

Mental health services in the age of neo-liberalism

Abstract:

The policy of deinstitutionalisation i.e. the closure of large psychiatric hospitals and a move towards community-based mental health services has been a feature of services developments in liberal democracies. This policy was the result of a series of criticism of the abusive nature of institutional psychiatry. Though the policy has its roots in a body of essentially, progressive ideas, the policy was pursued at a time when neo-liberal governments were in power – this is particularly the case in the USA and UK. The anti-statist, individualist themes of the critics of chimed with several tenets of neo-liberal ideas. The results of deinstitutionalization have been largely very poor. Community mental health services were largely underfunded, poorly organized and unable to cope with the demands placed upon them. In addition, other social problems such as mass unemployment, the destructive impact of increased substance misuse combined with the reduction in other aspects of welfare state provision meant that the institution was replaced, for many, by a bleak existence for the margins of urban society. More people with mental health problems were drawn into the Criminal Justice system.

Key words: deinstitutionalization: neo-liberalism: social exclusion

Neo-liberalism

The West, following World War II, Government largely followed a series of Keynesian economic policies. Governments invested in a range of public services such as health and education. Unemployment was at very low levels for most of the period 1945-74. This period of expansion came to an end with the oil crisis. The rise in the price of oil and subsequent inflation led to a retrenchment in the public sector. The late 1970s and early 1980s saw the election of a series of right wing Governments, most notably those of Margaret Thatcher and Ronald Regan, who were committed to solving these difficulties by reducing the levels of public spending.

In the period of the dominance of Keynesian economic policy, there were always dissenters on the right. The most influential of these was Friedrich Hayek subsequently knighted by the Thatcher government. His influential book, *The Road to Serfdom* was published in 1944. This is an attack on the whole notion of state intervention. For Hayek, the key political value is freedom and this is defined in the Hobbesian negative sense. In the political sphere, Hayek emphasizes that the notion that freedom can be obtained by any government planning or intervention is completely contradictory. Such approaches are doomed to fail.

The Thatcher and Regan governments' economic policies were heavily influenced by Hayek and one of his modern disciples Milton Friedman. Friedman argued that the control of the money supply was vital to reducing inflation. This approach was characterised by reducing public spending and the level of taxation. For neo-liberals, the role of government was essentially to create conditions, in which the market could flourish. Therefore, the state should ideally only concern itself with ensuring the safety of the citizen and the realm. All other areas most effectively left to the functioning of the market. Any other role for the state was bound to fail because of bureaucratic ineptitude as state employees were not subject to the rigours of a competitive market where inefficient organization went to the wall.

In addition, the expansion of the state comes at the cost of individual liberty. This is most forcibly argued by Novick (1974). State services inevitably reduce choice and allow for greater government interference in the lives of citizens. For Novick, taxation is almost presented as a form of theft. He argues that the highest individual contributors to the funding of government services are those who are least likely to use them. In a minimalist state, individuals make choices about which services they should support. The model here has echoes of Victorian philanthropy.

In the world of practical party politics, Governments are coalitions rather than driven by purely ideological considerations. Despite her reputation as the *Iron Lady*, even Mrs. Thatcher had to make some compromises with the more traditional elements of her party (Gilmour 1992). However, the key themes of the Thatcher project were clear. Levels of direct taxation were reduced, State assets were sold ("*privatization*") and there was an emphasis on individualism. At the same time, there was a shift towards a more punitive law and order policy.

Deinstitutionalisation and the development of community care

In this section, it will explore the changes in mental health policies in England and Wales that have led to the development of community-based services for people with severe and enduring mental health problems. Though the focus is on the UK, similar themes emerge in the North American context. This section will include an analysis of the decline of the asylums and an examination of the crisis that mental health services faced in the early 1990s.

The policy of deinstitutionalization has been pursued across the world. As Pilgrim and Rogers (1999) suggest the asylum is set apart both physically and metaphorically from its general hospital counterpart. The general hospital was easy to access and usually found in the centre of town and cities. The reverse is the case for the asylums. These institutions were built on sites away from the main centres of population thus physically separating the mentally ill from the rest of the population. Scull (1977) sees the rise of the asylums as part of the Victorian response to the problems of urbanisation.

In this analysis, asylums along with schools, factories and prisons have a key role to play in social control. Scull argues that as the mentally ill were deemed not to be economically useful, they had to be isolated and removed from society. The net effect was to also serve as a warning to the wider populace of the perils of non-conformity. In addition, this period saw the wider acceptance of a medical view of the causes of mental illness. The asylums therefore were the confirmation of the new status of psychiatry as a distinct branch of the medical profession. Nye (2003) argues that the development of this discourse was part of the wider Enlightenment project. He suggests that "*reason*" was seen as the domain of the rich and powerful. The result was that "*unreason*" was thus found among the poor and marginalized – women, the mad and the criminal classes

Foucault's (1977) analysis of the development of asylums and prisons has been incredibly influential and it should be said controversial. At this point, I will consider some of the main themes of Foucault's argument. Foucault is concerned with the exercise of power both by individuals and the state. Foucault does not accept the Enlightenment idea of progress and the belief that social problems can be solved by rational means. As Bauman (1997) argues the changes in this period were as much about the control of emerging group such as the urban, workless poor as they were about solving problems. Urban problems were problems of order (Bauman 1997).

In his work both on prisons and asylums, Foucault argues that the development of these institutions represents an ideological shift. For Foucault the "*repressive hypothesis*" fails to take account of the creative aspects of power. He sees it as a much fluid force. The focus for state intervention was no longer the body of prisoners or patients but their minds. He argues that this is a more pervasive form of social control. In this analysis, power and the power to punish are much more dispersed throughout the social system. It therefore operates on a number of levels. Foucault terms this ideology of discipline "*savior*". Expressions of this ideology can be found amongst all groups apart for the deviant and it operates as a mechanism of repression both of the self and others. This analysis recognizes that it is not only the professions that are involved in the disciplinary mechanism of social control. The disciplinary mechanism becomes an internal one. The physical and psychological geography of institutions mirrored, in a number of respects, the monasteries. For example, incarcerated individuals were not allowed to speak to each other. Cells in prisons, asylums and religious orders were to separate the penitent. The focus of punishment thus became the internal rather than the body of the prisoner.

As with the more traditional Marxist analysis of Scull, Foucault argues that the development of these institutions is part of series of bourgeois response to the

threat posed by the urban poor. For Foucault, the level of investment required in these institutions is such that if they did not serve this function they would not have been built. In his writings, Foucault draws attention to the symbolism of the institutions. Bentham's panopticon (Foucault 1977) becomes not just an architectural design but an embodiment of new society, whose institutions form a "carceral archipelago" for the management of deviant populations, be they criminals or the insane. For Foucault, it was this quarantining of the urban poor that was the aim of these institutions. Despite the failure on an individual level of prisons or asylums to create model citizens, they succeeded in warning the rest of the population of the consequences of breaching conventional norms. Foucault has termed these developments as the "great *confinement*" This period sees a fundamental shift in attitudes to mental illness and insanity. The outcome, for Foucault, is that the insane becomes the lepers of modern industrial capitalist society. Seddon (2007) in a consideration of the development of policy towards "*mentally disordered offenders*" raises the question of how this group, which was seen as potentially treatable or might benefit from developments in psychology and psychiatry, came to be viewed through a prism of risk, management and control. He argues that the "*dividing practices*" applied to this group reflect the shift from modernity to late modernity.

The accounts that Scull and Foucault give of the rise of the asylums can be seen as a response to the more traditional view that the asylums with all their faults should be seen as progress on the way to more enlightened treatment of the mentally ill. In this schema, the asylums are part of medical progress and the motives of the reformers are undoubtedly humanitarian and concerned with the relief of suffering (Jones (1960). In this narrative of progress and reform, individuals such as Tuke in York as seen as pursuing an heroic path in the face of the hostility of the wider society. The resulting institutions were attempts to provide safety and succor for a variety of the weaker members of society. In this account, the issue of social control is barely considered, similarly for Scull or Foucault there seems to be no

acknowledgement that some reforms might have been the result of humanitarian concerns.

The liberal progressive view of the development of asylums is based on a several key premises about the nature of mental illness and society. As Ignatieff (1985) argues the orthodox view assumes that mental illness is an identifiable feature of the human condition. Following on from this basic premise, is the idea that those who are involved in the management of mental health problems are motivated by humanitarian concerns for the relief of the distress of their fellow citizens. The final feature of this model is the acceptance of the dominant position of the medical profession in this process. This is seen as a logical outcome and allows for the application of rational, morally neutral medical knowledge to the symptoms of mental illness. The motor for change is a progressive impulse to find ways of improving services by the application of knowledge. As Rothman (1988) suggests this lead to a peculiar narrative, in which reformers design new systems, then expose the failings of the new system and eventually replace it with another one. In this account, there is a danger that historical development is seen as linear and teleological. There a number of implicit assumptions in this narrative: all change is the progressive, the current system is the best available and the development of new knowledge will lead to further improvements. In many ways, the criticisms of community care follow a similar narrative structure.

The term *anti-psychiatry* covers a range of critical perspectives on psychiatry (Foucault (1977), Scull (1977), Laing (1959, 1967), Szasz (1971)). Such is the divergence of views that it would be simplistic to group together as a movement. However, a number of common themes can be identified. The first is a questioning of the assumption that mental illness exists in the way that psychiatrists and medicine suggests. In the critical accounts, there is a skeptical approach which sees mental illness as largely socially caused by the injustices of a capitalist society: poverty, racism, gender discrimination and social inequality or socially constructed.

Whereas treatment is seen as a therapeutic intervention in progressive accounts, from a critical perspective it becomes part of the means by which capitalist society maintains social order and reproduces the class divisions required to ensure its continued existence.

For Scull (1977) the squalid conditions in the 19th century asylums were inevitable. It would be impossible to think of an alternative as there was no system of welfare payments that existed to support these individuals. In addition, families often welcomed the removal of a non-contributing member as this reduced the burden on the family as whole. As he points out most of urban society, apart from ruling elite, lived a marginalized existence in very poor conditions indeed. In such circumstances, those who could not make any contribution would be seen as an economic danger. For Foucault (1977), the investment in the asylums was justified because of the role they played in social control not because of the humanitarian zeal of the builders of these institutions. Both approaches argue that what later come to be seen as the failings of the asylums: cruelty, squalid living conditions and inhumane treatment are, in fact, inherent features of their design.

The revisionist accounts, in themselves, are part of the moves towards the policy of community care. The response has come from both medicine and the humanities. It is hardly surprising that medicine (Wing (1978) Clare (1976) has sought to challenge accounts of the development of psychiatry that emphasise the elements of social control inherent in the profession. It is, however, somewhat ironic that the most powerful denouncers of this aspect of the exercise of professional power are psychiatrists themselves - Laing, Szasz, Cooper. The "*medical defence*" is based on the clear view that the main aim of medicine is humanitarian and altruistic, i.e. the relief of suffering. Within these accounts, there is an acceptance that certain practices would now be seen as cruel or even amount to torture. However, the argument is that this was the state of medical knowledge at the time. The intention was clearly therapeutic within the definitions of the period. This is not presented as a defence of cruel or inhumane practices. It is, rather, a counterbalance to the post-

modernist trend to apply retrospectively moral codes. Wing (1978) and Clare (1976) highlight the role of doctors in pushing forward reform and challenging

The critics of Foucault's work and other revisionist accounts have fallen into two very broad categories. The first focus on what are seen as the fundamental historical flaws in the arguments. Sedgwick (1982) has demonstrated that the links Foucault makes between the decline in the treatment of leprosy and the development of psychiatric asylums does not hold. For Foucault, prior the "*great confinement*" the mentally ill had essentially been tolerated and allowed to live in society. At certain junctures, he argues that the "*mad*" had a status which enabled them to act as commentators on society. The role of the Fool in Shakespeare would be an example of this. Sedgwick argues that this portrayal of the mentally ill as the lepers of modern society ignores the fact that the mentally ill had been held in various forms of custody prior to the period Foucault is discussing. Rothman (1971) highlights the fact that the institutions that are usually described as a response to the problems of urbanisation also developed in the USA, which was an overwhelmingly agrarian society at that point.

A second critical approach to Foucault's work is concerned with the nature of morality and humanity in this discourse. Rothman (1971) argues that though Foucault's main thesis is conceptually attractive, it has imposed its own schema on a very complex story. He suggests that it is simply not possible to reduce the complex causes of the development of asylums to "*conspiratorial class strategies of divide and rule*". Wacquant put this view more strongly:

".. I emphatically reject the conspiratorial view of history that would attribute the rise of the punitive apparatus in advanced society to a deliberate plan pursued by omniscient and omnipotent rulers, whether they be political decision-makers, corporate heads or the gamut of profiteers who benefit from the increased scope and intensity of punishment and related supervisory programs trained on the urban castoffs of deregulation."

The founders of such institutions often came from religious backgrounds - for example Tuke at York- which would appear to be in conflict with their ascribed role as the oppressors of the wretched of the Earth. Ignatieff (1985) argues that the revisionist account falls because of a series of misconceptions about the nature of society and social order. He suggests that accounts that assume that the State holds a monopoly of power over social control simplify the complex ways, in which, laws, morality and public sanctions combine. A further paradoxical feature is that some professions that become associated with the maintenance of social order appear on the surface committed to a more equal and just society. The revisionist account is based on a premise that social order is maintained by a combination of moral authority and practical power. Foucault is forced to discount the motivations of individuals – in fact any such consideration would be outside of his analysis. His argument is so concerned with symbolism and process that it does not allow for individual motivation. This is both a strength and weakness. The strength comes from the radical challenge to the liberal progressive view. The weakness lies in the fact that, ironically Foucault dehumanises staff in institutions. Stone (1982) goes further and suggests that this exposes the ultimately nihilistic streak in Foucault's work. All human relationships are analysed through the prism of power, domination and subordination. This ignores or denies the existence of other factors in relationships such as mutuality, humanity and interdependence.

The revisionist accounts of the rise of asylums are very challenging as they force the reader to consider what is meant by such terms as *progress* or *humane* treatment. In addition, though this is not always made explicit there is a consideration of the history of the institution from the viewpoint of the incarcerated. This is instinctively more appealing than the narrative which sees the history of the asylums as the struggle of psychiatrists to humanise an inhumane system. However, there is a fundamental difficulty with the revisionist accounts in that they appear only to be able to consider or describe human relations in the language of subordination and domination. In challenging the notion of progress, there seems to be a denial of its possible existence whatsoever. For Foucault, the development of the "surveillance" state seems to lead him to conclude the modernist attack on the custom, tradition

and dogma of the *ancien regime* has led to the erosion of civil rights for most citizens. For Stone (1982), this has had a destructive impact on the development of mental health services and gave intellectual support to the push towards deinstitutionalisation.

Giddens (1991) argues that modernity is characterised by the scope and nature of change along with the emergence of new institutional forms that had not previously existed. One of the core beliefs of modernity is that rationality can be applied to the solution of social problems. Modernity brings with it a series of risks. The pre-modern or pre-industrial community is broken down by the development of an industrial market economy, which lacks the traditional patterns of authority and deference. This can be seen as liberating as it allows for the development of individualism. However, it is also accompanied by a sense of ambiguity. For example, the modern city can be seen as offering the opportunity for individual self-expression or as a shifting amoral and alienating wasteland. In such an environment, social order and control will become more problematic. The older systems were based on individual, family, kinship and hierarchical ties. Modernity requires a shift to a Weberian bureaucratic approach. In the mental health field, the asylum can be seen as the triumph of this technocratic rationality,

The starting point for the crisis in asylums is usually identified as the late 1950s and the early 1960s. This period saw the emergence of "anti-psychiatrists" such as Laing, Cooper and Szasz. It would be inaccurate to describe them as a group and only Cooper accepted the label of anti-psychiatrist. However, the themes that emerged in their work challenged the nostrums of the psychiatric profession. Psychiatry finds itself in an unusual position in modern medicine in that treatment can be imposed against the will of the patient. This group of thinkers was concerned to develop a form of psychiatry that would adopt a much more holistic approach which looked at the social causes of distress that their patients were suffering. This would necessarily involve a paradigm shift from the institutional, coercive, pharmacological care that dominated at that time to a voluntary, more

psycho-dynamic, social and community-based modes of service. Szasz is an exception here. His arguments stem from a libertarian position which leads to conclude that psychiatric diagnosis is a process, which not only allows the State to restrict the liberty of individuals but also allows others to escape responsibility for their actions.

Scull argues that asylums were never humanitarian institutions and could never be despite the claims of their founders. The rates of admission to asylums had begun to decline in the 1930s. However, in 1954 there were still 154,000 patients in British mental hospitals. The criticisms of these institutions grew in the following decade. Barton (1959) identified the negative effects that institutionalisation could have on patients comparing the behaviour of patients on long-stay wards to the observations of similar behaviour that he had observed amongst prisoners in concentration camps. Scott (1973) argued that the hospital itself made individuals passive. This meant that they would be unable to cope outside of the institution. This followed earlier work by Wing (1962), which had shown how the process of social withdrawal developed amongst long-stay patients. The majority of patients would fall into this category at this time. Overall the picture is one of a physically, socially and culturally isolated institutions cut off from the main stream of health care and the wider society.

The most influential work in the literature of the crisis of the asylum is Goffman's *Asylums* (1961). Goffman's study of a large state psychiatric hospital has been seen as a pivotal point. Goffman was concerned with the way that "*total institutions*" function. In such institutions, he argued that there was a strict divide between staff and patients. The staff exercised control over all aspects of the patients' daily lives. The institution was so large it could only function if it worked to a strict timetable. The net result was that the organisational needs of the staff took precedence over any therapeutic needs of the individual patients. In this system, all aspects of daily living were monitored - if you were a patient they had to be carried out in front of staff. Two distinct and opposing cultures develop that of the staff and patients. Goffman argued that patients need to maintain some sense of self, which they do

by transgression - often in very minor ways. The staff then interpret these transgressions as evidence of illness or a lack of ability to stay within those ensuring that the individual remains incarcerated. The theme of the individual confronting a repressive and often incomprehensible system was brilliantly exploited by Ken Kesey (1963)

In the UK, the moves away from a system based on institutional care were supported the nascent service-users movements. In addition, the aims and aspirations of these movements chimed with other protest movements in society in the 1960s such as the movement for civil rights, the feminist movement and gay rights. It should be noted that the history of psychiatry - and present day practice - is scarred by its use to abuse women, members of ethnic minority communities and gay men and lesbians. The failings in hospital based care were highlighted further by Martin (1985). Martin identified the ways, in which, these institutions had become isolated from mainstream service provision. As noted above, these institutions were geographically isolated from the communities that they served. Within the institutions, wards could become isolated with small numbers of staff in charge of very large numbers of patients. In his study, Martin also highlighted the way that on the worst wards there was a lack of leadership from consultant staff. The final factor that allowed for abuse was the isolation of the patients themselves. Martin found that patients with regular visitors were less likely to be abused. The overall picture is a very depressing one: large numbers of patients, little therapeutic work, poorly trained and poorly paid staff, who lack a sense of professionalism or a commitment to rehabilitation. If the hospital scandals that Martin studied were an impulse in the move towards community care, those policies in themselves have failed to prevent the repetition of such scandals (Fallon 1999), which have often identified similar themes.

The above is part of the liberal interpretation of the rise and fall of the asylums as it rests on the idea that the moves towards community care came about because of a humanitarian impulse to improve the quality of life for those suffering from long-term mental health problems. The most common explanation by policy makers for

the decline of the asylums is the development of the new major tranquillizers. As Pilgrim and Rogers (1999) argue this is a problematic explanation as it does not explain why community care came to an umbrella policy or approach that was adopted across a range of settings including groups such as people with learning disabilities, who were not actually treated with the medication that was alleged to be at the heart of the revolution. Another barrier that such an explanation would have to overcome would be the differential rates of the implementation of the policy of deinstitutionalisation.

The general portrayal of the asylum is one of a large dehumanising institution, which acted as warehouses for the insane. In the literature, there have been relatively few attempts to look at the asylum as a functioning organism. Gittins (1998) is a study of one long-stay hospital - Severalls Hospital in Essex. The value of this study is that it acknowledges the complexity of such institutions and the motivations of the staff. The hospitals were communities and formed the focal point of the working lives of staff. Such institutions were usually the main employers in an area. It was not uncommon for members or generations of the same family to work at the same place. In addition, it is often possible to overlook the fact that despite its many failings the asylum was home for patients.

As Gittins argues for certain groups the asylum did fulfill its real role.

" It seems that for some, particularly women, the fact that they could withdraw from the outside world, from family time and body time dominated by endless pregnancies, poverty and abuse meant that life in Severalls could provide a time of peace and a possibility of asylum, in the original sense of the word" (Gittins 1998: 9)

Scull (1977) argues that following the post-war development of the Welfare State the fiscal cost of maintaining asylums was too prohibitive. He argues that costs had risen in the US because workers had become more unionised thus increasing wage rates and the unpaid labour of patients was no longer used. For Scull, the consequences of this policy have been an unmitigated disaster for the mentally ill, who have been abandoned in Scull's terms "*deviant ghettos*"

Whatever the debates about the causes of deinstitutionalisation, it is clear that it is a policy that has been widely adopted, for example, in North America, Western Europe and Australia and New Zealand (WHO 2001). The same report highlights that long-term facilities are still the most common form of service provision - 38% of countries worldwide have no community-based mental health services. This reflects the variation in the structure and delivery of health services throughout the world (Hicking: 1994, Mizuno: 2005, Ravelli; 2006).

The justification for the development of community-based mental health services is based on a moral and a clinical argument. It is a combination of idealistic and pragmatic approaches. The idealism can be seen in the civil rights arguments that were put forward. Community -based services, it was argued would be by definition be more humane. Lamb and Bachrach (2001) argue that this was based on a moral argument with little evidence to support it. The pragmatic element was one of cost. The idealistic approach did not fully address the issue of cost. It is notoriously difficult to cost effectively health care. The hidden cost of community care meant that large savings were not made immediately. In addition, the initial cost of resettling patients with very complex needs, who had often spent most of their adult lives in hospital meant that for a short period community care would prove to be more expensive than institutional care.

The Hospital Plan (1962) is seen as the official commencement of the deinstitutionalisation policy in England and Wales. Its aim was to ensure that there would be a reduction in bed use from 5.4 per 1000 to 1.8 per 1000 over a fifteen year period to 1977. The result of the policy can be seen in the fact that in 1955 there were 151,000 patients were in hospital and the figure had fallen to 71,000 in 1984. The policy of deinstitutionalisation can be divided into three distinct sections or phases. This is because the policy is really an amalgamation of a series of policies aimed at distinct groups of patients.

The first phase of the implementation was the resettlement of groups of patients who had been long-term residents of the large asylums. This process has been portrayed largely as a success, certainly when compared to the media discussion of community care in the late 1980s and early 1990s. Leff and Trieman's (2000) study of 737 resettled patients from Friern and Claybury Hospitals found that there was actually no change in the symptoms or social behaviour of the group but that the patients appreciated their new found freedom. This group of patients were more likely to have been in hospital for longer. The long-term effects of institutionalisation combined with the severity of illness meant that this group would be likely that these patients would need the most support to adjust to their new living environment. This work confirmed that the adjustment could be made but that this could only be achieved with high levels of support from multi-disciplinary teams. This cohort of patients were the most likely to have received the highest level of support. This supports the argument that the move to community care services was about switching the use of resources rather than reducing the level of investment. Lamb (1993) warned that good community care does not cost less. In addition, he suggested that though there were some good services in existence, they had, in fact only served the needs of a very small proportion of the severely mentally ill.

Langley-Hawthorne (1997) suggests that schizophrenia is one of the most costly illnesses in terms of the impact on the economy. The illness usually has its first onset in early adult hood when individuals are beginning to establish themselves in the world of work or obtaining qualifications in further or higher education. This is clearly a crucial time and disruption can have long-term effects on life opportunities. Schizophrenia is a term that covers a range of symptoms any estimate of cost has to adopt a very general approach in an attempt to measure lifetime costs. This would allow for variations in the onset of illness, the extent of the symptoms and the various treatment programmes that are adopted. The overall outcome is a very negative picture. The ODPM's report on Social Exclusion (2004) uses a range of measures to demonstrate that those suffering from long-term mental health problems are one of the most marginalized groups in society. For example amongst

people with disabilities those suffering from mental illness are most likely to be unemployed.

The second wave of deinstitutionalisation is the phase that is most associated with the failure of community care. The first group of patients that had been discharged from long-stay hospital had been fully engaged with services - this was, of course, a function of the nature of the regimes that they had endured. Following this group, there was a new cohort of patients. This group had not experienced the same institutional environment. Members of this group of patients were likely to have been in hospital for shorter periods. The weaknesses and shortfalls in the implementation of community care were identified at an early stage (Lamb: 1984 + 1988). Baron (1981) highlighted the fact that the public' negative views of the mentally ill was a barrier to re-integration. In addition, the appearance of increased numbers of homeless people, who were clearly experience mental distress served to re-enforce this prejudice. Aviram (1990) argued that the crisis in community care in the US reveals the desire of society for social control. For most commentators, apart from those Scull or Foucault who see it as the same policy by different means, Community care is seen as a progressive set of ideals. However, it should be noted that the main shift towards community-based services occurred following the fiscal retrenchment of the 1970s and early 1980s.

Conclusion

Galbraith argued in *The Affluent Society* (1999), that public investment is needed in social goods in areas of provision where the private sector will not invest. This provision could be in types of services or social goods for particular groups. If this investment fails to take place the result is “*private affluence, public squalor*”. The modern civic and urban landscape has led to the reduction of public space and the policing/ surveillance of those spaces in more punitive fashion. As Davies (*City of Quartz*) argues the architecture of cities excludes the urban poor not just physically and psychologically.

The paradox of deinstitutionalization is that a policy that has its roots in progressive ideals and an optimistic vision of community cohesion has resulted in a situation where the figure of the homeless, itinerant acutely mentally ill has become a constant feature of the modern urban landscape. If this is not depressing enough, this scar on modern social policy seems to be accepted largely uncritically.

One of the effects of deinstitutionalisation has been to increase the contact between those with mental health problems and the Police and prison systems (Robertson (1988) Singleton et al (1998) Shaw et al (2004)). In addition, Barr (888) argues that the policy of “*zero tolerance*” where civic authorities introduce a series of measures to tackle low level public order or nuisance offences disproportionately impact on the mentally ill. As well effectively criminalizing homelessness, they serve to further embroil the severely mentally ill in the Criminal Justice and prison systems. Others have argued that the asylum has been replaced not by the community-based mental health services that were envisaged but bedsits, housing projects, day centres and soup kitchens (Moon 2000, Wolch and Philo 2000, Wolff 2005,). The argument here is that individuals are physically living in the community but are denied the opportunity to be active citizens. Many of their major social interactions are with professional staff. Other social outcomes such as physical health and employment are very poor (Brown et al 1999). Eaton (1980) pointed out the fact that people with schizophrenia are likely to be the poorest members of industrialized societies. Kelly (2005) uses the term “*structural violence*” (*adapted*

from liberation theology) to outline the interplay between economic and health factors combine to restrict the life chances of this group. In the UK, the Office of the Deputy Prime Minister's (OPDM) report on social exclusion highlighted the deeply entrenched nature of the barriers outlined above. In 1998, when launching a new start for mental health policy in England and Wales (DH 1998), the Secretary of State for Health Frank Dobson famously stated "*community care has failed*". Unfortunately, the focus on the response to this has been a legalistic one that ultimately led to the introduction of community treatment orders. This approach does not tackle the fundamental underlying issues. A policy based on the civic values and ideas of a community engagement would be far too effective (Mental Health Foundation 1994). The failure of deinstitutionalisation has led to the further marginalization of the severely mentally ill.

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