Using Fraser's model of "progressive neoliberalism" to analyse deinstitutionalization and community care

Abstract

This article will argue that Nancy Fraser's notion of *"progressive neoliberalism"* (Fraser, 2017, 2019) provides a conceptual lens that can be effective in the development of a critical analysis of mental health policy in England and Wales during the period of deinstitutionalisation and community care. Mental health policies that came steeped in an originally progressive discourse of choice, empowerment and wider service user rights were introduced by governments largely committed to free market. In the UK and the USA, this produced the contradictory position where moves community orientated vision of mental health service provision were overseen by administrations that were committed to a small state and fiscal conservatism. There were similar developments in other areas. Fraser (2017, 2019) terms this mixture of socially progressive rhetoric and market economics- *progressive neoliberalism.* Fraser's model of *progressive neoliberalism* argues that neoliberalism has colonised progressive discourses. The paper outlines this theoretical model and then applies it to the development of community care. It argues that policy responses to the perceived failings of community care focused on increased powers of surveillance. This includes the introduction of legislation that allows for compulsory treatment in the community. The focus on legislation was at the expense of social investment. The paper concludes that the introduction of austerity in the UK has strengthened these trends. For example, The Coalition Government (2010-2015) introduced new mental health policies such as *No Decision about me without me* which emphasised inclusive approaches to service organisation and delivery. At the same time, it followed social and economic policies that increased inequality, reduced welfare payments and entitlement, and cut services.These are all factors that contribute to higher levels of mental distress across society.

Key words : deinstitutionalization, neoliberalism, Fraser

Introduction

This paper outlines Fraser's (2017, 2019) model of what she has termed "*progressive neoliberalism"*. This term captures the way that neoliberal political discourse has coopted terms from radical social movements. This process has meant that terms such as *choice* and *empowerment* have been used in very specific ways, within neoliberal discourse, to buttress individualism rather than to challenge structural inequalities. This article uses the development of mental health policies, particularly deinstitutionalization as a case study to examine the tensions between fiscal conservatism and social liberalism. It argues that fiscal conservatism and the development of the audit and inspection culture within public services became the dominant driver of mental health policy. These moves were combined with more coercive forms of mental health policy, which culminated in the introduction of Community Treatment Orders with the reform of the Mental Health Act (MHA) in 2007. This marks the end of official support for a policy of community care as envisaged by those who challenged the power of institutionalised psychiatry and asylums.

Fraser's model of "progressive neoliberalism"

Garrett (2018) notes that neoliberalism is now a contested term. For some, it has become a concept that has lost genuine theoretical, conceptually or analytical value. Garrett (2018) notes that critics suggest that neoliberalism has become a meta narrative that can be used as an overarching explanation for all social problems. Neoliberal is such an elastic term that it is applied to the analysis of political and economic policies from Pinochet's Chile to Deng Xiaoping's China (Harvey, 2005). There is also a danger in the current approaches to policy analysis of a form of presentism that both ignores historical similarities and trends but also assumes that there was some sort of golden period before the arrival of Thatcher and Reagan and the political dominance of the Chicago School.

Dunn (2017) notes that the term has most traction in academia and amongst "*left elites"*. Other writers have continued to find the term useful as an analytical tool. Bourdieu (2001) saw neoliberalism as a *"conservative revolution"* that sought to overthrow the postwar social democratic consensus.This required the

extension of the market to all areas of life and the monetisation of human activity and relationships and the maximisation of profits (Harvey 2005, Brown (2015). Neoliberalism is, on its own terms, committed to a small state and personal freedom. Giroux (2011) highlights the way that neoliberal ideas have been able to set the agenda across social, political, economic and cultural fields. Bauman (2007) describes a culture of "*hyperindividualism*" which leads to a loosening and weakening of social and community ties. From the 1980s onwards, the role of the state has undergone a radical change. The expansion of the market or market mechanisms into a range of areas has seen the state become an equal player - in the jargon "*a stakeholder"* alongside others. One can thus see the overlaps between a philosophy committed to the reduction of the state and progressive ideas by focusing on individualism and choice identify the shortcomings and exclusionary nature of the post war social democratic welfare state.

Fraser (2019) in her analysis of the rise of Trump and the outcome of the Brexit referendum argued that these shifts marked the end of what she termed*"progressive neoliberalism"*. She used this term to capture the processes whereby neoliberalism had coopted ideas that had originated in new social movements. These social movements, for example, the women's and civil rights movements questioned and challenged fundamental societal structures.These different movements shared a core vocabulary of equality, individual freedom, respect and inclusive citizenship. Fraser (2017, 2019) argues that this language has been become a key feature of the discourse of late modern capitalism. As she argues that there is a disconnect between this discourse and the daily reality of late capitalist society where social protections have been swept away. Fraser (2019) suggests that these organisations and governments have used the language of social movements such as feminism and anti-racism - diversity, choice, empowerment whilst pursuing economic, political and social policies that contradict these core values. This can be seen in the way that huge global corporations such as Apple, Facebook and Amazon, present themselves as dynamic and committed to key issues such as diversity whilst at the same time engaging in anti-social behaviour such as selling private data and avoiding paying

corporate tax. The Blair and Clinton administrations were the leaders in this shift. Fraser (2017) concludes that

"*Clinton was the principal engineer and standard-bearer of the "New Democrats," the U.S. equivalent of Tony Blair's "New Labor." In place of the New Deal coalition of unionized manufacturing workers, African Americans, and the urban middle classes, he forged a new alliance of entrepreneurs, suburbanites, new social movements, and youth, all proclaiming their modern, progressive bona fides by embracing diversity, multiculturalism, and women's rights. Even as it endorsed such progressive notions, the Clinton administration courted Wall Street"*

https://www.dissentmagazine.org/online_articles/progressive-neoliberalism-reactionary-populism-nancy-fraser

Asylums, deinstitutionalisation and community care

Deinstitutionalisation is a term that is used to describe the policy of the closure of large, long stay mental health hospitals. This is a policy that has been followed across the world. It is often seen as a mark of progress or a move towards more humane treatment of the mentally ill. Community care is a phrase that does not appear in many contemporary mental health policy documents. It seems to have disappeared. One possible explanation is that the main tenets of community care are so deeply entrenched in services that there is no need to make statements in support of it. This is a rather limited, naive analysis. Mental health services have become the sites of increasing bureaucracy and managerialism which stifle the idealism that underpin the initial support for deinstitutionalisation and community care (Cummins, 2019).

Asylum

One way of understanding the development of community care is to see it as a response to the failings of the asylum regime. The asylum is situated physically apart from the wider community (Rogers and Pilgrim, 2014). This physical distancing, subsequently, became a metaphor for the social, political and civic isolation of patients. These institutions were built on sites away from the main centres of population thus physically separating the *"mad"* from the rest of the

population. Scull (1977) sees the rise of asylums as part of the Victorian response to the problems of urbanisation. In tracing the rise of the asylum, Scull (1977, 1986) outlined the way that the development of the institution was linked to and played a role in the new status of psychiatry as a distinct branch of the medical profession. The new asylums were established to rescue the mad from the kinds of maltreatment and neglect, with which, they themselves became synonymous.

The contemporary view of the asylum is largely dominated by their representation as a Gothic institution. Tuan (1979) described them as key markers in *"landscapes of fear"*. Many of the design features, that were therapeutic at the time add to this image. Fresh air and other aspects of the rural idyll were regarded as having recuperative properties. The asylums were built on rural slightly elevated sites to avoid the dangers of miasma - foul smelling vapours that were the result of poor sanitation. Until the development of germ theory, it was believed that miasma spread disease (Franklin, 2002). The geographical position and architecture of the asylums were cited by its 20th century critics as evidence of an ideology that sought to banish or exclude the mentally ill and other *"undesirables"* from the wider society (Foucault, 2003, Goffman, 2017). This was not the case at the time. Many asylums such as the one in York were called Retreats for the very specific reason that they were just that - a place to escape the pressures of the modern world. It is a representation of an ideological response to the problem of madness (Franklin, 2002). The same is equally true of the modern notions of community, which form the basis of community care. The asylums built following the 1845 County Asylum Act were often designed by famous architects such as Sir George Gilbert Scott. The great architect critic Pevsner praised several asylum designs for the scope and ambition of their design.

In exploring the history of the asylum, there is a danger of presenting it in a somewhat one-dimensional way. This is not an attempt to air brush psychiatric abuses from history. It is rather an acknowledgement that these institutions were more complex and contradictory than is often recognised. Parr et al (2003) in their discussion of the Craig Dunain Hospital near Inverness, Scotland show that the patients' narratives of the institution are complex and contradictory. The

authors note that the institution had a negative reputation with outside observers. However, the memories of the staff and patients were much more nuanced and complex. The former patients highlighted the lack of personal privacy, space and the other indignities of the asylum regime. At the same time, the former patients spoke about the friendships that they had developed. For example, the grounds of the asylum were particularly fondly remembered. A place were patients were able to enjoy a measure of personal freedom - smoke cigarettes, have intimate relationships and so on. The asylum in this approach is viewed as a much more complex and ambiguous set of social and physical relationships than is allowed for Goffman's (2017) *total institution* narrative. As one former resident put it " *That awful place was home".* These contradictory views are lost in one dimensional representation of the asylum. Leary (2011) outlines what he calls *"ruin pornography*", by this he means the stylish and artistic photographs and media representations of once great industrial cities. He terms this trend *Detroitism* (https://www.guernicamag.com/leary_1_15_11/) as the city has gone from being a metonym for post war growth to one for deindustrialisation. In a rather similar vein, there is a thriving interest in neglected and abandoned asylums. These haunting photographs of abandoned wards, strange equipment used in treatments and images of neglected patients all add to the Gothic reputation of the asylum.

Community

Community care that has its roots in idealised notions of community. Raymond Williams (2014) suggested that community is a word that is never used in a negative fashion. Community is long established in the English language. It originally meant the common people as opposed to those of rank, the people of a local area or the quality of holding something in common (MacCabe and Yanacek, 2018). The authors note as society became more complex community was the word used for alternative approaches to group living, for example, a religious community. This use made its way into the history of mental health - for example Laing's establishment of therapeutic communities (Cummins, 2017). These communities were self -contained and in a sense self-governing. They were attempts to live an alternative, healthier life. The use of community has spread. It is used in a broader political sense - for example the emergence of the term gay

community in the 1980s - to represent a grouping of individuals with shared political interests. The notion of community politics is used to denote a more informal, localised approach to campaigning. This is presented as a purer form of political activity. Here community stands in opposition or contrast to the tainted world of machine politics. In one of those ironies of usage, in recent times, there has been the emergence of "*gated communities"* - a number on the site of former asylums. The use of community plays to notion of inclusion and a nostalgic vision of what life used to be whilst they are gated to ensure that unwanted elements are kept out. Community carries with it implicit notions of inclusion and exclusion, be they physical or metaphorical.

Community, then, is a term that carries within it elements of nostalgia but also positive notions of making better social connections between individuals and groups. There remains a sense of flexibility in the use of the term community. It can be used as a cipher for a range of values. In the political and policy sphere, it is used as a marker to claim that there is something of an ethical core to proposals. Bauman (2001) community acts as a counter to a more individualistic present or what Rose (1996) termed the *"death of the social"*. Thus community is presented as the solution to a whole range of social and other problems. Arendt (1959) argues that some form of commonality is central to our physical survival. Individualism and autonomy are core values of our increasingly dislocated present. However, there are contradictions here as we can survive without care from others - as infants but also at other times in our lives (Fineman, 2004). The notion of community remains a very powerful one. Politicians and elites can make calls based on the idea that though citizens will never meet most of the members of the imagined community, they share interests or an identity (Anderson, 2006).

The multiplicity of meanings attached to community thus allow it to be used with little analytical work (Crow and Allan, 1995). In the late 1970s and early 1980s, as policies of deindustrialisation began to take effect, there was an increasing interest in the notion of community. Community was seen as providing a bulwark against the impact of New Right economic and social policies. Even though many on the Left were attracted to these notions, the use of the term across the political spectrum meant that it was problematic. In particular, the term seems to imply

some sense of greater localised, democratic involvement in decision making, but this was often not the case. Policies were often constructed and shaped by the needs of the wider state. The result was that the responsibility for hugely significant social problems was localised limiting the role of state actors and policies in their creation. Brown (2015) notes the way that neo-liberal politics pushes the nexus of social problems and their solutions further and further away from the site of their creation. Calls to communities are part of this process. Issues such as class and inequality become marginalised.

Community Care

The asylum was not replaced by a well resourced system of community mental centres, crisis accommodation, supported and independent living schemes and employment, which would enable people with mental health problems to complete the journey from "*patient to citizen*" (Sayce, 2000) As the asylum closed a fragmented, dislocated world of bedsits, housing projects, day centres or, increasingly, prisons and the criminal justice system replaced it (Moon, 2000 Wolff, 2005). For many, as Parr et al (2003) demonstrated the friendship and communal living aspects of the asylum were lost. Knowles (2000) in her study of the way that former patients negotiated the public spaces, shopping malls and urban environment of Montreal shows that rather becoming integrated into the wider community, this group were isolated and shunned in similar ways to asylum patients. A series of powerful black and white photographs captures the ways that the *mad* exist alongside but are ignored by the wider society. Knowles (2000) highlights the ways, in which, the responsibility for the care of the "*mad*" has moved from public to private institutions. She goes on to suggest that the restructuring of mental health services acted as a model for other '*problematic populations'*. This represents an extension of the market into areas of welfare provision that was then taken up in other areas, for example, the penal system. Cross (2010) suggests, pre-existing social representations of the *'other'* are very powerful in their ability to create a new identity for social categories. In this case, the representation of the *mad* from the asylum era has followed those people into the community. The homeless mentally ill (black) man became a TV and film drama cliche of gritty urban realism. The representation has changed – the *mad*

are not now dishevelled creatures chained to walls – they are the homeless of the modern city living on the streets with all their belongings in shopping carts. Their presence on the margins has become accepted as a feature of modern urban life.

The failings of community care

Leff (1997) demonstrated that the early resettlement programmes of long stay patients were managed successfully. These schemes were, on the whole, better planned and resourced. Leff (1997) highlighted that community based provision was marginally more expensive than institutionalised care. The progressive argument for community care was never about reducing costs. The funds would be spent on a range of community mental health provision. The period that Leff (1997) described was relatively short lived. One of the key lessons that can be drawn from deinstitutionalisation is the need to build community services at the same time as closing asylums. There are very few circumstances where this occurred. The result is that community services were and continue to play catch up. There are too many examples of the state simply abandoning its responsibilities to the most marginalised.

In the earliest criticism of community care, it was the progressive critics of institutionalised psychiatry who were deemed most responsible for its failings. In 1982 Weismann wrote *Foucault and the Bag Lady* about the admission of a homeless woman to Bellvue Hospital in New York. This paper as well as painting a very sympathetic portrait of the woman comes to the strong conclusion that the closure of asylums had led to her living on the streets. In 1982, in a debate with Foucault conducted in the book review section of the New York Times, the historian Lawrence Stone made a similar claim. One of the most vocal critics in the USA was the psychiatrist E. Fuller Torrey. Torrey (1997, 1998) argued that changes in mental health legislation had strengthened the rights of individuals vis-a-vis the state. However, he suggested that the pendulum had swung too far in favour of individuals. The focus on individual rights meant that services could not intervene at all. For Torrey, the notion of the exercise of rights became meaningless because individuals with severe mental health problems became

homeless or were swept up into the Criminal Justice System (CJS). In the UK, Cummins (2013) shows that the newspaper reporting of the incident where Ben Silcock climbed into the Lions Den at London Zoo claimed that mental health professions were hamstrung by their commitment to a patients' rights agenda. it was claimed that this led to the marginalisation of families and carers alongside the professional neglect of individuals.

A series of high profile cases in the USA and UK were used to calls for reform of mental health legislation. The case of Andrew Goldstein, who murdered Kendra Webdale at a metro station in New York, led to the introduction of *Kendra's Law* and involuntary outpatient treatment. Andrew Goldstein had been admitted to hospital on a voluntary basis on thirteen occasions. He was then virtually abandoned by the therapeutic state. The most high profile such case in the UK, in this period, is the murder of Jonathan Zito by Christopher Clunis in 1992. Clunis had been detained four times in an eighteen month period prior to the murder. He was, therefore, legally entitled to aftercare under section 117 Mental Health Act (MHA, 1983)(Ritchie, 1994). The Inquiry that followed Clunis's conviction outlined a disturbing pattern of short admissions to hospital when he was acutely unwell and often homeless. Clunis was discharged from hospital to bed and breakfast accommodation without adequate support from social workers and other mental health professionals. This, in no way lessens the appalling impact of those crimes, it is rather to ask fundamental questions about the nature and structure of mental health services in the period. Any analysis that ignores the economic context and wider pressures on services will be fundamentally flawed.

The insights of Fraser's model of *progressive neoliberalism* show that in these circumstance of policy failure, the focus is on the alleged failings of the progressive discourse. The solutions are presented as lying in bureaucratic systems of risk management and audit.The response of successive UK governments, in the period 1983 -1997, to the developing crisis in the provision of mental health services was to focus on the legislative and policy framework, rather than the organisation, funding and delivery of services. HC (90)23/LASSL (90)11 established the *Care Programme Approach* (CPA).The initial aim of the CPA

was to develop a system of case management. The introduction of the CPA was followed in 1993 by *Guidance on the introduction of supervision registers.* People considered to be *'at risk of harming themselves or other people'* could be placed on a supervision register, with the aim of ensuring that they remain in contact with mental health services. HSG (94)/27 established Inquiries must take place following a homicide by a person with previous contact with Mental Health services (Cummins, 2013). In 1995 the *Mental Health (Patients in the Community) Bill* introduced *'supervised discharge'* a short-lived piece of legislation which can be seen as a forerunner of the current Community Treatment Order The main themes of these developments are moves to more systematic surveillance of patients and the audit of mental health professionals. Mental health social workers became increasingly frustrated with systems that focused on risk assessment. The CPA, for example, was meant to be a means of the effective provision of services but became an inspection and auditing tool. These shifts can be places in the broader context of social work's increasing bureaucratic and managerialist focus on risk at the expense of relational social work (Webb, 2006). Turner and Columbo (2008) argued that in mental health professional practice risk assessment has replaced the ethic of care as the main focus of service user contact.

If the modern period of deinstitutionalisation in the UK , symbolically began with Powell's Water Tower Speech, then it ended with the introduction of CTOs in the 2007 reform of the MHA. Moves to CTOs can be traced back to the Inquiries of the 1980s and 90s. New Labour's position as outlined in *Modernising Mental Health Services* (DH, 1999) was as follows the failure was caused by:

- *inadequate care, poor management of resources and underfunding;*
- *the proper range of services not always being available to provide the care and support people need;*
- *patients and service users not remaining in contact with services;*
- *families who have willingly played a part in providing care have been overburdened;*
- *problems in recruiting and retaining staff*
- *an outdated legal framework which failed to support effective treatment outside hospital.*

It is important to note that the document includes underfunding as one of the key factors in what is termed - the failure of community care. It is, perhaps, not too surprising that the Blair administration elected with a huge majority after almost twenty years of Tory government was prepared to make such a statement. It should also be added that there then followed a period of investment in mental health services. However, within these statements one can also see clear traces of the pendulum has swung too far towards patients rights argument. This is a recurring theme in the analysis of community care, it is the legal rather than the fiscal framework that is most often see as the cause of failure.

Austerity

In the UK, the impact of the 2008 banking crisis continues to be felt across the public and welfare sectors. The bail out of the banks—an act of government intervention to rescue the loudest supporters of the free market—required the injection of huge sums of public money. Oxfam (2013) estimated that the cost was £141 billion. Austerity as a policy involves huge cuts in public and welfare spending. Austerity cannot be understood as purely or solely a matter of economics. It was a clear political project to recast and reduce the role of the social state (Cummins 2018). It is thus a form of neoliberal statecraft. Taylor-Gooby (2012) concluded, the result of austerity is that the UK public sector has shrunk to the lowest amongst major economies. This includes the United States. Taylor-Gooby (2012).The links between poverty, inequality and poor mental health are outlined in the Marmot Review (Marmot, 2010). Wilkinson and Pickett (2010) used the prevalence of mental illness as one of their measures of the impact of inequality. Mental health and mental illness can thus be regarded as signifiers of the broader nature of society. Wilkinson and Pickett (2010) noted greater economic equality generates wider social cohesion, lower crimes and more trust amongst citizens. All these have an impact on mental health. The links between socio-economic factors and mental health play out in a number of complex ways. Silva et al. (2016) outlined the potential impact of a range of socioeconomic factors on mental health. These include income inequality, poor housing and living in communities with a lack of resources. Research indicates

that lower socioeconomic is a potential factor in suicidal behaviour (Platt et al. 2017). In November 2018, Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights visited the UK and wrote a devastating report on the impact of austerity policies. The report (https://www.ohchr.org/Documents/Issues/Poverty/EOM_GB_16Nov2018.pdf) demonstrates the way that austerity policies have shredded the social welfare safety net.

In Bourdieu's model of the right and left hands of the state, the right disciplinary and punitive has become more dominant. In mental health, this is demonstrated by the increased use of the MHA, which allows for the compulsory admission to hospital. In 2015/16, there were 63,662 detentions under the MHA. This represented an increase of 9% from the 2014/15 figure of 58,399. This is quite a staggering statistic. A longer perspective shows that the 15/16 increase was part of an upward trend in the use of the MHA. In 2005/06, there were 43,361 detentions. This means that there has been a 50% increase in the use of the MHA over a ten-year period. If these trends continue the 2025/26 will see nearly 100,000 admissions under the MHA. Keown et al (2018) in their analysis of trends in the use of the MHA concluded that paradoxically community care had led to significant rises in the use of compulsory powers. It is also important to note that there has been an increase in the use of private hospital placements. On 31 March 2016, 5,954 patients were detained in private hospitals. This represents 30%of all detained patients. This is the highest percentage since 2006, when 17% of patients were detained in private hospitals. This follows a neoliberal model of expanding the market or private provision to as many areas as possible.

There is one area where neoliberalism is not committed to a small state – law and order and disciplinary mechanisms. Scull (1976, 1977, 1986) argues that societal responses to mental illness have to be seen in a much broader context of the emergence of the technologies of the management of deviance within modern, capitalist societies One of the most significant developments in social policy in the past forty years has been the expansion of the penal state. The USA has "*led the way"* with staggering increases in the rate of imprisonment. The standard comparative measure for imprisonment is the rate per 100, 000 of the population.

Since 1999, the overall world prison population rate has increased from 136 per 100, 000 to 144 per 100, 000. The USA remains at the top of this incarceration league with a rate of 716 per 100,000. This overall average hides huge disparities between individual states. Carson and Golinelli (2013)'s analysis shows that the five states with highest imprisonment rates: Louisiana (1, 720), Mississippi (1,370) Alabama (1,234) Oklahoma (1,178) and Texas (1, 121) have rates well above the national average. Wacquant (2009a 2009b) sees the expansion of the penal state as an endogenous feature of neoliberalism. Other penal scholars argue that there are broader cultural and social factors that explain the rise of mass incarceration (Harcourt, 2005, Simon, 2007, 2014 Lacey, 2008 and Parsons, 2018). The expansion of the use of imprisonment amongst European countries has been most marked in England and Wales (Cummins, 2017). It is apparent that the CJS has become a de facto, if often inadequate provider of mental health care.

Service user perspectives

Fraser's model emphasizes the way that the progressive discourse of the social movements of the 1960s have been adopted and colonized by neoliberal elites. This process has led to the decoupling of the redistribution from recognition (Fraser, 1995, 2000). The adoption of a radical, progressive discourse is apparent in the development of mental health policy. Mrs. May's speech is a prime example, she uses a language of social injustice – somewhat at odds with her role in the imposition of policies of austerity that had such a devasting impact on people with mental health problems (Marmot, 2010, Karban, 2016 and Cummins, 2018). The radical critique of institutionalized psychiatry had much in common with other social movements of the 1960s such as feminism and the civil rights. These movements argued that members of particular groups were denied full citizenship because of their gender, race, or sexuality. Goffman's total institutions had the same impact on those seen as mentally ill. There has always been a challenge to the power of psychiatry. Porter (1987) quotes the English playwright, Nathaniel Lee (1653-1692) who was admitted to Bedlam and afterwards remarked *"They called me mad, and I called them mad, and damn them, they outvoted me*". Crossley (1999, 2004) identifies the anti-psychiatry movement of the late 1950s and 1960s as a "*revolution from above".* The *"leaders"* of the revolution were

academics and psychiatrists. Crossley (2004) notes that the anti-psychiatry *"revolt from above"* preceded and gave some impetus or ideological support to the *"revolt from below"* that created the modern user/survivor movement. The Scottish Mental Patients Union was established in 1971 followed by the Mental Patients'Union in 1973. There then followed the Community Organisation for Psychiatric Emergencies (COPE) which campaigned for local and ward changes but also established "*crash houses*" as alternative safe places for those members who were experiencing crisis. In Italy, the work of Basaglia led to the establishment of the campaigning movement *Psichiatra Democratia* (Foot, 2015). The radical challenge to psychiatry that groups such as the British Network for Alternatives to Psychiatry established by Laing and Cooper represented part of the wider 1960s counterculture. In 1986, *Survivors Speak Out* was established. The use of the term survivor represents not just a change in language but a shift in approach.

The radicalism of the service user/survivor movements challenge to the power of mental health professionals is still readily apparent. However, Fraser's notion of "*progressive neoliberalism"* can provide a conceptual framework for the analysis of the response to it. The language of rights, inclusion and has become a feature of mental health policy documents. For example, in 2010, the *White Paper, Equity and excellence: Liberating the NHS* was published. The response to the consultation was entitled *No decision about me without me* with the government envisioning a future NHS where *all patients are fully involved in decisions about their own care and treatment so that the principle of shared decision-making - "no decision about me, without me"- becomes the norm across the NHS* (DH, 2011). This would include mental health services. Another example of this form of discourse is the term *"recovery".* Recovery became one of the buzzwords that dominate services . At its core, is a recognition - really a call for a paradigm shift - that diagnosis is not destiny. Such a shift requires a commitment to the involvement of service users in the design and development of services. The recovery paradigm is an essentially optimistic one. However, the success of the Recovery model has led to some groups becoming critical of the way that it became subsumed in mental health services. There is a danger that the radical edge of such moves are lost as they become absorbed into mainstream thinking.

Radical Groups, for example, Recovery in the Bin (https://recoveryinthebin.org/) argue that mainstream services have used terms such as recovery to mask the actual impact of the retrenchment of mental health services. RITB makes an explicit link between the current economic and social policies of austerity and neoliberalism and the failings of mental health systems. From this perspective, neoliberal economic and work policies generate mental health problems whilst its social and welfare policies lead to cuts in services.

Implications for mental health social work practice

Neoliberalism has also entailed a sustained attack on the position of organized labour and the pay and conditions of working people. The rise of precarity (Standing, 2011) has involved the introduction of zero hours contracts and the loss of benefits such as sickness and holiday pay. In addition, the conditions, in which, people work have been marked by increasing control, surveillance and monitoring (Ehrenreich, 2010 Bloodworth 2018). Workers in the social care sector have seen their pay and conditions worsen over the period of austerity. Wages in the public sector have been effectively cut. Workers face increasing pressures to spend less time with the people they are meant to support. *The Guardian* reported of the continuing scandal of agencies not paying support workers for their travel time between visits. This is in addition to the fact that workers are not entitled to sickness and holiday pay. The net effect is to reduce wages to below the minimum wage (https://www.theguardian.com/society/2019/jan/29/care-workers-cut-short-home-visits-travel-time). The period of austerity has seen significant cuts to LA budgets – placing increasing pressure on the social care sector. Alongside these developments, there has been an erosion of professional autonomy and the growth of a bureaucratic managerialist culture (Cummins, 2019). These trends combine to push relational and value based forms of care to the margin.

Mental health social work practice

Bourdieu's notion of habitus is a complex one and often difficult to define (Hillier and Rodksby, 2002). Habitus is the reworking or reformulation of a notion that

has long philosophical roots (Wacquant, 1998). Bourdieu described habitus as a combination of values, experiences and social attitudes. It is not a static concept - habitus will change overtime depending on individual experiences and social and cultural changes. In discussing habitus, in the context of social work, Houston concludes that it should be seen as *" a very loose set of guidelines permitting us to strategise, adapt, improvise or innovate in response to situations as they arise. "* (2002 p157). It should not be seen as rigid or as providing solutions to all moral or other questions that arise in a given circumstance.

Social workers may carry out different roles within the mental health field - for example, care co-ordinators,AMHP or acting as an Appropriate Adult under PACE (2004) - they do so from a particular perspective and having undergone a particular form of training and education. The development of Community Mental Health Teams (CMHTs) and case management has further marginalised social work values and practice (Morriss, 2016). The danger here is that social work's critical perspectives on the current structure and provision of services are lost. There are still examples of social work as profession providing a challenging to social injustices. This occurs on a national, local and individual level. For example, BASW'S Boot Out Austerity campaign or highlighting the injustice of and damage caused by the Work Capability Assessment regime. Bourdieu et al (2002) note that social workers are agents of the state but *"shot thorough with the contradictions of the state*" and that there is a tension between *"the logic of social work which is not without a certain prophetic militancy or inspired benevolence and that of bureaucracy with its discipline and its prudence*". The habitus of a mental health social worker will have at its root a critical perspective towards institutionalised and coercive forms of mental health care. Whilst recognising progress in mental health services, it acknowledges that there is a need for an understanding of the historical, social, political and cultural factors that combine to produce the current system. Bourdieu saw social workers and other public sector workers as fighting on two fronts. The first was clearly to work alongside service users to tackle the barriers they face to full citizenship. The second was the battle within the bureaucracies, in which, they are inevitably forced to practice.

Discussion

Mental health and responses to it take place within specific geographical locations. These locations provide an insight into the theoretical underpinnings of treatment but also wider social attitudes. Two idealised notions or representations of the asylum and the community came to play a dominant role in understandings of mental health policy. The asylum/community binary contains within it a series of other binaries: *past/future, rural/urban, inclusion/exclusion, abuse/dignity, institutionalisation/independence, tradition/modernity and deterioration/progress*. The development of asylums involved the institutionalisation of populations who were regarded in some way as deviant (Castel, 1988 and Scull, 1989).The asylum dominated the landscape in a physical but also a metaphorical sense. The closure of the asylums represented not just the transfer of the location of services but a switch in the modality of service provision (Joseph and Kearns, 1996). The seclusion of the asylums and their architecture ironically made them attractive to property developers in the 1980s. Those sites that were abandoned became part of the Gothic myth of the asylum.

Community care was seen as an antithesis to the dehumanising regime of the total institution that Goffman (2017) and others outlined. Community was used in a problematic way that overlooked some of the philosophical difficulties with the concept. The community was assumed to be an entity rather than an abstraction but also a welcoming one. This proved to be naive, perhaps even wildly optimistic. As community care was being introduced, a series of economic and social policies placed tremendous pressure on the poorest urban communities. The asylum disappeared and its place was a rather hidden world of B+Bs and often poor supported housing projects or homelessness. These moves were at odds with a narrative of independence and civic rights that was to be found in policy documents. Moon (2000 p241) argues that the "*concealed others*" of the asylum regime were replaced with the *"visible others"* of the new system. The asylum was a site of social hygiene. Community care became associated with the *"street"* as a public space of potential danger. It led to calls for more the provision of more secure psychiatric beds. Community should not be viewed as

simply a geographical location. It is a shorthand for a set of philosophical values that were seen as underpinning a new era of mental health provision.

Conclusion

Fraser's notion of "*progressive neoliberalism"* can be used as a tool of analysis to examine the development of the policies of deinstitutionalization and community care. There are two element to her development of the term (Fraser, 2017, 2019). The first is the way that the "market" and "market forces" have penetrated or been applied to all areas of life. Brown (2003) notes the monetization of human relationships marks one of the key shifts from liberalism to neoliberalism. One of the key reasons for the closure of the old mental health hospitals was cost. The symbolic beginning of deinstitutionalization in England and Wales is often seen as Powell's Water Tower speech of 1961. Powell is more usually remembered for his racist "Rivers of Blood" speech in 1968 (Hirsch, 2018). He was also one of the early proponents of monetarist economic policies that were later taken up with such enthusiasm by the Thatcher Governments in the 1980s. The NHS +CC Act (1991) as well as calling for people to be able to live more independently explicitly created a market in social care. The market in social care has grown exponentially since the introduction of this legislation. This has involved an expansion in the number of private nursing and residential homes, alongside the NHS signing a series of contracts with private providers. Multi national corporations have focused on increasing their market share in this area. These developments cut across all areas of social care provision and can be seen in mental health services. As noted above one of the first criticisms of the policy of deinstitutionalization was that the state had abandoned vulnerable people who became homeless or lived in a series of poor B+B type accommodation. It was not explicitly presented as such but this is a form of privatization and marketisation.

Fraser (2019) argues that the election of Trump and the fallout from the Brexit vote marks the end of the hegemonic domination of *progressive neoliberalism*. She notes that this term will appear to be an oxymoron to many. She describes it as a "*powerful alliance of unlikely bedfellows"* (Fraser, 2019 p 11) - the progressive elements of liberal social movements and the high end of American capitalism

and culture - Wall Street, Silicon Valley and Hollywood. Fraser argues that in the political sphere

"*The progressive -neoliberal bloc combined an expropriative, plutocratic program with a liberal -meritocratic politics of recognition"* (Fraser, 2019, p12)

There were inevitable tensions and fissures within this inherently unstable bloc. These have led to the political crisis that is unfolding at present. I have argued that Fraser's notion of *progressive neoliberalism* can be used as a conceptual lens for the analysis of mental health policy. The progressive elements lie in the radical challenge to the power of psychiatry and mental health professionals as represented by the service user /survivor movement. The neoliberal elements can be clearly seen in the fiscal conservatism that was a driver of deinstitutionalisation and the privatisation and marketisation that was such a key element of community care. The response to the failings in mental health services has been to focus on punitive and disciplinary approaches - a more intrusive, restrictive welfare regime, the increase in the use of the CJS as a de facto provider of mental health care and compulsory admission to hospital. The base of the new community care needs to be a revitalised and reinvigorated value base with the concept of dignity at its core.

References

Alston, P (2018) *Statement on Visit to the United Kingdom, by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights* https://www.ohchr.org/ Documents/Issues/Poverty EOM_GB_16Nov2018.pdf

Anderson, B., (2006) . *Imagined communities: Reflections on the origin and spread of nationalism.* London Verso Books.

Arendt, H., (1959). *The human condition: a study of the central dilemmas facing modern man.* New York Doubleday

Bauman, Z. (2001) *Community: Seeking Safety in an Insecure World.* Cambridge: Polity Press

Bauman, Z. (2007) *Liquid Modernity: Living in an age of uncertainty*, Cambridge: Polity Press

Bloodworth, J., (2018). *Hired: Six months undercover in low-wage Britain*. Atlantic Books.
Bourdieu, P. (2001) *Acts of Resistance,* Cambridge: Polity.
Brown, W (2003). "Neo-liberalism and the End of Liberal Democracy." Theory and Event 7(1):37–59.
Brown, W., (2015) *Undoing the demos: Neoliberalism's stealth revolution*. Cambridge Mass MIT Press
Carson, E and Golinelli, D (2013) *Prisoners in 2012: Trends in Admissions and Releases1991-2013* www.bjs.gov/content/pub/pdf/p12tar9112.pdf

Castel, R. (1988) *The Regulation of Madness*. Cambridge: Polity
Cross, S., (2010) *Mediating madness mental distress and cultural representation.* Basingstoke Palgrave Macmillan
Crossley, N., (1999). Fish, field, habitus and madness: the first wave mental health users movement in Great Britain. *The British journal of sociology, 50(4),* pp.647-670.

Crossley, N., (2004.) Not being mentally ill: Social movements, system survivors and the oppositional habitus. *Anthropology & Medicine,* 11(2), pp.161-180.

Crow, G.P. and Allan, G., (1995). Community types, community typologies and community time. *Time & Society*, *4*(2), pp.147-166.
Cummins, I., (2017). Social work and the penal state. *European Journal of Social Work*, *20*(1), pp.54-63.
Cummins, I., (2017) *Critical psychiatry: a biography*. Northwich Critical Publishing.
Cummins, I., (2018). The impact of austerity on mental health service provision: A UKperspective. *International Journal of Environmental Research and Public Health*, 15(6), p.1145.

Cummins, I., (2019) *Mental Health Social Work Reimagined*. Bristol Policy Press.
Department of Health, (1999). *Modernising mental health service, safe, sound and supportive.*DH.
Dunn, B. (2017) Against neoliberalism as a concept *Capital & Class*, 41 (3): 435–454.
Ehrenreich, B. (2001). *Nickel and dimed: On (not) getting by in America*. New York, NY: Henry Holt

Fineman, M. (2004) *The autonomy myth a theory of dependency*. New York: The New Press

Foot, J., (2015). *The man who closed the asylums: Franco Basaglia and the revolution in mental health care.* London Verso Books.

Foucault, M., (2003). *Madness and civilization*. London Routledge.

Franklin, B., (2002) Hospital-heritage-home: Reconstructing the nineteenth century lunatic asylum. *Housing, Theory and Society*, *19*(3-4), pp.170-184.

Fraser, N. (1995). From redistribution to recognition? Dilemmas of justice in a 'post-socialist' age. *New Left Review*,*1*(212), 68–92

Fraser, N. (2000). Rethinking recognition. *New Left Review*, *3*, 107–120

Fraser, N., (2017). *The end of progressive neoliberalism*. *Dissent*, *2*(1),

Fraser, N., (2019). *The Old Is Dying and the New Cannot Be Born*. London Verso.

Garrett, P.M., (2018). Revisiting 'The Birth of Biopolitics': Foucault's Account of Neoliberalism and the Remaking of Social Policy. J*ournal of Social Policy*, pp.1-19.

Giroux, H. (2011) Neoliberalism and the death of the social state: Remembering Walter Benjamin's Angel of History Social Identities: *Journal for the Study of Race, Nation and Culture*, vol 17, issue 4

Goffman, E., (2017). *Asylums: Essays on the social situation of mental patients and other inmates*. London Routledge.

Harcourt, B.E., (2005). From the asylum to the prison: Rethinking the incarceration revolution. *Tex. L. Rev.*, *84*, p.1751

Harvey, D. (2005), *A Brief History of Neoliberalism*, Oxford: Oxford University

Hirsch, S., (2018) *In the shadow of Enoch Powell: Race, locality and resistance*. Manchester Manchester University Press.

Joseph, A.E. and Kearns, R.A., (1996). Deinstitutionalization meets restructuring: the closure of a psychiatric hospital in New Zealand. *Health & Place*, *2*(3), pp.179-189

Karban, K. (2016) Developing a health inequalities approach for mental health social work. *Br. J. Soc. Work* , 47, 885–992

Keown, P., Murphy, H., McKenna, D. and McKinnon, I. (2018). Changes in the use of the Mental Health Act 1983 in England 1984/85 to 2015/16. *The British Journal of Psychiatry*, 213(4), pp.595-599.

Knowles, C., (2000). *Bedlam on the streets*. London: Routledge.

Lacey, N (2008) *The Prisoners' Dilemma: Political Economy and Punishment in Contemporary Democracies.* Cambridge. Cambridge University Press
Leahy, JP (2011) *Detroitism What does "ruin porn" tell us about the motor city*? *https://www.guernicamag.com/leary_1_15_11/* accessed 18th February 2019
Leff, J. ed., (1997). *Care in the community: illusion or reality*. London Wiley.
MacCabe, C. and Yanacek, H. eds., (2018). *Keywords for Today: A 21st Century Vocabulary*. Oxford Oxford University Press
Marmot, M. (2010) *Fair Society, Healthy Lives, The Marmot Review*; Department of Health: London, UK; Available online: www.parliament.uk/ documents/fair-society-healthylives- full-report.pdf (accessed on 18 February 2019)
Moon, G., (2000). Risk and protection: the discourse of confinement in contemporary mental health policy. *Health & place*, *6*(3), pp.239-250.
Oxfam (2013) *Truth and Lies about Poverty: Ending Comfortable Myths about Poverty*. Available online: www.oxfam.org
Parr, H., Philo, C. and Burns, N.,(2003). '*That awful place was home*': 1 Reflections on the Contested Meanings of Craig Dunain Asylum. *Scottish Geographical Journal*, *119*(4), pp.341-360.
Parsons, A.E., (2018). *From Asylum to Prison: Deinstitutionalization and the Rise of Mass Incarceration After 1945*. UNC Press Books
Platt, S., Stace, S. and Morrissey, J., (2017). *Dying From Inequality: Socioeconomic Distadvantage and Suicidal Behaviour. Samaritans: London, UK*.
Ritchie J, Dick D, Lingham R. *Report of the Inquiry into the Care and Treatrnent of Christopher Clunis. London:* HMSO, 1994. (North East Thames and South East Thames Regional Health Authorities
Rogers, A. and Pilgrim, D.(2014) *A sociology of mental health and illness.* Maidenhead, McGraw-Hill Education (UK).
Rose, N., (1996). The death of the social? Re-figuring the territory of government. *International Journal of Human Resource Management*, *25*(3), pp.327-356.
Sayce, L., (2000). *From psychiatric patient to citizen: Overcoming discrimination and social exclusion*. London St Martin's Press
Scull, A.T., (1977) . Madness and segregative control: The rise of the insane asylum. *Social Problems*, 24(3), pp.337-351.

Scull, A., (1986). Mental patients and the community: A critical note. *International journal of law and psychiatry*.

Scull A. (1989) *Social Disorder*. Cambridge, UK. Polity Press

Silva, M., Loureiro, A. and Cardoso, G., 2016. Social determinants of mental health: A review of the evidence. *The European Journal of Psychiatry*, *30*(4), pp.259-292.

Simon, J., (2007). *Governing through crime: How the war on crime transformed American democracy and created a culture of fear*. Oxford Oxford University Press.

Simon, J., (2014) Law's Violence, the Strong State, and the Crisis of Mass Imprisonment (for Stuart Hall). *Wake Forest L. Rev.*, 49, p.649.

Standing, G (2011) *The Precariat: The New Dangerous Class* New York: Bloomsbury

Stone, L., (1982). An exchange with Michel Foucault. *New York Review of Books: New York*.

Taylor-Gooby, P., (2012). Overview: Resisting welfare state restructuring in the UK. *Journal of Poverty and Social Justice*, *20*(2), pp.119-132.

Torrey, E.F., (1997). *Out of the shadows: Confronting America's mental illness crisis*. New York: John Wiley.

Torrey, E. F (1998) *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill* New York: Harper & Row, 1988

Tuan, Y.F., (1979). Space and place: humanistic perspective. In *Philosophy in geography* (pp.387-427). Springer, Dordrecht.

Turner. T and Colombo A. (2008) *Risk* in R. Tummey and T. Turner (Eds) *Critical issues in mental health*. Basingstoke: Palgrave Macmillan

Weissmann, G., (1982). Foucault and the bag lady. *Hospital Practice*, *17*(8), pp.28-39.

Williams, R., (2014). *Keywords: A vocabulary of culture and society*. Oxford Oxford University Press.

Wilkinson, R. and Pickett, K., (2010). *The spirit level: Why equality is better for everyone*. Penguin UK.

Wolff, N., (2005). Community reintegration of prisoners with mental illness: a social investment perspective. *International Journal of Law and Psychiatry*, 28, 43–58.