’ – as mode for political and social integration which should eventually result in self-transformation of participants into responsible citizens (Schmidt 1995). As a second theoretical strand, participation has been addressed in theories of social service production and consumption where it has been regarded as an integral part
of any service provision/consumption process (Schnurr 2001). A case in point is that production and consumption of social services take place at the same time which always involves the user. Concerning social planning, user participation based on democracy theories is proposed as a means to finally develop democracy, while from the perspective of service production and consumption theory it has been argued that increasing participation of users in planning and providing services is conditional for successful and effective service provision (Schaarschuch in Schnurr 2001).

Thus, form and level of ‘participation’ can be multifaceted. In its prevailing meaning in social planning as “the ways in which ordinary citizens can or do take part in the formulation or implementation of policy decision”, the meaning of ‘taking part’ varies according to ideological perspectives and values of its users. (Richardson in Rowe and Shepherd 2002, 278). For example, Hickey and Kipping (1998) illustrate different forms of user involvement in mental health care on a continuum with ‘information’ at the one end and active involvement in the form of ‘user control’ at the other. In between, participation can mean ‘consultation’ and ‘partnership’. Therefore, various patterns of user involvement, ranging from a consumerist approach to a democratic approach can be termed ‘participation’, correlating to the different theoretical foundations which I have mentioned above. Concerning the level, ‘participation’ can take place on the individual level (where issues concerning personal care are influenced), the service level (where organisation and service provision are influenced) or the strategic level (where users are involved in local and national policy development) (Scottish Development Centre for Mental Health Care 2001). Despite this substantial diversity, contradictory understandings of the term ‘participation’ are not addressed in the documents, nor are practical considerations visible in the texts, as to how different perspectives among interest groups and the likely conflicts this entails might be handled. That different concepts of participation do exist among actors, becomes apparent when analysing their statements. While planners and payers mainly follow the consumerist approach, users and relatives wish for more user control. Yet, in the end they accept the passive role ascribed to them.

“Ahm, der Prof. X [Psychiater] hat das ja immer wieder versichert, dass die Angehörigen eingebunden sind, dass sie auch in jeder Region Mitspracherecht haben sollen usw. Ah, er hat mir auch immer wieder etwas geben zum Durchschauen und Lesen, mehr kann und konnte man auch gar nicht erwarten und gar nicht verlangen.“ (14)

(“Ahm, Prof. X [psychiatrist] has always made sure that relatives are involved, that they should have a say in every planning region and so on. Ah, he has also given me something to read through now and then. You cannot expect more than that and you cannot demand more than that.”)
When asked about ‘participation’ a politician gave the following answer:

“Auch das haben wir gemacht, wir haben im Vorfeld der Erstellung zwei größere Landesveranstaltungen gemacht, wo wir alle Betroffenen alle Institutionen, Vereinigungen, eingeladen haben und sie gebeten haben uns ihre Bedürfnisse in dem Zusammenhang **mitzuteilen**, sodass die einfließen können, und wir haben dann auch den Psychiatrieplan wieder in der selben Form präsentiert vor diesem Forum, das ist eigentlich ganz gut ankommen.” (15)

(“We have done that, too. Before the plan was written we organised two quite large events where we invited all institutions and users and where we asked them to tell us their needs so that they can be incorporated. And then we presented the plan in the same way in front of this audience. This was actually quite appreciated.”)

Among payers, the focus on the ‘advisory-concept’ is not only visible in terms of user-participation but also in terms of other actors’ involvement in the planning process. In one province, selection of an applicant for the planning project was described in the following way:

“Wir [Sozialabteilung] sind dann hergegangen und haben einen Landesarbeitskreis einberufen mit diesem partizipativen Prinzip,...der Landesarbeitskreis hat dann Stimmen abgegeben...und wir haben uns dann eigentlich für jemanden anderen entschieden, als was das Stimmungsbild dort war, haben wir aber begründet; also wir haben das als beratendes Gremium gesehen.” (17)

(“What we [department of social affairs] did next is to call a meeting according to the principle of participation...the team there voted but we actually decided that someone else should carry out the project which was contrary to the results of the voting; but we justified our decision; we had perceived the group as consulting body.”)

Additionally, a representative of a social services provider describes the form they were involved in as

“...Befragung – und dann aber ohne Korrekturlesen, was mir nicht taugt. Aber sonst is des einfach über Befragung der Anbieter abgelaufen.“ (17)

(“...interview – but without proof reading later on which I don’t like. It was simply interviewing providers.”)

From a comparative perspective, in Upper Austria ‘participation’ played a considerably more significant role during the planning process than in the other
provinces. Thus, the planning project was commissioned on condition that regular collective meetings with representatives of the numerous actors were an integral part of the planning process. While similar forms of participatory processes have already happened in other planning fields in Austria for several years (e.g. in urban development processes) (Albrechts 2002), it is a novel experience in mental health care that participation is stipulated by the commissioning political-administrative body. Despite the controversies in definition and perception, the experience of participation seems to bear potential for developing new processes of communication. An actor who was involved in this ‘participatory process’ emphasises the valuable experience she has gained:

“...wie geht man damit um, wenn ein Mitarbeiter das [eine Maßnahme] so super findet und der Betroffene sagt, das ist ein Blödsinn,...also das war für mich beeindruckend...und da sag ich, sind wir bei weitem noch nicht so weit, dass ich sage, das nimmt man ernst...aber ich denke mir, da sind wir in einem Entwicklungsprozess.” (17)

(“...how should you deal with the situation where a professional employee says that something is a perfect service and the user disagrees.... I was impressed by this process...and I have to say, we still don’t take everything seriously what they say but I think this is a learning process.”)

Furthermore, an involved user, somehow surprised, mentions:

“Eigentlich, alles was ich gesagt habe (lacht) mehr oder weniger ist schon eingebunden worden, steht in diesem schriftlichen Dings drinnen.”(13)

(“Actually, everything I said (laughs) has more or less been incorporated, is part of this written thing.”)

The results indicate that in the mental health care planning field forms of collective learning are developing, however they differ considerably in scope and form. When undertaken in larger scale, participation appears to be mainly experimental, yet strongly controlled by the contracting political authority.

In addition to leaving the definition of ‘participation’ unaddressed, there is only token acknowledgement in the documents of how participation may be affected by social factors, social inequalities and power imbalances and what strategies are planned to overcome these inequalities. One of these social factors is the socially constructed demarcation between the ‘normal’ and the ‘abnormal’ discourse and associated inequalities concerning opinions of people with mental disorders, which users experience.

“Leider darf ich das [Träume, Visionen] nach wie vor nicht sagen, weil sonst wird alles wieder als psychiatrisch eingestuft...ich habe gelernt zu schweigen
und auch, zu reden, nur – ich schweige oft nach wie vor, weil ich einfach das Gegenteil kenne.” (I3)

("Unfortunately, I still don’t feel allowed to talk about my dreams, my visions, because anything is easily categorised as psychiatric...I have learned to be silent but also to talk, however, I am still silent in many situations because I simply have experienced the opposite.")

Furthermore, participating users are constructed as a homogenous group. The statement below gives an example of how the concept of ‘a generic service user’ neglects power-relations and specific obstacles which certain groups of users may face. A female user who is involved in planning and campaigning observed:

"Was ich immer wieder sage, ich bin die Jüngste und ich bin eine Frau...und das war am Anfang immer so, dass das was ich gesagt habe die anderen [männlichen Betroffenen] in eigenen Worten noch einmal wiederholt haben und dann hat es getan."... Ich hab schon oft die Erfahrung gemacht, ja so quasi, was möchte uns denn das junge Mädchen erzählen" (I3)

("What I constantly tell people is that I am the youngest one and that I am a woman...and at the beginning the typical pattern was that anything I said was repeated by the others [male users] and then it was fine. I have learned that people sort of ask who does this young girl think she is?")

In general, participation in any form may be restricted due to limited material resources which is acknowledged in only one document (Land Oberösterreich 2002). There is little in the proposals that acts to enhance the users’ material resources. The discourse of different actors, however, reflects that material resources are a vital issue.

"Sehr viele Betroffene haben kein Internet, haben nicht diesen Zugang zu Informationen...es nutzt mir nichts, wenn ich Betroffene selbst anspreche und es scheitert dann wieder an der Mobilität.” (I3)

("A lot of users don’t have internet, they don’t have the same access to information...it’s useless to address users when lack of mobility makes participation impossible.")

"...und was absolut nicht angegangen wird, ist dass immer mehr an der Armutsgrenze leben...das heißt zum Krankheitsbild kommt noch das Finanzielle und das geht soweit, dass dann gesagt wird, wenn z.B. Betroffenenvertreter angestellt werden ... sie sollen ehrenamtlich arbeiten." (I7)
("...and what is absolutely left unaddressed is their increasing poverty risk... that means that in addition to the image of illness there is the financial issue. When users are, for example, being employed it is suggested that they should work voluntarily.")

The results are similar to an analysis of user participation in Scotland by Lewis (2003). The author concludes that „the rhetoric of user involvement often appears to have more to do with incorporation and control than democratisation and empowerment“ (Lewis 2003, 8). Users are ascribed the role of consumers who learn to articulate needs but who are otherwise in a passive role. Extension of the consumer status to people who are using public services has been described earlier in other countries (e.g. Barnes 1999; Keat, Whitely and Abercrombie 1994). That ‘consumerism’ has also been transferred to Austrian mental health care, is illustrated by further discursive elements in the documents. While in older documents the term ‘patient’ is predominately used for service users, in more recent ones a diversification of terms occurs where notably, the term ‘customer’ appears. This term is usually accompanied with the logic of ‘freedom of choice’.

("Nicht das Angebot darf länger über die Kund/innen, sondern die Kund/innen müssen über ihr Angebot entscheiden.“ (Landesregierung Oberösterreich 2002, 3)

("Customers must no longer be selected according to available supply, but customers must decide on their supply.")

In that context, Hugman (1994) has identified two sets of relationships between users and providers/payers. One form he has termed “market consumerism” which aims at consumers’ ability to choose between different options in a ‘market place’. The other one he calls “democratic consumerism” which means developing products rather than choosing between finished products. Similarly Barnes (1999, 84) distinguishes between “‘making and creating’ the services...rather than simply ‘consuming’ them.” In stressing freedom of choice, the mental health discourse seems to reflect the latter rather than the former. However, some elements of ‘product-development’ occur.

("Die Kund/innen wählen künftig nicht nur ihr Angebot aus, sondern (mit)entscheiden über neue Konzepte und beurteilen und bewerten bestehende Angebote.“ (Landesregierung Oberösterreich 2002, 3)

(„Customers not only choose their service but they (partly) decide on new concepts and assess existing supply.")

When relating these results to general developments within the welfare state, they fit well with a common trend of transformation which Bröckling, Krasmann and
Lemke (2000) have called "economisation of the social". Roughly speaking, "economisation" means that market principles, their logic and concepts are transferred to the public sector. The starting point of this process can be dated back to the 1980s, when the public sector in Western European welfare states became increasingly described as being in a crisis (e.g. Ferrara and Rhodes 2000). Arguments of overspending and under-serving, demographic changes or technical progress have initiated major restructuring processes since the end of the 1980s in various parts of the public sector. On the one hand, privatisation and deregulation occurred. However, apart from changing ownership from public to private, another pattern of "economisation" has been to transform the remaining public services through internal rationalisation and adoption of the market-logic. Characteristics of this logic are firstly, "commodification", which means transforming health and social care services into "buyable" goods. Secondly, creating business-like structures within organisations similar to private companies and finally, establishing competition between institutions and their activities (Novy 2002). This form of "economisation" has particularly taken place within health and social sector services. For instance, in the UK, "economisation" was clearly visible when the National Health Service (NHS) was changed into the so-called "internal market" which meant that market-principles were introduced in a still publicly financed health care system. One example for the Austrian health care sector which mirrors this development is the DRG-related hospital financing system (Leistungsorientierte Krankenanstalten-finanzierung) which was described in the previous chapter 4. A vital characteristic of this financing model is that it introduces competition between hospital care providers and between departments within hospitals. The aim is to contain costs by forcing hospital administrators towards higher technical efficiency.²⁶

Apart from those fairly obvious restructuring processes, transformation is also visible in more subtle forms. Thus, in order for the constructed "quasi-market" to function, services which are provided have to be defined and constructed as single "packages". Pelizzari (2003, 9) remarks that "once it has been accepted that all services can be clearly separated from each other, they can be quantified according to market prices". This process of segregation is, again, visible in the mental health care discourse. One document, for example, has re-named services as "products" and uses the term "Ist-Produkte" (available products) or "Soll-Produkte" (products which are needed) (Landesregierung Salzburg 2002).

²⁶ Technical efficiency refers to the physical relation between resources (capital and labour) and health outcome. A technically efficient position is achieved when the maximum possible improvement in outcome is obtained from a set of resource inputs. An intervention is technically inefficient if the same (or greater) could be produced with less of one type of input (Palmer and Torgerson 1999, 1136). This efficiency level is focused on the individual person and organisation and does not address the societal level.

("The customer, who comes first in every activity of public administration, is for the first time guaranteed to receive services of defined minimum quality, according to the criteria which have been determined in the descriptions of the products.")

As the quote shows, ‘economisation’ is not restricted to the level of health or social care provision but has to be embedded in a wider context of public administration sector restructuring. Public sector reforms have been triggered by the introduction of ‘New Public Management’ (NPM), which meant transferring the market logic to the general public administration level. The theoretical basis for NPM is firstly, the theory of ‘New Political Economics’ which applies the concept of ‘methodological individualism’ for the analyses of actors’ behaviour in the field of politics (Pelizzari 2001). As a second theoretical root, Hood (1991) identified ‘The New Institutional Economics’ with the focus on contestability, user choice, transparency and incentive structures. Mental health care has adopted the NPM-logic as it is, for example, visible in the aims of a project entitled ‘Kunde-Leistung-Qualität-Steuerung’ (customer-performance-quality-control), which accompanied the establishment of the mental health care plan in Upper Austria (Landesregierung Oberösterreich 2003). According to Atzmüller and Redak (2000), one central characteristic of NPM is that it changes public administration into a service industry and re-constructs citizens into consumers of public services. Equally, Barnes (1999, 85) notes that “changes in the system of governance associated with new public management provided opportunities for users to play a more active role in influencing the nature of health and social care services. However, those changes emphasized the creation of more effective consumers as a spur to increase service responsiveness, rather than community development as a basis for collective empowerment.” ‘Participation’ in mental health care is therefore likely to be framed within a NPM perspective.

With NPM, a new language – the language of accounting – has entered the public sphere and has since then dominated the discourse. In that context, technical efficiency has become a primary goal in public services. As Rowe and Shepherd (2002) observe, user views in NPM are sought to make services more responsive to consumers’ needs and preferences so that public resources are used more efficiently and effectively. Consequently, as Fairclough (1994) remarks, the ‘consumer-discourse’ is not only be understood as the frequent use of the term ‘consumer’, but as the growing development of specific discursive forms which he calls ‘hybrid discursive forms’. They emerge, for example, when elements of
former authoritative discourses are combined with promotional modes of appropriately addressing customer-oriented discourses.

Another central feature in this restructuring process of public services has been the strong focus on quantitative indicators, be it for quality control or for planning purposes (Rowe and Shepherd 2002). These indicators are crucial instruments for making activities comparable and subsequently, competitive. The importance of quantitative indicators seems also to be prevalent in mental health care.

"Die [Evaluation der psychiatrischen Versorgung] wurde halt einfach notwendig, weil man gesagt hat, die Zahlen stimmen nicht mehr." (I2)

("Evaluation of mental health care was found to be necessary because the figures were not correct any more."")

A professional employee critically observes:

"Der Schlüssel [Bettenschlüssel, Personalbedarfsschlüssel] muss passen und darüber hinaus gibt es nichts." (II)

("The only concern is to find the correct quantitative indicator for bed numbers and numbers of personnel; apart from that, there is no discussion.")

According to Rose’s (1999) critical analysis of using numbers within the technologies of government, figures are not to be seen as neutral or objective, as their quantitative nature might suggest. On the contrary, they are implicitly political if one, for example considers the choice of what to measure, or how to measure something. Similarly, MacKenzie (1981) remarks that despite their apparently unambiguous nature, numbers can neither be ideologically nor theoretically innocent which, most importantly, is grounded in the process of their development. When describing the unmet need of mental health care services, the majority of authors in the plans state figures for hospital beds, places in different types of accommodation, day structure and employment related services per 1000 inhabitants. When tracing back the origins of the figures in the reform documents, it becomes clear that the history of their development is intransparent. Two documents of 1992 and 1993 provided the source from which figures were adopted for the following plans (Zechmeister 2002). The development of the original figures, however, lacks intelligibility in terms of methods and data used for their calculation. Critics have argued that despite their seemingly precise nature, the figures published are to a great extent based on values and estimates (e.g. Rössler 1998). Authors of more recent documents have tried to use other methods of defining met and unmet needs for services, such as expert interviews, or utilisation data (e.g. Püringer et al.). Others have particularly stressed the shortcomings of using figures for service components as a means to define future
needs (e.g. Landesregierung Oberösterreich 2002) without, however, abandoning the figures in the actual plan.

This result has to be embedded into the broader context of social policy. Rose (1999, 197) remarks that "numbers have achieved an unmistakable political power within technologies of governments." Not only do they reduce complexity, but they make governments judgeable and confer legitimacy. For public spending on mental health care they are undoubtedly a valuable instrument to operationalise reform objectives and to justify resource allocation to an area of social policy which has never belonged to the most ‘popular’ ones. Additionally, national fiscal policy has come under pressure by regulations on the supranational level. Under the headline ‘quality of public finance’, national policies are obliged to justify their types and amounts of spending which increases the demand for quantifiable indicators for spending public money (BEIGWUM 2000). Furthermore, Porter (1996) has pointed out that the recourse to quantification is linked to a climate of distrust and suspicion. The allure of numbers increases when authority is mistrusted and when experts are met with scepticism. People respond to the climate by referring to figures, thus trying to justify their judgements on the grounds of objectivity. Psychiatry, as an unpopular part of social policy, may be exposed to such pressure. With psychiatrists being seen as ‘stepchildren’ within medical profession they may be particularly prone to such patterns of behaviour.

In a way, numbers de-politicise the areas of political judgement. The formalistic systems ignore the extent to which they are politically constructed. Rose (1999, 208) remarks that “‘the power of a single figure’ is here a rhetorical technique for ‘black boxing’ – that is to say, rendering invisible and hence incontestable – the complex array of judgements and decisions that go into a measurement, a scale, a number.” In that sense, the concepts of care as transported via figures in the reform plans become subtle and difficult to identify. Consequently, this underlying data, decisions and concepts are not easily challenged from actors other than the producers of the reform documents.

Weber (2001) has analysed that the rising significance of quantitative indicators in the NPM model not only leads to de-politisation but also to de-democratisation. He argues that decision-making takes place increasingly informally and shifts away from formal democratic processes. Thus, the restructuring process changes the role of health policy. Similarly, Sheldrick (2003, 149) notes that “the restructuring of health care systems...has made it more difficult for people to participate in allocation decisions and to hold decision makers accountable. The adoption of the internal market in the UK, for example, resulted in greater autonomy for health authorities, while limiting individual participation and parliamentary and ministerial oversight.” Additionally, due to the argument of scarce resources, decisions about which services to provide for are increasingly being made according to principles of cost-minimisation. This procedure reduces experts’ responsibility to a technical problem of minimising...
costs. Consequently, the impression appears to be that political conflicts don’t exist or that every conflict is related to scarce resources which can be solved technically and rationally.

5.2.5.4. Towards a Liberal Model of Mental Health Care?

Against the backdrop of the previous chapter it is finally of interest to address some further significant terms in the planning documents, which are ‘needs-based’ and ‘person-oriented’ services. The focus on person-oriented needs in mental health care originates in increasing dissatisfaction with existing services, particularly in the field of social care. It has been criticised that services have not been provided according to users’ needs but providers have, on the contrary, defined their own type of mental health care resulting in inflexible and fragmented types of different services being established. This has led to the users’ shifting between services whenever their needs were changing. The situation has been particularly difficult for people with multiple needs. As a matter of fact, those people usually have had to be institutionalised because this has been the only place where multiple needs have been able to be met. Mental health care planners regard the shift to a person-oriented and needs-based service as solution to overcome fragmentation of service provision, because focussing on the individual’s needs requires co-ordination and integration of services such as integration of primary and secondary care or health and social care (Bundesministerium für Gesundheit 1999). From that perspective, needs-based service provision goes hand in hand with the aim to establish an adequate community-based system of care.

Viewed through the ‘CDA-lens’, however, some further dimensions of the ‘needs-based’-'person-oriented’ discourse formation need to be addressed. Firstly, questions to be asked in that context are what the documents say concerning how needs are assessed, how they are rated and what the plans indicate about the measures which are planned to meet needs. As with participation, there exist some terminological problems with the term ‘need’. Thus, two terms, namely the German ‘Bedürfnis’ and ‘Bedarf’ are randomly used in the documents, usually without explicitly outlining what meaning they refer to. According to the definition by Heinze and Priebe (1995), ‘Bedürfnisse’ are the subjective needs which are those needs users personally experience and articulate. ‘Bedarf’, on the contrary, is politically determined or normatively postulated. ‘Needs-based service provision’ in documents (randomly expressed as ‘bedürfnisorientiert’ and ‘bedarfsorientiert’) therefore involves both dimensions, a subjective one and a normative one. Assessment of needs can take place in various ways. Subjective needs can, for instance, be assessed via institutionalised ‘quality of life-research’, via informal conversations between user and professionals or via individual
standardised interviews, to name just a view options. Comparably, normative needs can also be defined through different modes. These range from a democratic formulation process to a ‘technical process’ of experts’ evaluation and calculation, such as cost-efficiency evaluations. The mental health care discourse, though not explicitly outlining, seems to reflect a specific amalgam of these two categories. On the one hand, the ‘consumer discourse’ transports a specific approach of individual needs assessment. Thus, mental health care consumers are asked to articulate their individual needs in analogue to market research. This appears to be visible in the development of specific instruments for individual needs-assessment in order to predict resources.

“[Es ist] daher erforderlich, ein geeignetes standardisiertes Instrumentarium zu entwickeln, das sowohl den individuellen Hilfebedarf ermitteln als auch in weiterer Folge den daraus resultierenden notwendigen Ressourceneinsatz prognostizieren kann.“ (Landesregierung Oberösterreich 2003, 2)

(“It is therefore required to develop an adequate standardised instrument in order to assess individual needs and to predict resulting resource implication.”)

Elements of normative needs-assessment can be considered to be the same as the previously mentioned quantitative indicators, thus needs are defined and/or calculated by experts or according to the listings of further normative experts’ criteria.

“Gerade für eine fachlich richtige und menschlich adäquate, also eine bedürfnisgerechte Versorgung dieser Patientengruppe ist es erforderlich, eine entsprechende Planung zu betreiben.” (Katschnig et al. 1996, 14)

(“Particularly to provide professionally correct and humanly adequate, hence needs-based services for this specific group of patients, mental health care planning is required.”)

Overall, this discourse formation seems to be an additional component of previously explored key orientations in the social sector. Hence, the described form of individual needs-assessment is one crucial element of the NPM understanding of public service provision. The same is true for the applied methods of needs-assessment on the population-level. With respect to the prevalent type of individual needs-assessment, Mayer (1982) criticises that simply asking individuals about their needs is problematic in several ways. Firstly, it is usually carried out during an artificial situation of an interview. Secondly, needs will typically be stated according to the specific experience and living situation. Thus, responses are mainly oriented towards the status quo of individuals and usually consist of issues which seem generally attainable for the individual
person. Results from socially disadvantaged groups will, thus, be influenced by their usual living conditions and their adaptation to them. This type of needs-assessment, furthermore, restricts the problem of ‘need’ to a problem of communication, leaving structural hegemony unaddressed. As Heinze and Priebe (1995) put it, sufficient communication between actors is then regarded as automatically removing hitherto existing disadvantages of specific social groups. Put differently, the focus on individual needs constrains political awareness of how needs have been developed. An individual needs-based focus is then just another dimension of the medical-oriented approach in health care, which is traditionally characterised by the emphasis on the individual person and her/his disease. In that respect, Lewis (2003) has expressed concerns about the potentially paternalistic nature of the concept. The ‘needy individual’, she considers, symbolises a passive and dependent individual.

Furthermore, Sayce (2000, 81) remarks that a person-oriented and need-based mental health care service may aim to establish a ‘perfect’ system of community care, that is a community care system which effectively changes places and organisation of services and ceases to resemble institutions. But she goes on to say: “It fails to set as an aim changes in the whole social environment, that would break down the barriers of exclusion from economic and social life. It fails to require that one role of mental health services should be to facilitate social inclusion.” From that perspective, users may contribute towards the development of service provision, when they are asked to list some of their unmet service needs in mental health care plans, yet this does not automatically guarantee conditions which facilitate the participation of a mentally ill person as a full citizen. In Sayce’s (2000) words, it does not guarantee full social inclusion of the mentally ill. Thus, focus on training and support for users in order to contribute to improve services leaves broader social dimensions uncovered. These dimensions are not addressed in the planning documents.

Bonell and Hilton (2002) have, furthermore, outlined that consultation-types of ‘needs assessment’ exercises may be carried out by service managers or planners in order to inform or merely legitimize their decisions. Similarly, Mayer (1982) notes that a market-research type of needs-assessment is unlikely to shape planning processes, but it rather provides information for planners as to how citizens’ expectations might be controlled.

Articulating needs can, additionally, be influenced by specific discursive norms which need not necessarily be located within the mental health care field. One example is the ‘zero-deficit spending’ discourse which dominated discussions on public spending in the period between 2000 to 2002 and the prevailing discourse of public cost-containment. The climate of fiscal imperative affects the notion of public resources and entitlements.
"Ich meine, die Euroumstellung haben wir auch gehabt, es ist wirklich alles
teurer geworden, und jeder versucht zu sparen, und des merkt man halt
schon auch bei Subventionen." (I3)

("There was the new currency, everything has really become more
expensive, everyone tries to save money and this can be noticed when it
comes to subsidies")

In such an environment, having to bear a considerable proportion of costs
privately becomes a much easier fact to be accepted.

"Wir waren in der unglücklichen Lage sag i iazt amal, letztes Jahr, dass uns
eben im Frühjahr versprochen worden is, dass wir eben Vereinssubvention
bekommen, dann hat sich die Lage geändert, dann war auf einmal kein Geld
finanziert." (I3)

("We were in this unlucky situation that we were promised subsidies in
spring. Then the situation changed and suddenly, no more money was left.
Thus, we covered the costs for the year 2002 with 7,000 € of private
capital.")

Support from the government then turns into something outstanding for which
gratefulness is expressed.

"Die [Personen der Sozialabteilung] sind sehr nett, die rufen auch immer
wieder an und so...und sind auch immer mit Rat und Tat zur Seite gestanden,
und wir haben von ihnen die bestmögliche und großzügigste Unterstützung
erhalten und das darf man auch nicht vergessen." (I3)

("The people from the department of social affairs are very kind, they call
now and then...and they have given advice several times. We have received
the best possible and most generous support from them and one must not
forget this.")

The financing discourse is, moreover, important in context with the measures to
meet defined needs and provision of services.

"Grundsätzlich sollen sich Menschen mit psychosozialem Betreuungsbedarf
sowie deren Angehörige frei entscheiden können, welche angebotenen und
bedarfsgerechten Leistungen sie von wem in Anspruch nehmen wollen.
Entsprechend dieser Wahlmöglichkeit sollen innerhalb der finanzierbaren
Möglichkeiten möglichst vielfältige und variable Angebote zur Verfügung
stehen. (Landesregierung Oberösterreich 2002, 11)
In principle, people with psycho-social needs for care and their relatives should be able to choose from those services which are supplied and regarded as adequate. According to this freedom of choice, the variety of supplied services should be as large as possible. They need, however, to be provided within a limit of available financial resources.

While freedom of choice is transported as being paramount, there is an important appositive saying that within the limit of available financial resources, the variety of supplied services should be as large as possible. Noticeably, ‘financial resources’ are constructed as something fixed and naturally predetermined. This runs contrary to the fact that the amount of ‘available financial resources’ is determined in budgetary policy processes (BEIGEWUM 2000; BEIGEWUM 2002). Particularly in the social sector, where sources of financing are predominately taxes, the proportion which is allocated to mental health care is eventually subject to negotiation. The rhetoric of predetermined resources, on the contrary, signals the impression that financial resources are an unchangeable natural fact, something which is not directly related to political actors and processes. This shapes individual perceptions and reduces possibilities and degrees of action.

It is, furthermore of interest that the concepts of needs-based and person-oriented services are usually accompanied by the term ‘individualisation’. Although referring predominately to the right of ‘self-determination’ and ‘individuality’, the concept implies yet another aspect which is the notion of individual responsibility:

Wir wollen eigentlich den betroffenen Menschen in den Mittelpunkt stellen...und aufgrund dessen müssen wir die Betroffenen stärken, dass sie sich auch um ihre Rechte sozusagen kümmern. Damit übernehmen sie aber auch mehr Selbstverantwortung. Also, net nur Rechte fordern, sondern auch mehr Selbstverantwortung.“ (17)

(“We actually want to follow a person-oriented approach...and this means we have to strengthen the users so that they can look after their rights. But then they also have to take over self-responsibility. As I said, they cannot just demand rights but they also have to bear responsibility.”)

This approach has also been adopted by several international user organisations. The activist Ron Thomson, for example, stresses that “in order to get...rights, people have to take responsibility. They cannot maintain their ‘secret unwillingness to be held at least in part accountable for some of their actions while mentally ill.” (Thompson in Sayce 2000, 118).

Remarkably, these utterances go in line with liberal arguments from both the Right and the Left, who have claimed that individual autonomy and responsibility has to be strengthened and that individuals have to adopt an active part in
governing. That kind of discourse has started to become dominant with the emergence of social-liberalism in Western Europe. In Austria, this was the case from 1986 onwards, when the Great Coalition superseded the social democratic hegemony. For Jessop (2000) this policy change is accompanied by the shift from the ‘Keynesian welfare national state’ (KWNS) to the ‘Schumpeterian workfare post-national regime’ (SWPR). While welfare policies are premised on rights attached to national citizenship, he argues that workfare policies are premised on mobile workforces and active integration into labour markets, accompanied by emphasising the individual’s responsibility. In Jessop’s view, this cannot simply be regarded as continuity of the welfare state but it is associated with a wide range of re-visionings of a new welfare society.

With respect to mental health care, this shift is particularly interesting, since it involves some strategies which sound very similar to mental health care reform goals. One of them is the emphasis on the ‘local’, the ‘community’, notably the focus on empowering community groups (Brodie 2000). The ‘community’ is therefore not only emphasised among mental health care reformers but, as Brodie (2000) remarks, also neo-liberalism has re-invented the community. Even more, she argues, community and individualism have been conflated. Notably, within the community, the individual subject has become more responsible and emotionally linked with other individuals of her/his community (Rose 2000). Governance, through activating the engagement of individuals, their strengths and readiness for decision making, has become the contrasting picture to the centralist and paternalist state which inhibits the individual.

The fact that different fields of problems are linguistically defined (such as community mental health care), at the same time constructs a field where political strategies are to be implemented. Communities become the geographical or virtual territory through which governance takes place. They become classified, documented and interpreted. Governance through communities requires several strategies which define the new dimensions and the individuals as part of them. It additionally requires strategies for integrating, instrumentalising or mobilising individuals. Rose (2000) points out that through the terminus ‘community’ an ‘ethnographic sociology’ entered the language of public authorities which replaced the initial discourse of critical activists who advocated for a less paternalistic welfare state. The movement of resistance has thus turned into a discourse of experts and has been consolidated into a professional field. Finally, Rose points out that through inventing the community, ‘the social’ as an overarching space has been fragmented into different communities. Put differently, governance has ceased to address collective social issues and is tailored to defined and demarcated communities and their individual members within. Individual rights and responsibilities are stressed while reciprocal responsibilities of society for providing equal opportunities for the individual person are barely addressed. Not surprisingly, in the Austrian mental health care reform processes,
‘the social’ in terms of addressing collective social complexities, plays a minor role compared to discussions concerning individual measures for individual persons in the mental health care community. An empirical indication for this in the reform documents may be that mental health care issues which are more concerned with ‘the social’ have received comparably low attention. For example, employment related initiatives and services have been addressed in much less detail and which much lower priority than hospital care.

Not least, during that transformation process the mode of governance changed. For the Austrian case, Novy and Hammer (2002) point out that social policy between the 1970s and the mid-1980s was characterised by a dialectic and open approach, leaving room for experiments and social innovation. Notably, during that period concepts of participation, empowerment and self-help were strongly supported, yet compared to the current situation, they were embedded in a different ideological context. With the onset of the social-liberal period, a shift towards a more technocratic and social engineering style of governance occurred. Understanding of politics changed from a dialectic to a positivist form that operates with clear and logical relationships between means and ends. Embedded in that context, the meaning of core-concepts has inevitably undergone substantial changes.

5.3. Conclusion

In this chapter, mental health care and current reform initiatives have been addressed. For the Austrian case, reform processes and the content of reform objectives have been analysed in detail, following the approach of a critical discourse analysis. I have aimed to demonstrate some of the linguistic aids which are used in the current mental health care discourse and the controversies which are linked to them. This chapter has additionally shed some light on the process of mental health care discourse development whilst the various social dimensions to which the discourse is linked to have also been explored. Furthermore, I have learned about the rhetorical aids which are used to define and portray actors in mental health care. In that context, it has been particularly focussed on the discourse about the mentally ill and attempted to exemplify what these findings indicate about the roles and status of the mentally ill within mental health care planning and provision. The findings provide a picture about the position of mental health care in general and that of the mentally ill in particular within the overall welfare state and society.

Although the plans differ in appearance and detail, core discursive strands can be observed collectively. Most importantly, mental health care planning tends to be influenced by overall welfare state transformation processes. Although core aims remain unchanged, they become a different meaning in the broader
transformation context. This is particularly the case when concepts are not clearly defined and thus can be used differently in changing ideological climates.

Generally, the plans focus on the content-dimension, while the process dimension is largely neglected both in the planning documents themselves and in the planned measures and procedures. Planning processes are rather intransparent. A case in point is that existing conflicts are not addressed, nor are proposals stated as to how conflicts might be handled in future. This gives the impression of existing consensus. Another example is that rather than valuing participation as a process in its own right, participation is mainly seen in instrumental terms; as a means to hearing public views on their health care needs. As Rowe and Sheperd (2002) put it, this is rooted in the NPM focused approach to participation.

When it comes to actor-relationships, on the one hand, hitherto privileged statuses remain unchanged. Thus, the medical profession still has a dominant role in mental health care planning and provision. At first glance, I tend to agree with Barnes (1999) who concludes for the British case that a fundamental shift in power seems not to happen. However, the previous ten years of planning processes have taken place under specific circumstances and social changes. Thus, when addressing the discourse-societal relation, the question of actors and power-relations becomes another dimension. Firstly, existing forms of participation provide a challenge and force those in positions of power to reconsider their practices. Moreover, involvement of further occupational groups and already existing forms of dialogue imply the potential for transformation and change. Yet, the transformation is itself a discursive hegemony. Standards and normative principles in the documents which go beyond psychiatry in a medical sense are part of a larger discourse formation. This is the discourse formation of welfare state restructuring, which is evidently invested by liberal ideologies. One example of that is the economisation discourse and the associated re-construction of the status of users. The analysis, therefore, suggests that medical dominance in terms of shaping and defining the discourse is in fact restricted to a very narrow 'playing field' which is equally true for the potential of the mentally ill to shape planning and provision.

Let me recur back to discourse theory which notes that social identities, roles, attitudes and value systems are transported via discourse, whilst users of discourse are not necessarily conscious of those processes. In mental health care this might be especially likely, because the rhetoric of several core elements has remained unchanged since the 1970s. Terms that have been used by psychiatrists in the 1970s are still observable in the documents. However, 30 years ago they were embedded in a different context. When looking at more subtle elements and linking them to broader socio-political changes, a transformation of meaning can be observed. This indicates that power is diffuse and cannot be ascribed to some single actors. It seems rather to be interwoven in the amalgam of knowledge-power formations.
When embedded in that context, the key-concepts of mental health care plans become multidimensional connotations. The deconstruction of the concepts has shifted the focus away from mental health care per se and has turned the attention to the relation between mental health care and social policy and the political economic context. While the discourse mirrors that, overall, financing issues play a minor role in mental health care discussions, the deconstruction process should in the following chapters allow for the identification of links between mental health care reform programs and financing issues and demonstrate how financing questions are addressed indirectly in many cases.