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Community Psychiatry and the Medicalisation of Unemployment

Samuel Vella*

Abstract
This article discusses how the development of community psychiatry throughout the twentieth century has expanded the management of workers' social lives through psy-professional techniques. I argue that the ideology of industrial psychology has promulgated a normative construction of mental health as an inner problem of the individual, and in doing so, has obscured the structural factors involved in the emotional lives of both employed and unemployed workers. Using the scholarship of Ralph, Illouz and Conrad, it is theorised that the medicalisation of structural unemployment constitutes an example of the continuation of the community psychiatry project in that it reproduces both the normative assumptions of the individual subject of the communicative model and acts to ameliorate the negative impacts of capitalist society experienced by workers through an activation ideology.

Keywords: community psychiatry; industrial psychology; medicalisation; mental health; unemployment

Introduction

From the 1840s, the colonial government in Aotearoa/New Zealand developed and implemented policies to manage mental health as a problem of social order. While mental health policy in Aotearoa/New Zealand has had its own characteristics, it has borrowed heavily from policies developed in the United Kingdom (UK) and, through the twentieth century, the United States (US) (Brunton, 2001). As in the UK and the US, during the mid- to late twentieth century there was a significant policy shift in Aotearoa/New Zealand from the long-running practice of institutionalisation towards new modes of community-based care and treatment. While Brunton (2003) frames the rise of community-based care as a response to the problem of institutionalisation, the deinstitutionalisation of Aotearoa/New Zealand's mental hospitals was shaped by a wider set of political and economic factors than merely the philosophy of community care (Joseph & Kearns, 1996; Ministry of Health, 1996; Williams, 1987).

Much of the study of this policy shift has focused on the institutions themselves, the types of knowledge within them, and the government policy that supported their development (Brunton, 2003; Joseph & Kearns, 1996; Scull, 1976, 2021; Williams, 1987). However, Ralph (1983) calls attention to a broader set of influences supporting the policy shift towards community care, arguing that beyond the domains of clinical psychiatry and the demands of custodial care within institutions, the transition to community-based care was also influenced by forms of industrial psychology and psychiatry. While contemporary policy debates have signalled a desire to move away from the narrow provision of mental health services targeting the three per cent of the population with the most severe needs towards a more general focus on supporting the mental health of working populations (Government Inquiry into Mental Health and Addiction, 2018), it is important to consider the expansion of community-based care in the context of its industrial origins.

Ralph (1983) highlights the expansion of the domain of psy-professions from the management of unemployed and ill populations to the management of the social life of employed populations. Illouz's (2007, 2008) work on the role of industrial psychology in the development of the contemporary culture of

* **Samuel Vella** is a PhD candidate in Sociology in the School of Social Sciences at Waipapa Taumata Rau, the University of Auckland, Aotearoa/New Zealand, where he is researching the history of mental health policy.
Email: svel008@aucklanduni.ac.nz

self-help supplements Ralph's analysis as it highlights some of the ways in which the communicative model of therapy, developed out of industrial psychology, has added to the normative construction of the self in capitalist societies. Ralph's and Illouz's respective accounts highlight the centrality of work in the shift to community-based care, in terms of both the management of workers on a structural level and the emotional self-work of individualised therapy.

While Ralph's work is oriented primarily towards understanding the development of community care, it provides a useful basis for considering the provision of mental health services today. The aim of this article, then, is to give an account of Ralph's research on the development of community psychiatry in order to relate that work to the particular development of Aotearoa/New Zealand's mental health policy today, specifically through an analysis of the 2013 welfare reforms, which engaged with the problem of mental health and work while maintaining an organisational separation from the mental health system as such. As the movement towards community-based care has expanded to include the management of the social life of workers, this article considers the medicalisation of unemployment within Aotearoa/New Zealand's work-focused welfare reforms as a continuation of community-based care policies, highlighting some problems regarding the relationship between employment and mental health.

There is little critical scholarship regarding the development of Aotearoa/New Zealand's mental health system beyond analysis of the asylum system and the impact of deinstitutionalisation. (See, for example, Brunton (2003), Coleborne (2015), and Joseph and Kearns (1996)). This article aims to further a critical understanding of mental health policy by relating Ralph's arguments to the construction of work and mental health in policy regarding the provision of welfare benefits today. The first half of this article introduces Ralph's research on community psychiatry, connecting it to critical scholarship focused on the development of industrial psychology (specifically, that of Illouz (2007, 2008)). The second half then discusses the situation in Aotearoa/New Zealand, focusing on the medicalisation of unemployment and the relationship between mental health and work in policy. This discussion is centred on a reading of the Welfare Working Group's 2011 report, which played a key role in shaping the current provision of welfare benefits.

Community psychiatry and capital

Against prevailing theories of the time, in *Work and madness: The rise of community psychiatry*, Diana Ralph (1983) argued that the roots of community psychiatry could be found in the development of industrial psychology. Ralph uses the term *community psychiatry* to mark the expansion of psychiatric and psychological treatment throughout capitalist societies during the twentieth century, specifically in the context of the social movement towards community-based care, as opposed to a discrete discipline of psychiatry. The designation of community psychiatry denotes a transition of psy-professional treatments from "an individual clinical model of treatment to a mass public health conception of its mandate" facilitated by the expansion of diagnostic criteria that increasingly included accounts of everyday behaviours as symptoms of mental illness (Ralph, 1983, p. 11). Cohen (2016, p. 97) identifies this development within capitalist states, arguing that:

> Psychiatry's role has moved from that of the social control and punishment of the unemployed and the non-able bodied in the asylums to a more subtle focus on reinforcing compliant work regimes and permanent 'self-growth' ideologies on the precarious worker in neoliberal society.

Earlier accounts of deinstitutionalisation and the rise of community care policies failed to adequately account for the centrality of work to the community psychiatry project. Ralph (1983) separates these accounts into four different theories: benevolent government theories, mental health lobby theories,

antipsychiatry theories, and Marxist theories. While benevolent government theories frame community psychiatry as merely a continuation of the enlightened progress of the science of psychiatry, the mental health lobby theory explains the development of community psychiatry as resulting from the lobbying pressure applied by professional groups promoting their own projects out of self-interest (Ralph, 1983). For example, Shorter's (1997) book *A history of psychiatry* reproduces the mental health lobby theory by framing his study of the development of community psychiatry in terms of the individual historical actors involved in the construction and promulgation of the therapeutic model as responding to the problems of the insane asylum (Shorter, 1997, pp. 229–238), without accounting for the role of structural changes in the capitalist system. Brunton's (2001, 2003, 2005) histories of mental health policies in Aotearoa/New Zealand also vacillate between benevolent government and mental health lobby theories.

While antipsychiatry theories framed community psychiatry as a "more sophisticated method for psychiatric oppression than the old straitjackets", Marxist theorists "suggest that community psychiatry reflects a general state policy to cut public expenses for services to unemployable people, under pressure of its fiscal crises" (Ralph, 1983, p. 20). As each approach captures aspects of the development of community psychiatry, each also assumes that community psychiatry developed out of clinical psychiatry and its institutions, and therefore "fails to address key differences between pre- and post-war public psychiatry" (Ralph, 1983, p. 20). As pre-World War II public psychiatry "had little direct relationship to employable people", community psychiatry extended to include the treatment of the paid workforce and the mental health of society as a whole (Ralph, 1983, p. 46). While Marxist scholars, such as Scull (1976), contributed important analyses of the deinstitutionalisation process, the acceptance of clinical psychiatry being preserved as the core ideology of community psychiatry resulted in an overgeneralisation of psychiatry's historic relation to people considered unemployable or problematic. This assumption resulted in an initial failure to adequately account for psychiatry's growing influence in the management of workers' social lives (Ralph, 1983). Building upon existing Marxist theorisation of the development of community psychiatry, Ralph (1983, p. 45) argues that while "work is almost invisible as a topic in clinical psychiatry", it is a central concern in the development of community psychiatry.

Seeking to explain the expansion of the psy-professions from the management of the unemployed to the management of the employed, Ralph emphasises the contributions of industrial psychology to the development of community psychiatry. Ralph (1983, p. 103) holds that "community psychiatry developed primarily to control the productivity side effects of worker alienation" observing that "the innovations of community psychiatry are precisely those which management adopted in order to speed up work and dissolve protest" in the world of industry. Ralph emphasises the centrality of control by capital over the conditions of labour for the persistence of capitalist societies, and identifies the central purpose of community psychiatry as the management of the social life of workers—through techniques developed and legitimated by psy-professional expertise—in order to maintain and enhance worker productivity and efficiency.

Ralph's analysis identifies a conspicuous absence of the role of work in historical accounts of clinical and community psychiatry, yet the management of mental health has been of central concern in the world of industry. For example, the director of the US National Institute of Mental Health, in a speech to the National Association of Manufacturers (cited in Ralph, 1983, pp. 48–49), argued that:

> Since we live in a working society in the largest sense, all our mental health is occupational mental health. It is to our mutual advantage [business and government] to promote the mental health of our population … our motives may stem from compassion or for a need for human productivity, but our success will profit all of us.

The following section considers the development of industrial psychology in relation to community psychiatry.

Industrial psychology

Techniques of scientific management, advocated by thinkers such as Frederick Taylor in the late nineteenth and early twentieth centuries, were highly influential in the organisation of capitalist industry (Kanigel, 2005). Combating what he identified as a tendency of workers to perform the minimum amount of work possible, Taylor (1919) advocated the atomisation of the industrial work process and an increased alienation of workers from control over the form and purpose of their labour. Taylorism amplified the technical or technological basis of the division of labour, identified earlier by Marx (1867/1976, pp. 545–546), further alienating workers from the scientific knowledge produced by labour collectively. As Ralph (1983, p. 63) describes it, management sought to "remove all discretion in the work process from the workers" as a principle of organisation. However, while theories of scientific development addressed questions of industrial efficiency and productivity, the increased control over the worker often failed to extend beyond the management of their movement within the workplace (Gramsci, 1999).

In response to growing labour militancy following World War I, Anglo-American industry turned to the psy-professions for aid, "emphasizing a need to isolate and treat malcontented or misbehaving workers, to train management in conciliatory skills, and to provide workers with an outlet to talk out their grievances to sympathetic-sounding listeners" (Ralph, 1983, p. 69). Psy-professionals began to be hired in this regard as early as 1915 in line with the National Committee for Mental Hygiene's position that "industrial unrest to a large degree means bad mental hygiene" (Ralph, 1983, p. 69). Industrial psychology had become its own discipline within universities by the 1920s, and over the following decades, a number of government, non-profit and industrial organisations were established in the UK and the US with the aim of further developing and promoting industrial psychology. However, as Rose (1990) shows, it was the adoption and incorporation of industrial psychology by the military which ultimately served to normalise the use of psy-professional knowledges within the apparatus of the state.

What the psy-professions, particularly industrial psychology and psychiatry, offered military and government organisations was a supposedly scientific basis for the calculation of workers' potentials and new possibilities for addressing worker efficiency (Rose, 1990). In Aotearoa/New Zealand, the Department of Scientific and Industrial Research established the Industrial Psychology Division in 1942 following a survey of munitions production in the Dominion. The Division's purpose was to promote the application of industrial psychology and to research "the human aspects of New Zealand industry" (Department of Scientific and Industrial Research, 1944, p. 14). With the express purpose of supporting industry, the Division collaborated with businesses to identify problems in the production process and improve labour efficiency. For example, in 1944 the Division performed an investigation into absenteeism by surveying a number of factory owners, managers and workers. The resulting report identified several causes of absenteeism along with recommended methods for addressing them. However, after distributing the report privately to manufacturers and government departments, it was decided that the report would not be made public due to concerns that public discussion would "probably [have] the effect of increasing, rather than diminishing" the problem of absenteeism (Department of Scientific and Industrial Research, 1944, p. 15). While the work of the Division was framed as being in the interests of improving worker welfare, as an "established science" (Department of Scientific and Industrial Research, 1944, p. 15), industrial psychology instead worked to internalise and individualise aspects of worker alienation.

Post-World War II, industry and military interests pushed for central government to take up the growing costs of managing the mental health of workers (Ralph, 1983; Rose, 1990). In the US, the 1946 Mental Health Act established the National Institute for Mental Health (NIMH), significantly increasing

funding for the training of psychiatrists and psychologists. Industrial psychiatrists dominated the National Advisory Mental Health Council which set policy for the NIMH, while business and military interests were represented as the interests of workers (Ralph, 1983, p. 96). The developments of US public mental health policies that moved towards the treatment of working populations in the community were mirrored across Western capitalist states, with Shorter (1997) and Scull (1991) both noting the growth of outpatient and day hospitals in Great Britain, along with a growing focus on early intervention in the working population as part of the international mental hygiene movement. This approach was also followed in Aotearoa/New Zealand, with outpatient and day clinics being established in some communities while the language of mental hygiene was incorporated into government policy (Brunton, 2001; Williams, 1987). These new community-based approaches "drew heavily on the innovations of military and industrial psychology", focusing on "early diagnostic testing and brief individual or group talking therapies conducted in outpatient clinics or general hospitals staffed by multidisciplinary mental health teams" (Ralph, 1983, p. 98). This type of therapy grew throughout the twentieth century, forming a key element of the idea of community-based care as articulated through the process of deinstitutionalisation.

The psy-professions offered industry a way to increase productivity and efficiency by managing the internal emotional lives of workers (Illouz, 2007; Rose 1990). For Illouz (2007), the amalgamation of scientific management and psy-professional discourse on the individual's inner emotional life established a model of emotional management centred around the idea of communication, which would become a normative model reproduced through the expansion of the psy-professions. This communicative model "instils techniques and mechanisms of 'social recognition' by creating norms and techniques to accept, validate, and recognize the feelings of others" (Illouz, 2007, p. 21). This new form of management was initially appealing to workers as it appeared to democratise elements of the workplace by emphasising the individual's personality as the locus of antagonism (Illouz, 2007, p. 21). However, this apparent democratisation of workplace relations at no point addressed the hierarchical organisation of corporate bodies. What Illouz's analysis highlights is not only the management of workers within the workplace, but the expansion of industrial psychology's focus on the individual beyond the workplace and into the social life of workers.

For Illouz (2008, p. 59), "psychologists, acting simultaneously as professionals and as producers of culture, have not only codified emotional conduct inside the workplace but more crucially made 'self-interest,' 'efficiency,' and 'instrumentality' into valid cultural repertoires." Illouz's point is that the expansion of the psy-professions, in their focus on mental health as an internal problem of the individual, normalised principles of workplace management as "new models of sociability", which have subsequently proliferated throughout capitalist societies (Illouz, 2008, p. 59). Psy-professional discourse supplemented the restructuring of individual workers under scientific management, as its "explanatory schema locates the source of pathology it identifies in individual forces, and in principle can allow the redefinition of all protest and deviation from the dominant social order in individualistic and pathological terms" (Scull, 1991, p. 168). A "scientific discourse dealing primarily with persons, interactions, and emotions was the natural candidate to shape the language of selfhood within the workplace" argues Illouz (2008, pp. 85–86). The therapeutic language of the communicative model, she proposes, has become one of the dominant discourses for constructing selfhood in capitalist states throughout the latter half of the twentieth century. As Rose (1990, p. 104) further observes:

> Work itself, it appeared, could be reformed and managed so that it could become an element in a personal project of self-fulfilment and self-actualisation … if work were reshaped according to a knowledge of the subjectivity of the worker, not only would the psychological needs and strivings of individuals be met, but efficiency, productivity, quality, and innovation would all be improved.

While Illouz is concerned with the expansion of the communicative model through social life, Ralph (1983, p. 52) remains focused on community psychiatry as a driving force in the movement for community-based care, arguing that "the central achievement of community psychiatry has been to develop the technology and organisation to put industrial psychiatry on a mass basis." Ralph shares Illouz's position to the extent that the ideas of industrial psychology have played a significant role in the shaping of social life within and outside of the workplace. However, unlike Illouz, Ralph more directly addresses the centrality of work in capitalist society and seeks to highlight the antagonisms between the interests of capital and workers as well as the ongoing role of the psy-professions in the mediation of that antagonism.

The expansion of mental health services to include ostensibly 'normal' members of society provided the basis for the growth of pharmacological 'solutions' to the problem of mental health and contributed to the increasing medicalisation of daily life through the reproduction of the communicative model central to talk therapies (Illouz, 2008; Morrall, 2008; Scull 1991). While Ralph's analysis is centred around a critique of the development of community psychiatry in the twentieth century, her emphasis on the centrality of work in relation to the state's provision of mental health services is useful for understanding the management of capitalist class interests in the provision of mental health services today. For the remainder of this article, I will consider the medicalisation of unemployment as an example of the continuation and consequence of the transition to community-based care. This discussion will specifically focus on work-based welfare reforms, arguing that the 'mental health' of unemployed workers serves to legitimate their current status within the welfare system, supported by a focus on mental health service provision in transitioning workers into employment.

The medicalisation of unemployment

In *The medicalization of society,* Peter Conrad (2007, p. 4) uses the term *medicalisation* to describe the "process by which nonmedical problems become defined and treated as medical problems". This process describes much of the history of Aotearoa/New Zealand's mental health system, which has from its outset legitimated the policing of mental health problems based on medical authority, resulting in the institutionalisation of individuals on a wide range of identified social—often moral—problems (Brunton, 2001; Coleborne, 2015; Williams, 1987). However, while the process of medicalisation is framed in terms of its development out of medical knowledge, Conrad (2005, p. 3) argues that it "is now more driven by commercial and market interests than by professional claims-makers". The provision of benefit entitlements today provides an example of the political construction of the structural problem of unemployment as a medical issue.

Following the transfer of mental hospital administration from a centralised government department to local health boards in the 1970s, greater demands were placed on institutions to reduce costs (Williams, 1987). This transitional period of deinstitutionalisation saw the gradual running down of institutions, along with a growing acceptance and use of the idea of community-based care. The passage of the Mental Health (Compulsory Assessment and Treatment) Act in 1992 marked the final stage of deinstitutionalisation in Aotearoa/New Zealand as government policy formally embraced community care. However, the new forms of service provision that followed did little to alleviate or address many long-running problems—such as understaffing and lack of capacity—while introducing new sets of problems (Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 1996). In fact, the development of government policy following the 1992 Act has been dominated by a drive to address the subsequent deficiencies of the new community-based mental health system (Government Inquiry into Mental Health and Addiction, 2018; Mental Health Commission, 1998, 2012; Ministry of Health, 1996, 1997, 2012). As Kearns and Joseph (2000, p. 159) highlight, these reforms followed from the "primacy of the ideology of restructuring over the philosophy of deinstitutionalisation" within central government, with

deinstitutionalisation unfolding as "a specific manifestation of welfare state restructuring rather than as a discrete process within the health care sector".

By the end of the 1990s, a new policy had emerged directing the provision of mental health services. District health boards would purchase community-based mental health services through a market-based system to provide for the three per cent of the population with the most severe needs (Government Inquiry into Mental Health and Addiction, 2018; Mental Health Commission, 1998). As part of this restructuring of mental health services in Aotearoa/New Zealand, the provision of welfare benefits became an important element of the new system of community care and effectively replaced what was previously referred to as the maintenance function of the institutions; that is, the provision of welfare supported the subsistence of people in the community who earlier would often have resided in an asylum or mental hospital (Ministry of Health, 1996). As Scull (1976, p. 174) observed in the context of the UK, the development of social welfare programmes during the twentieth century had "rendered the social control functions of incarcerating the mentally ill much less salient", with the same institutional redundancy observable in Aotearoa/New Zealand.

However, while Aotearoa/New Zealand's welfare system incorporated part of the historic function of the mental health system, the subsequent development of welfare and mental health policies has maintained a clear separation between each service. While government-initiated reviews of mental health service provision have acknowledged links between social and economic conditions in terms the impacts of poverty and unemployment on mental health, the provision of welfare and its conditions have remained outside the scope of those reviews (Government Inquiry into Mental Health and Addiction, 2018; Mental Health Commission, 2012; Ministry of Health, 1997). On the other hand, the development of welfare policy (specifically, the work-focused welfare reforms that set the current state of welfare provision) has largely overlooked or ignored the role that the provision of welfare serves in relation to the historic maintenance function of the mental health system (Welfare Working Group, 2011).

As part of the 2013 work-focused welfare reforms, Aotearoa/New Zealand's benefits system were reorganised into three categories: jobseeker support, supported living payment and sole parent support. Supported living payments are for people with long-term health conditions that affect their ability to work for more than 15 hours per week. This category has remained stable since the 2013 reforms, comprising three per cent of the working-age population (Ministry of Social Development, 2021). Jobseeker support is split into two main categories: those who are considered 'work ready' (that is, people who are actively looking for work), and those who cannot look for work due to a health condition, injury or disability. As noted in the most recent general review of mental health services in Aotearoa/New Zealand, *He Ara Oranga*, "For over 40% of all recipients of health and disability income support, mental illness is the primary barrier to being able to work" (Government Inquiry into Mental Health and Addiction, 2018, p. 76).

Holmqvist (2009) argues that the process of medicalisation can be seen in the production of legitimating reasons for unemployment within welfare systems. Holmqvist (2009, p. 408) notes that "labour market programmes tend to individualise unemployment, removing it from the broader social context." By threatening the reduction or withdrawal of unemployment benefits due to the failure of an individual to 'collaborate' with the programme's administrators, the state compels some unemployed workers to adopt diagnoses that construct the cause of their unemployment as a problem of their inner self (Holmqvist, 2009, p. 415). In practice, many of these programmes are oriented towards the management of mental health problems in the working class (Holmqvist, 2009). Holmqvist (2009) describes the tendency to reduce the structural realities of unemployment to problems of the individual through the implementation of back-to-work programmes as an *activation ideology*. This activation ideology frames the role of the state in the management of unemployment as being merely to enable individuals to "activate themselves" through participation in programmes designed to get them back in the labour market (Holmqvist, 2009, p. 416).

Here the state is reproducing the models of sociability, such as self-interest and instrumentality, identified by Ralph (1983) and Illouz (2008) as a key part of the ideology of the psy-professions within the world of industry. The legitimation of unemployment through the diagnosis of mental illness reflects the logical development of the community psychiatry project, as the medicalisation of unemployment constitutes a government response to the problems of worker alienation in the form of the amelioration of structural unemployment through the provision of welfare, legitimated by psy-professional knowledge.

In Aotearoa/New Zealand, the diagnoses of an individual's mental health problems serve to legitimise the state's provision of unemployment benefits to workers not actively seeking work. The idea that everyone must or should work, barring legitimate or 'deserved' unemployment (such as in the case of disability or illness), was a central theme in the discourse of politicians pushing welfare reforms in Aotearoa/New Zealand (Welfare Working Group, 2011). However, despite the fundamental reliance of the political economy of modern capitalist states on the reproduction of a pool of unemployed workers, the medicalisation of unemployment works to rationalise this structurally produced unemployment as a problem of the individual. Simultaneously, the refusal of work, in the absence of evidence of mental illness or another 'legitimate' reason, is constructed as irrational in that such a position sits in antagonism with the normative assumption of the individual's expectation to sell their labour. The following section considers this problem in terms of the relationship between mental health and work.

Work and mental health

Rogers and Pilgrim (2003, p. 117) argue that although it has been found that "overall, unemployment has a negative impact on mental health ... it cannot be taken for granted that losing employment always represents a shift from a secure to a less secure existential state." That "insecure and stressful employment may create enduring psychological instability" (Rogers & Pilgrim, 2003, p. 117) is a problem for theorists and policymakers assuming a direct causal relationship between an individual's employment status and the state of their mental health. What Rogers and Pilgrim's (2003) analysis of the relationship between mental health and employment highlights is that while employed workers in general can be said to experience better mental health than unemployed workers, the differential distribution of mental health across populations is not discrete and therefore cannot be attributed to the division between employment and unemployment alone. For example, "inadequately employed people tend to have poorer mental health scores than those who are unemployed" (Rogers & Pilgrim, 2003, p. 122). This position is shared by Graetz (1993, p. 715), who argues that "the health consequences of employment and unemployment are directly contingent upon the quality of work" (see also Cohen, 2022; Memish et al., 2017). Butterworth et al.'s (2011, p. 806) study on the relationship between quality of work and mental health found that "the transition from unemployment into a poor-quality job was more detrimental to mental health than remaining unemployed." It is, then, the actual conditions of work, rather than the status of being employed as such, that have a more direct bearing on the mental health of individuals (Graetz, 1993).

Orientating the provision of mental health services towards the individual's relation to employment also obscures the relation of social class to mental health. Rogers and Pilgrim's (2003, p. 18) research into the relationship between mental health and inequality demonstrates "that higher prevalence rates for a range of mental health problems are to be found amongst those in the lowest social classes". Despite observed connections between poverty and increased rates of mental health problems in Aotearoa/New Zealand (Government Inquiry into Mental Health and Addiction, 2018; Organisation for Economic Co-operation and Development, 2015), the activation ideology of modern welfare programmes continues to frame the state's relation to the problem of structural unemployment through the individual's relation to work. However, the service provision itself—which embodies the government's position as activator of the individual's inner potential—is justified in economic terms, with the growing cost of welfare cited as a key

driver of reform (Welfare Working Group, 2011). While the economic management of neoliberal governments necessarily reproduces the conditions of unemployment, activation ideology frames the role of government responses to structural unemployment as being the mere facilitation and encouragement of mentally ill workers' recovery, measured in their gaining of employment. This idea—that the role of government is to get people into paid employment because it is innately good for them as individuals—was central to contemporary work-focused welfare reforms in Aotearoa New Zealand (Welfare Working Group, 2011, p. 1).

In their 2011 report, the Welfare Working Group (WWG) argued for a work-focused welfare programme in Aotearoa/New Zealand which reframed benefit entitlements as purely transitional support services designed to get people into the socially acceptable and 'normal' state of life—that is, producing surplus value for capital. Unemployed workers receiving welfare, regardless of their health and immediate capacities to enter paid employment, were redefined as 'jobseekers'. Despite the WWG's findings that "the current benefit system does not readily provide for different levels of work ability" (Welfare Working Group, 2011, p. 49) and that there are numerous circumstances that mean that there does not necessarily exist, at any given time, appropriate employment for unemployed workers with mental health problems, the WWG offered few ways to address these structural factors of employment beyond the suggestion that central government ought to 'do something' about the situation. The work-focused welfare system thus compels beneficiaries to look for work that might not exist, while placing the world of work and the conditions of labour outside of the scope of the provision of welfare. The WWG's report also established a significant gap between the needs of mentally ill beneficiaries and support services, finding "significant shortcomings and lack of capacity in core health services such as mental health" (Welfare Working Group, 2011, p. 7). The report went on to argue that these shortcomings would need to be addressed if the government were to address "beneficiary dependency" (a stated aim of the reforms) (Welfare Working Group, 2011, p. 1).

Work-focused welfare was also framed as a response to a problem created by the medicalisation of unemployment within the welfare system. The WWG argued that the previous organisation of the welfare system was oriented towards establishing medical justifications for why beneficiaries are not in employment and had therefore produced a large pool of long-term sickness beneficiaries. The chair of the WWG report, Paula Rebstock, argued that the government's welfare reforms would need to address "the high degree of hidden unemployment and the medicalisation of labour market dislocation" represented by the number of long-term sickness and invalid beneficiaries (as ctited in Black, 2010, n.p).

While the WWG's report identifies mental health as a factor in the employability of beneficiaries, no specific attention was paid to the relationship between work and mental health beyond assertions that work is good for people's mental health. The analysis of sickness and invalid benefits is framed predominantly in terms of disability and offers no direct account of mental health as such (Welfare Working Group, 2011). Consequently, despite the WWG emphasising the importance of supporting individuals' mental health throughout its 190-page report (Welfare Working Group, 2011), the determinations of a potential beneficiary's entitlement remain in the hands of psychiatrists, psychologists and general practitioners external to the welfare system. Individuals applying for support are required to produce evidence in the form of medical certificates which are then subjected to Work and Income New Zealand's own approval criteria.

The WWG's recommendations iterate the normative assumption of psychiatric expertise, citing the Organisation for Economic Co-operation and Development's (OECD) position that the "medical professionals who assess sickness and disability claims are key actors in determining the take-up of sickness and disability benefits" (Organisation for Economic Co-operation and Development, 2010, p. 139). The OECD's report *Sickness, disability and work: Breaking the barriers* argues that because "the decisions [medical

experts] make about a person's fitness for work determine how long that person can remain detached from their workplace and claim benefits" (Organisation for Economic Co-operation and Development, 2010, p. 139), central governments need to emphasise the importance of work for improving mental health. The OECD (2010) and WWG (2011) both stress the importance of work as a fundamental good for the mental health of unemployed workers, with the latter arguing that medical practitioners should be more concerned with "promoting the benefits of work to their patients" when providing medical exemptions (Welfare Working Group, 2011, p. 154).

While the WWG, in line with the position put forward by the OECD, acknowledges a relationship between work and mental health, they construct it as a one-way relationship. Within their arguments for the work-focused welfare system, the absence of work is accepted as having an impact on the mental health of individuals, but the idea that work itself can have an impact on mental health is unaccounted for. Given the persistence of precarious and insecure work in modern capitalist states, the role that work itself plays in the mental health of workers, both employed and unemployed, should be of particular importance to an analysis of the operations of the welfare system. However, the work-focused welfare system frames mental health problems as a factor outside of the sphere of employment, requiring the diagnosis of a psy-professional. Here, the uncritical acceptance of psychiatry as a legitimate body of medical science establishes psy-professionals' discourse on mental illness as a standard of measure, one that both determines the access of workers to government assistance and legitimates the provision of that assistance. This legitimation is deemed necessary by central government, as the provision of support is limited not by necessity but by political decision; the constraints on funding for mental health services being produced by the economic policies of government.

Conclusion

As public health policies have expanded to incorporate a broader view of mental health as an active site of possible preventative intervention amongst working populations, it is important that such developments are considered beyond an individualised view, within the context of the economic realities presupposed by neoliberal political economy. While the transition to forms of community-based care have been previously understood as a response to problems of institutionalisation, this article has highlighted the industrial origins of community psychiatry with its focus on the management of workers' social lives and the individualisation of mental health problems. Consequently, through the provision of welfare benefits that serve to ameliorate the structural problem of unemployment, we can understand the basis of community psychiatry in the world of industry as borne out in the medicalisation of unemployment. In presupposing work as a basic good for the mental health of unemployed workers, the activation ideology informing the provision of welfare constructs mental health as merely a problem of individuals through the continued reliance on psy-professional diagnoses.

Aotearoa/New Zealand's work-focused welfare system pushes unemployed workers with mental health problems into paid employment while simultaneously establishing diagnosed mental health problems as that which justifies unemployment and therefore access to welfare benefits. While the Welfare Working Group acknowledged mental health as an important element affecting the employability of workers, the relationship between mental health and work has been given little to no consideration, resulting in a significant proportion of unemployed workers being now classified as jobseekers. On the assumption that it serves their best interests, programmes put in place to push unemployed workers with mental health problems into employment, act to reinforce and affirm the logics of capital as the normal principles of social organisation. While the welfare system today continues the maintenance function previously maintained by the asylum system, the current form of benefit provision continues to presuppose work as a fundamental good for the mental health of workers, even where mental health problems render

employment inaccessible or potentially harmful for some. As this article has demonstrated, the role of work in capitalist society is important to an analysis of community care and current mental health service provision, as unemployed workers continue to be subjected to the medicalisation of their inability to sell their labour in conditions where paid employment is not necessarily accessible.

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