THE INCARCERATION ARCHIPELAGO OF LUNACY 'REFORM' ENTERPRISES: AN EPOCHAL OVERVIEW

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INTRODUCTION

Caring for the vulnerable and dependent like people with chronic and severe mental illness has always been, in theory, a collaborative effort by society's fundamental institutions. Each of the four dynamic pillars of modern society (the state, market, family and charity), has a long history of involvement in the care and support of the less fortunate. The less fortunate include people disabled with mental illness. The key focus of this article is the transformation that has taken place in regards to the 'care' and 'control' of people with serious mental illness in most advanced capitalist societies since the eighteenth century.

The basic underlying question I am asking is whether the lives of people disabled with serious mental illness have improved, at least in terms of the traumas and extreme human suffering that they experience, since the dismantling of large institutions in the mid-1960s and the cessation of 'warehousing' practices. The unusual degree of incoherence and volatility that characterise contemporary mental health policy and practice questions government claims that change from past policies and practices constitutes progress.

This article consists of a historical survey that highlights critiques of the failure of previous lunacy reform interventions.[1] The greatest criticism of earlier reform strategies and initiatives is the consistency with which they have failed to fulfil their promises. The charge of false promises can be levelled equally at more contemporary reforms based on ideals of community mental health care and control. The transition by rich Western

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[1] I adopt Richard Henshel's meaning of intervention to include '*all* of the conscious, organised efforts' to alleviate one of the modern state's ongoing social ills. See Richard Henshel, *Reacting to Social Problems* Canadian Social Problems Series (1976).

societies from the Keynesian Welfare State model of the 1960s to a market/contract state model of the 1980s can, for some people with serious mental illness, be characterised as neither progress nor regress.

The thesis of this article is that emphasis on the social control rather than the care of people disabled with serious mental illness mirrors, in modern forms, their past persecution and consequential extreme suffering and social exclusion. These contemporary forms of persecution and suffering should be understood as evidence of continuity of the oppression of people disabled with mental illness despite the rhetoric of modern reform. The principal focus is on two fundamental transformations (ideological and institutional) of the control system that relates to the mentally ill, principally the creation and the dismantling of the asylums. These reform interventions are of particular interest because they are the most outstanding in terms of their widespread exclusionary impact on the lives of those who became unwilling participants.

The exclusion of people with serious mental illness continues despite the benign rhetoric that heralded their implementation. The first movement took place in England around the late eighteenth century and the second around the latter half of the twentieth century. Both involved major ruptures from the lunacy reform initiatives of their times and both resulted in extreme forms of exclusion.

The article is divided into three parts: part one discusses the cyclical pattern of mental health reform interventions over the epochs. It contains a table that summarises key transformations in the control of people with a mental illness from pre-modern times to the present-day state of modernity. Part two gives a brief overview of the mental health system as it developed in England and then in Australia as part of the Great Incarcerations. In part three, I examine the system's transmutation through the deconstruction of psychiatric institutions and the introduction of community-based mental health care.

Instead of the word institutionalisation, I use the word 'incarceration'. The word is used here in a broad sense to mean more than physical exclusion like confinement in prisons or asylums. It includes the more subtle systems of surveillance and control of mentally ill people like modern involuntary treatment orders that involve a process of compulsory administration of drugs and therapies, despite their often permanent and potentially lethal side effects. These serve to incarcerate those who do not conform to the demands of those of 'sound mind'. The term 'archipelago' is used here as a metaphor of the different loci of care of the mentally ill

throughout the centuries.[2] With every new reform enterprise, these people are shifted from one form of incarceration to another, from one set of islands to another, under the wide umbrella of the 'deviancy control system'. This movement from place to place within an expanding orbit of homelessness is a consequence of the modernising process. A world that is running out of places to put redundant human waste characterises present day modernity.[3]

An epochal grid of the deviancy control system based on the work of historians like Andrew Scull and Roy Porter, and especially the work on social control by sociologist Stanley Cohen is used to map the contours of the 'carceral archipelago'[4]. These scholars provide useful dimensions through which to view fundamental changes over the epochs. Their historiography of the control of the insane in eighteenth and nineteenth century England is used to locate and analyse cyclical patterns of 'reform' and development over time in the context of 'the system's original foundations'.[5]

The deviance control system grid below does not attempt to challenge existing histories of social control or psychiatry. Instead, the grid summarises the rich history of 'lunacy reform' to provide an overview from which comparisons of past and present mental health policy and practices can be made. In particular, the grid's focus is on contemporary phenomena such as deinstitutionalisation and community mental health care.

I CYCLICAL PATTERNS OF SOCIAL INTERVENTION: SYMPTOMS OF CHAOS?

Morrissey and Goldman describe the history of public intervention on behalf of people with mental illness as a 'cyclical pattern' of reforms based on an environmental approach to treatment and a new locus of care.[6] Although they identify three cycles of reform in the United States, similar patterns of reform have also been identified in the histories of Australia and other modern Western societies. The introduction of 'moral treatment'

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[2] Stanley Cohen, *Visions of Social Control: Crime, Punishment and Classification* (1985) 14.

[3] Zygmunt Bauman *Wasted Lives Modernity and its Outcasts* (2004).

[4] Michel Foucault, *Discipline and Punish: The Birth of the Prison* (1979). See also, Michèlle Perrot, *L'Impossible Prison* (1978).

[5] Cohen, above n 2.

[6] Joseph Morrissey and Howard Goldman, 'Cycles of Reform in the Care of the Chronically Mentally Ill' (1984) 35 *Hospital and Community Psychiatry* 785-793.

and the asylum in the early nineteenth century was the first cycle; the second cycle was the mental hygiene movement and the rise of the psychopathic hospital in the early twentieth century; and the third cycle was the community mental health movement of the mid-twentieth century.[7] Each cycle promised that new forms of treatment would prevent the personal and societal problems associated with long-term mental disability, each eventually faltered.[8]

A detailed grid of cycles of reform reflected in techniques of social control has been developed from Stanley Cohen's work and is represented in the table below. The table provides an overview of the *epochal*, or 'master changes' in the social control of people perceived, and now classified as having chronic mental illness.

Grid of Transformations in the Deviancy Control System for the Mentally Ill (grid adapted from Cohen)[9]

Epoch	**Pre-18th C**	**End 18th- early 19th**	**Mid 20th C on**
Ideological transitions	feudalism to capitalism & nation state; religion based to science based medicine	Rise of capitalist liberal state; decline of religion	Keynesian welfare state; democratic citizenship to market state; individualism & redefinition of labour market.
Management transitions	Minimalist, decentralised state intervention	Centralised state control, intervention intensified, rationalised; rise of modern bureaucracy	'Decentralisation Decriminalisation Diversion'; 'destructuring': state divests functions but intervention & control expands through growth in community based agencies and indirect state sponsorship
Theories of Treatment	Moral, classical school; metaphysics; Focus on controlling 'body';	Positivism based on 'just' treatment ideal; 'neo-positivist' focus on controlling 'mind'	Return to 'justice' ideology, 'neo-classicism'; social schools explain behaviour; focus or

[7] Ibid 785.
[8] Ibid.
[9] Cohen, above n 2, 16-17 (Table 1).

	neglect/ persecution at village level	& 'inner states'; classification & 'moral treatment'	body & mind but shift to controlling external behaviour & compliance rather than the minds or actors
Control/ care Framework	'open', 'inclusive' primary institutions; criminal law only form of official control	'closed', segregated institutions; incarceration theme; 'monopoly of criminal justice system'; later mental health system supplement	Back to mostly 'open' community alternative; de/non-institutionalisation theme; Purpose built institutions remain; mental health system expands but criminal justice system remains
'Professional dominance'	Not present; clergy dominant, supplemented by law	Psychiatry established & grew to be expertise; monopoly for services.	'de-professio-nalization', anti-psychiatry; pro-self-help but dominance by managers as professionals expand
Impact on Mentally Ill	Assimilate or die	Brutalisation of insane; exclusion through internment; state controlled for life; no identity/choice	'dependency' stigmatised but class influence (eg. clinics for rich, hostels & the streets for poor); homeless demonised; social exclusion; assimilate or die.

A Different Versions of History

In the mental health field, the connections between 'reform' and 'progress' have come to be questioned by some social commentators.[10] Some reform enterprises impelled by the optimism of their creators have not turned out to be progressive. The false promises of lunacy reform interventions are, as Cohen suggests, evident from the inconsistency between what is said and what is done, what is apparent and what is real. Doubt and suspicion about the motives and the ideologies that are at the root of social transformations now abound. Hence, how a particular cycle of transformation is interpreted will depend on which of the different versions

[10] Ibid 20.

of history (based on a common set of 'factual' events as the table suggests) is adopted.[11] The hegemonic official version of history depicts reforms as progressive and modernity as the epitome of progress.

This version of history, premised on unilinear progress, presents reform enterprises, like the asylums as 'progressive' because they are based on benevolent, altruistic, and philanthropic ideas construed as victories of humanitarianism over barbarism and of 'scientific knowledge over prejudice and irrationality'.[12] Cohen suggests that this version is plausible because the reforms replace 'early forms of punishment, based on vengeance, cruelty and ignorance' by 'informed, professional and expert intervention'.[13] The immediate forerunner of the mental asylums of the eighteenth century was centuries of witch-burning and the elimination of the 'mad'.[14] Bauman's counter-hegemonic version of history highlights the regressive dimensions of modernity.

Bauman characterises modernity as economic progress and a process that involves the quest for order – an incessant, obsessive *process*.[15] For Bauman, the 'project of modernity', if there ever was such a project, 'was the search for the state of perfection'.[16] He uses liquids as a metaphor for the present phase of modernity because 'liquid modernity' is unlike earlier fixed forms of the modern world.[17] Liquid, Bauman says, 'makes salient the brittleness, breakability, ad-hoc modality of inter-human bond'.[18]

I agree, above all, with Bauman's analysis of one important outcome of the spread of modernity, the production of waste, including 'human waste' or more precisely, 'wasted lives'.[19] 'Wasted lives' are human beings deprived of adequate means of survival because they are 'unneeded, of no use' in a world running out of places to put them. Theorizing about the

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[11] Ibid 15.
[12] Ibid 18.
[13] Ibid.
[14] For critiques of different versions of the history of mental health reforms see, eg, Sheldon Gelman, 'Looking Backward: the Twentieth Century Revolutions in Psychiatry, Law, and Public Mental Health' (2004) 29 *Ohio Northern University Law Review* 531-585; Ralph Slovenko, 'The Transinstitutionalization of the Mentally Ill' (2004) 29 *Ohio Northern University Law Review* 641-659.
[15] Milena Yakimova, 'A postmodern grid of the worldmap? Interview with Zygmunt Bauman' (2002) Eurozine < http://www.eurozine.com/articles/2002-11-08-bauman-en.html> at 13 July 2006.
[16] Ibid.
[17] Zygmunt Bauman, *Liquid Modernity* (2000) foreword.
[18] Ibid.
[19] Zygmunt Bauman, *Wasted Lives Modernity and its Outcasts* (2004).

production of human waste as the chronic and persistent exclusion of redundant populations, modernization makes the need to periodise modernity unnecessary. I depart from Bauman's liquid metaphor, however, in only one sense—for people disabled with mental illness, without money and without homes, their experience of modernity is concrete and replete with suffering and exclusion. For these people, their crisis of suffering remains solid and fixed, not 'liquid' or 'fluid', despite the passage of time into present-day modernity.

II REMEMBERING THE PAST: A CRITICAL HISTORY OF 'SOCIAL CONTROL' OF PEOPLE WITH MENTAL ILLNESS

A The Old System: Enlightenment Modernity - An 'Inclusive' World?

The seventeenth century was a period when 'external' or outdoor relief such as the provision of food for the 'deserving' or 'impotent' poor (some of whom were also intellectually impaired or mentally ill) was more common than 'internal' forms of relief provided in poor houses or almshouses. There was a paucity of purpose-built establishments to care for such people.[20] However, by the eighteenth century, official workhouses were built to provide work in exchange for relief. Those unable to work still had to fend for themselves or starve but for the relief provided by parish 'poor-houses'.

B Modernity and the Victory of Rationality: Enter the Exclusive World

The seventeenth century marks the 'golden age' for science in terms of both the expansion of scientific research, and the development of the

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[20] Two different classes of poor were created by the Old Elizabethan Poor Law of 1601. These included: i) the 'impotent' poor such as the elderly, the sick and those unable to work, entitled to outdoor forms of relief or to a place in an almshouse because they were unable to work and, ii) the able bodied poor who were thought as being able to work. Members of the latter group were susceptible to severe beatings until they realised the error of their ways. The type and level of relief offered also depended on the parishes to which the pauper belonged. Some were more sympathetic than others. In outline, this endured until the New Poor Law of the 1830s ended the Speenhamland System. See Marjie Bloy, *The Old Poor Law 1795—1834* (2004) The Peel Web: A Web of English History <http://dspace.dial.pipex.com/town/terrace/adw03/peel/poorlaw/plaa.htm> at 2 June 2004.

concept that 'science is measurement' and therefore is more exact.[21] The majority of the indigent 'mad' or 'fools' in England was cared for by family members or kept under the watchful eye of the parish community.[22] However, from the eighteenth century onwards, a modern concept of 'rationality' and science became hegemonic.

The use of reason and the desire of humans to become the masters and possessors of the earth became central to modernity.[23] Science and technology, a market economy, the development of bureaucracy and formalisation of the law, literacy and education were all important modernising processes.[24] As society increasingly defined itself as 'rational' or 'normal', abnormality and irrational behaviour 'provoked anxiety' serving to further stigmatise the 'mad'—this time, as Porter points out, as having a total absence or perversion of reason.[25] A Foucauldian account of the justification for hiding 'unreason', at least in the Classical Age[26], rests on intentions 'to prevent imitation, to safeguard the reputation of the Church, to preserve the honour of families or simply 'to avoid scandal'.[27]

By the nineteenth century, the avoidance of unreason ideology led to an intensified demand in England for institutions in which to detain those deemed lacking in reason. The 'different', 'difficult' or 'dangerous' lacked reason because they least conformed to the expectations of the central state or the market economy.[28] Scull's account of madness in the Victorian Era confirms that some lunatics were kept behind locked doors

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[21] Roberto Margotta, *The Hamlyn History of Medicine* (1996) 98.

[22] Roy Porter, 'Foucault's Great Confinement' (1990) 3 *History of the Human Sciences* 47-54, 48.

[23] In the Enlightenment (Europe in the late 17th and 18th centuries) the appeal to reason was based on the desire to be freed from the bondage of false belief and the hierarchies of feudal society. But there are different theories of modernity. In *Theoretical Criminology: from modernity to post-modernity* (1995) especially in Chapter 3, Wayne Morrison reproduces and provides a useful discussion of the theories of Max Weber, Karl Marx, Emile Durkheim and Fredrich Nietzsche.

[24] Roy Porter, *A Social History of Madness: Stories of the Insane* (1987) 14.

[25] Ibid.

[26] Foucault uses the term 'Classical Age' to refer to a period in his analysis of the developments in France. Foucauldian theories are rich and controversial but have been purposefully left out of this discussion because they are specific to a given period in French historiography sufficiently different to the English experience to resist their inclusion.

[27] Gary Gutting (ed), *The Cambridge Companion to Foucault* (1994) 58.

[28] Ibid 17; Andrew Scull (ed), *Madhouses, Mad-doctors and Madmen: The Social History of Psychiatry in the Victorian Era* (1981) 110.

of attics or in poorhouses, almshouses and eventually madhouses.[29] The incarceration of the mad was more of an expression of 'civil policy, an initiative of magistrates, philanthropists and families' who viewed it as best for everyone, including the lunatic in need of institutional discipline.[30] Public opinion began to swing towards the idea that institutional or psychiatric forms of relief, rather than external forms, would be more appropriate in providing the necessary safeguards (based on concepts of surveillance and control) for society itself.

The 'Great Incarcerations' in the late eighteenth and early nineteenth centuries were the result of this process. The process represents the touchstone of what Cohen describes as the 'first phase of transformation'.[31] Incarceration of the 'other' was a fundamental rupture with the past. Coercion was now the only 'natural' approach. All forms of 'conquered' people, including the mad, had to be controlled by a single entity, the state. The state adopted the technology of the institutions to do this. The movement witnessed an increased involvement by the state and a shift from a decentralised arbitrary system to a centralised and rationalised system of social control through institutions.

The nineteenth century witnessed the corralling of rural masses driven off the land into manufactories. The idea of work as the road leading simultaneously out of individual poverty and towards a wealthy nation rang true for the rational and normal.[32] Those that did not conform (the idle and the wretched) were warehoused in panoptical institutions.[33] The objective was clear. Those who could not be reformed or converted toward a work ethic were beyond redemption and could provide no benefit or service to society. Such hopelessly idle persons had to be separated from the rest of the community to avoid 'morally morbid contamination'. Inmates were stripped of their legal rights and kept behind massive walls and locked doors, usually for life, mostly to die in filthy prisons or poorhouses.[34]

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[29] Porter, above n 24; also Scull, above n 28, 109.
[30] Ibid.
[31] Cohen, above n 2.
[32] Zygmunt Bauman, *Work, Consumerism and the New Poor* (2005).
[33] See *Panopticon* or the *Inspection House* containing the idea of a new principle of construction available to any sort of establishment aiming to attain one standard of conduct by its inmates (persons of any description) who are to be kept under inspection, in B Bentham, *The Works of Jeremy Bentham* Vol 4 (1843) 40-126.
[34] Bauman, above n 32, 13-14.

C Classification, Science, Control and Change

Early attempts to classify psychiatric disease were made in the eighteenth century.[35] In the 1790s, a handful of radical reformers like physician Philippe Pinel in France and Quaker tea merchant William Tuke in England[36], were haranguers for propositions of 'moral' treatment.[37] The movement vehemently opposed what it saw as enormous harms perpetrated on the mad through barbaric, cruel and violent methods. Instead, it championed treatment based on kindness, reason and tactful manipulation aimed at remodelling the lunatic into the bourgeois ideal of the rational individual.[38]

The new system did not hold the insane to be absolutely deprived of reason,[39] citing several cases that seemingly substantiated claims that insanity could be cured by humane methods.[40] The idea of isolating the 'distracted' into small, pastoral asylums away from bad influences in order to cure them eventually gained support. Through the humane reprogramming of the inmates' minds through mental discipline, rectification and retraining in thinking, asylums were transformed into 'schools' of reform viewed as crucial instruments in the 'regeneration' process.[41]

1 Insanity as a Disease

Early nineteenth century scientific advances brought new expectations that the causes of insanity would be found to be rooted in organic, neurological

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[35] Margotta, above n 21, 178.

[36] Samuel Tuke, *Description of the Retreat* (1813). Tuke founded a retreat in York arguing that 'madhouses' were not medical institutions. He provided humane care for insane Quakers that attracted attention first from English and foreign visitors and then from parliamentarians and others who had taken up the cause of lunacy reform: at 141.

[37] Margotta, above n 21, 178. Pinel proposed that those physicians with 'strong personalities' could treat the insane without loss of dignity by means of moral persuasion rather than by counter productive methods like intimidation and torture.

[38] For a discussion on moral treatment see Scull, above n 28, 105-118; Porter, above n 24, 18, 106, 111.

[39] Scull, above n 28, 110.

[40] Ibid. See also Slovenko, above n 14.

[41] See R. Gardiner Hill, *A Lecture on the Management of Lunatic Asylums* (1839) 4-6; J. Mortimer Granville, *The Care and Cure of the Insane* (1877) 1, 15 cited in Scull, above n 28, 9. See also Porter, *A Social History of* Madness, above n 24, 19.

or biochemical disorders.[42] The practice of categorising and differentiating the insane from other forms of deviancy was now well established. Treatment at this time usually involved drug therapies,[43] or physical and mechanical treatments.[44] The intention was that such treatments would 'pacify the body' and render the person receptive to reason.[45]

It was also a time of the 'rechristianisation' of the now urban working classes, that demanded the reform of the 'character' of every workman to fit the new industrial system[46], and no doubt to dilute any tendencies towards political radicalism.

This approach was compatible with the evolution of industrial capitalism, which in the nineteenth century, had moved from the simple textile plant factory to more complex industries that demanded higher levels of knowledge and skill on the part of the workers. Industrial capitalism brought forth a mystifying, purely economic and 'objective' forcing of nearly all workers to labour for another.[47] Lunatics, like prisoners, came to be viewed as 'defective mechanisms', machines in need of repair that could be 'remoulded' or cured through confinement and the use of 'gentle discipline' in an asylum.[48] The rapid growth of such schemes during the course of the century arose from the rationale that if asylum psychiatry could cure the insane, the state apparatus that represented society's will had a duty to legislate and care for them until they were cured.[49]

Alas, industrialisation and population growth were not always accompanied by a commensurate growth in employment opportunities. The rise in urban unemployment brought pauperism, social dependency

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[42] Porter, above n 24, 18.

[43] For instance, in the form of bloodletting, vomits and laxatives.

[44] Including the use of electric-shock techniques, hot baths and cold showers, and restraining chairs, accompanied by the use of manacles, chains, whips, straitjackets, or manual labour. See William Cullen, *First Lines in the Practice of Physic* (4th ed, 1808) warning that although physical force that included the use of whips and stripes was necessary, stripes although appearing more severe, were much safer than strokes or blows about the head.

[45] Porter, above n 24, 18. Francis Willis, a psychiatrist of the times, was charged with treating the King, see Scull, above n 28, 107, 108.

[46] Sydney Pollard, *The Genesis of Modern Management* (1965) 297.

[47] Maurice Dobb, *Studies in the Development of Capitalism* (1963) 7.

[48] Scull, above n 28, 115; J. Howard, *The State of the Prisons* (1778) 8.

[49] The laws of England, so far as they applied to the circumstances in Australia, applied in the colonies until Australia passed its own legislation such as the *Lunacy Act 1898* (NSW) and the *Lunacy Statute 1867* (Vic).

and dangerous deviancy that led to demands for institutional care and control as a major social concern. The Poor Law of 1834 was introduced to provide external forms of relief by way of the publicly funded assistance to be administered by Vestries—but only for the 'deserving'[50] poor.[51] The state responded to the escalating problem by expanding the capacity of existing facilities and building larger ones. For the mentally ill, beneficial therapeutic practices based on smaller caseloads and intimate staff-patient relationships were eroded. The incessant rise in chronic cases (some of which had migrated to the cities from poorer rural regions after being driven off the land) ensured a precipitous drop in 'cure' rates.[52]

Wealthier families responded to the crisis in quality care by directing their funds towards endowing the construction and expansion of private institutions to care for their 'addled' relatives, who were usually described as 'voluntary' patients.[53] Public funds, on the other hand, were allocated for the establishment of separate state run institutions primarily for involuntary and indigent mentally ill people.[54] The central purpose of state asylums was custodial care and community protection. This came to be defined and regulated by legislation. Treatment was a secondary concern.[55] The emergence of a few psychiatric hospitals linked to universities facilitated the study of mental illness; however, this did not dissuade a general acceptance that the 'mad' were destined to remain in state institutions for life.

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[50] These were individuals who could show they could not support themselves, had nowhere else to turn, and truly were unable to alleviate their own distress. See Robert Goodin, *Protecting the Vulnerable—a Reanalysis of Our Social Responsibilities* (1985) 147.

[51] The undeserving poor included, for instance, the idle, extravagant or profligate, see Bloy, above n 20. See also, David Schmidtz and Robert Goodin, *Social Welfare and Individual Responsibility, For and Against* (1998) 173. Goodin states that traces of the underlying ideology of the Poor Law remains in contemporary policies and laws. This he points out is powerfully reflected in the traditional and deliberate political practice of setting welfare benefits lower than in the workplace in the hope of driving prospective claimants back to work.

[52] Morrissey and Goldman, above n 6, 786.

[53] This was not always the case. Laws were written that allowed relatives (mainly men) to have their inconvenient family members 'committed' with the help of cooperative doctors as was the case of T.S. Eliot's wife who was 'committed' against her will.

[54] Morrissey and Goldman, above n 6, 787.

[55] Ibid.

D The Birth of Psychiatry

Along with the birth of the asylum came a new legally recognised group of expert doctors, the psychiatrists. Their professional identity consolidated in England with the formation of the Association of Medical Officers of Asylums and Hospitals for the Insane in 1841, later becoming the Royal College of Psychiatrists in 1971.[56] The new experts incited new hope of curing the insane through fresh medical theories of insanity which spurred on the injection of new funds.

With the rise in experts came the further classification of the mentally ill. Mental illness once viewed as separate from deviance expanded into new sub-classes such as alcoholics[57], sex maniacs, paralytics or the criminally insane, adding to the burden of public asylums.[58] In time, regimes based on moral treatment collapsed with the growth in the size and population of institutions.[59] A gaping fissure between promise and fulfilment became apparent and, towards the latter decades of the nineteenth century, signs of failure were evident. Control, not care, was the primary function of the asylum. Further, disillusionment about finding a 'cure' for insanity, led to erosion of public support and further cuts on expenditures.

A sprinkling of 'radicals' lobbied for the return of apparently harmless chronic lunatics to their homes in the community. This was met with strong opposition from a variety of different stakeholders. The psychiatrists, for instance, voiced strong opposition to the release of patients deemed to be clearly in need of confinement.[60] Their monopoly on psychiatric services depended on the existence of asylums in which to practice. Opposition also came from a public who feared it was not safe to

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[56] Scholarly Societies Project, *Royal College of Psychiatrists* (2006) <http:www.scholarly-societies.org/history/1841rcp.html> at 8 August 2006.

[57] A push to characterise alcoholism as a 'disease' began to emerge in the United States in the early nineteenth century with a view to providing alcoholics with institutional care in facilities separate from those for criminals and lunatics. Although England, Canada, Australia and New Zealand similarly recognised the need for differentiated institutional care for alcoholics, Carney states that the dearth of historical records in the early part of the century suggests that specialised facilities did not occur until the latter half of the century. See Terry Carney, *Drug Users an the Law in Australia: from Crime Control to Welfare* (1987) 2-3.

[58] Porter, above n 24, 20. For an insightful discussion on the history of civil treatment legislation in England, Scotland, Canada, the United States and Australia, see Carney, above n 57.

[59] Scull, above n 28, 13.

[60] Ibid 16.

have lunatics roaming at large or from poor families struggling with the intolerable burden of caring for 'mad' relatives.[61]

By the end of the nineteenth century, early signs of a fragmenting mental health care system were clearly visible in most capitalist states. In Australia, for instance, public confidence in the care of people in asylums diminished with the release of scandalous reports of inhumane treatment.[62]

Public confidence in psychiatrists as professionals was also seriously impaired by the development of fierce rivalry between neurologists and psychiatrists. In their later work, German psychiatrist, Emil Kraepelin, and Austrian psychoanalyst, Sigmund Freud, exemplified the growing rivalry between disciplines.[63] Rival theories of mental illness, the suitability of asylums as places for treatment of the insane, the respective merits of each discipline's understanding and treatment of mental disorders[64] and for funds from the state and from the private benefactors were all sources of friction. Their ideological rivalries were simultaneously scientific, political and economic and they persist today.

Continued lack of medical certainty about the causes and cures for insanity created major conflict on another front—this time between psychiatry and the law. Scull explains that the focus of debate rested in profoundly controversial matters, such as the evaluation techniques used to certify someone as mentally ill and the issue of culpability in criminal law.[65] Psychiatrists resented the doubt cast on their decisions by lawyers arguing that their privileged knowledge of the brain, nervous tissue and neural blood circulation 'ought to secure for their judgements a unique and unchallengeable truth status'.[66] In much legal discourse, however, a 'common sense approach' is adopted to determine the intention of wrongdoers. This is the central issue, since intentionality forms the legal

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[61] Ibid.

[62] New South Wales, for instance, conducted its first parliamentary inquiry on mental health services in 1877. See Legislative Council, Parliament of New South Wales, *Select Committee on Lunatic Asylum* (1877).

[63] For Kraepelin, the fundamental causes of mental illness lay in the physiology and biochemistry of the human brain, hence psychiatric disorders, as disease entities, could be classified like physical illnesses. Psychiatrists such as Freud, offered 'the talking cure' as another therapeutic innovation which in time, also proved unsuccessful in curing madness. Porter, above n 24, 21. See also *Mental Illness* (2000)
<http://www.iversonsoftware.com/reference/psychology/mental_illness.htm> at 7 December 2000.

[64] Scull, above n 28, 16.

[65] Ibid 24.

[66] Ibid 26.

mens rea basis of voluntary criminal acts. For Scull, the choice between these two approaches was and remains inherently evaluative.[67] Psychiatrists who contested this were 'repeatedly impeached' by their inability to agree on a diagnosis.[68]

Scull describes 'organised psychiatry' as originating in part as an entrepreneurial response to the opportunities offered by the creation of an asylum system rather than as 'the logical institutional expression of an expanding body of knowledge or the crystallization of particular therapeutic techniques'.[69] Further psychiatry's inability to cure mental illness, coupled with growing reports of cruel and inhumane treatment of residents in institutions, whether in spite of or because of the ruling 'theories of madness', served to erode public confidence in psychiatry and asylums.

However, the turn of the twentieth century brought a new wave of humanitarian reform energy devoted to the search for 'alternatives' to the failed practices of the past. Ideas of 'administrative flexibility, discretion and greater choice of dispositions', coupled with the ideal of 'individual treatment, the case by case method and the entry of psychiatric doctrines' formed the basis for a whole series of innovations in the criminal justice system and the mental health care system.[70] Yet, like their predecessors, these reform enterprises also failed to produce the results that their designers had hoped.[71] Again, the suffering and exclusion of people with serious mental illness persisted.

E Twentieth Century Treatment

Psychoanalysis brought about a paradigm shift in early twentieth century psychiatry. This was followed by the neurological-pharmacological revolution.[72] The result of cross-pollination in new scientific methods of research, and new discoveries in different developing fields like biochemistry and pharmacology led to the development of new forms of biological treatments. Three such treatments that date from the 1930s include insulin coma therapy, electroconvulsive therapy and lobotomy.

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[67] Ibid.
[68] Ibid.
[69] Ibid 17.
[70] Cohen, above n 2, 20.
[71] Ibid.
[72] In his critique of the historiography of psychiatry, Gelman points out that rather than complement psychoanalysis, some portray medications as a force 'that undermined psychoanalysis'. See Gelman, above n 14, 551.

These major therapies presented alternatives to psychoanalysis and the 'warehousing' of patients.[73]

Yet, each reform, in turn, was found to harbour serious risks for patients and each, in turn, came to be criticised in terms of efficacy.[74] For example, insulin coma therapy in the United States had a death rate of about one per hundred; drug induced convulsions produced horrible side effects depending on the convulsive drug used on terrified patients; frontal lobotomy caused enormous harm in the form of irreversible brain damage.[75] Frontal lobotomy was the only 'treatment' of the three that came to be described as ethically 'indefensible'. Decline in public confidence in the procedure eventually lead to its abandonment by the early 1950s.[76] Electro-convulsive treatment continues especially for severe depression.

After the Second World War, new forms of biological treatments emerged. This time, change was in the form of the dismantling of the asylums and the apparently more humane 'chemical incarceration' of the mentally ill in the community.

III THE DAWN OF A NEW EPOCH? DEINSTITUTIONALISATION AND COMMUNITY CARE

The end of the Second World War marked a crucial period of fundamental change that would come to initiate Morrissey and Goldman's 'third cycle' of mental health care reform—community based mental health care. The community based mental health movement was sparked by enthusiasm that flowed from optimistic psychiatrists returning from military service whose interest in preventing mental illness was stimulated by the level of success produced by brief hospitalisation techniques used in the United States to treat 'war neurosis'.[77]

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[73] Ibid.

[74] Ibid.

[75] Edward Shorter, *A History of Psychiatry From the Era of The Asylum to the Age of Prozac* (1997) 212-216 in Gelman, above n 14, 552.

[76] Ibid 557-559. The kind of supposed successes portrayed by optimistic psychiatrists were unsubstantiated and 'outlandish'. See also, Sheldon Gelman, *Medicating Schizophrenia* (1999) 23-27.

[77] Morrissey and Goldman, above n 6, 788.

A The Human Rights Revolution

The post World War period was also a paradigm shifting period in terms of international political, economic and social activity. Rich Western societies spoke of a renewed commitment to the promotion of democracy. A human rights revolution was sparked by the recognition of the Holocaust and the need for an ambiguous bundle of human rights through the drafting of the United Nations Charter.[78] The United Nations *Universal Declaration of Human Rights*[79] proclaimed 'the will of the people shall be the basis of the authority of government' and each individual human being was endowed with these rights regardless of age, gender, class, race, ethnicity or sexuality. In 1966, a second instrument, the *International Covenant on Civil and Political Rights* (ICCPR)[80] promoted the protection of participatory rights and freedoms of every individual.[81] These newly packaged bundles of rights were labelled 'universal' and 'international' but not every nation endorsed them.

The post World War II human rights revolution included recognition of participatory rights of specific vulnerable groups, including people with physical and psychiatric disabilities in many advanced-capitalist societies. These eventually received national endorsement.[82] In Australia, for

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[78] Human Rights and Equal Opportunity Commission (HREOC), *Human Rights & Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (1993) 20.

[79] GA Res 217A, 3rd sess, 183rd plen mtg, UN Doc A/810 at 71 (1948). This Declaration, adopted by the General Assembly on 10 December 1948, was a reformation of declarations made in the late eighteenth century in France and the United States.

[80] *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, GA Res 2200A (XXI), 999 UNTS 171, UN Doc A/6316 (1966) (entered into force 23 March 1976, entered into force for Australia 13 November 1980, except Article 41 which entered into force on 28 January 1993).This Covenant was adopted by the General Assembly on 16 December 1966.

[81] Office of the United Nations High Commission for Human Rights, *Democracy* (1996-2004) <http://www.ohchr.org/English/issues/democracy/index.htm> at 6 October 2006 (quoting the Universal Declaration of Human Rights, 'The will of the people shall be the basis of the authority of Government').

[82] In particular, see *The Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 119, UN GAOR, 46th session, 75th plenary meeting, UN Doc A/Res/46/119 (1991). See also Lawrence Gostin, 'Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights' (2000) 23 *International Journal of Law and Psychiatry* 125-159; *Convention on the Rights of the Child*, opened for signature 7 March 1966, 4 ATS 1991, art 24(1) (entered into force 2 September 1990, entered into force

instance, the *Principles for the Protection of Persons with Mental Illness*[83] was enshrined in the National Mental Health Strategy of 1992. The Strategy, designed to overhaul the mental health system in Australia, put forward an ambitious five-year agenda that broadly consisted of three aims: i) to promote the mental health of the community and where possible, prevent the development of mental health problems and mental disorders; ii) reduce the impact of mental disorders on individuals, families and the community; and notably iii) assure the rights of people with mental illness. The *Principles* have since been articulated in several major national documents.[84]

The human rights revolution was responsible for creating the platform necessary for social reformers and health and welfare advocates to argue for the right of return for long-term residents of large psychiatric institutions to their lives in the community. The human rights phenomenon was only one of four changes largely attributed to the shift. The other three contributory changes include the redefining of health to include social and mental components, psychopharmacological advancements and the discovery of new psychotropic drugs, and the development of innovative forms of psychosocial interventions.[85]

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for Australia 16 January 1991); *International Convention on Elimination of All Forms of Racial Discrimination*, opened for signature 7 March 1966, UNTS 195, art. 5(e)(iv) (entered into force for Australia 30 October 1975 except Article 14 which entered into force for Australia 28 January 1993); *Convention on the Elimination of All Forms of Discrimination Against Women*, opened for signature 18 December 1979, 9 ATS 1983, art. 11(1)(f), 12 (entered into force 3 September 1981, entered into force for Australia 27 August 1983) (CEDAW).

[83] *The Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 119, UN GAOR, 46th sess, 75th plen mtg, UN Doc A/Res/46/119 (1991).

[84] These include the Australian Health Ministers *Mental Health Statement of Rights and Responsibilities Report of the Mental Health Consumer Outcomes Taskforce* (1991); the *National Mental Health Policy* (1992); the *National Mental Health Plans* (1992), (1998), (2004); and the Medicare Agreements (1993-1998).

[85] World Health Organisation, *World Health Report 2001 Mental Health: New Understanding New Hope* (2001) <http://www.who.int/whr/2001> at 24 August 2002.

B *The Expansion of the Scope of Health to Include the Right to Mental Health*

By stating in 1947 that, 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being', the World Health Organization was responsible for expanding the scope of health.[86] Setting aside questions of the enforceability of this new right to health,[87] the stage was set for the emergence of a utopian vision of a 'right to health'. Most notably, the *Universal Declaration* bestowed on 'everyone' the right to a standard of living adequate for his or her health and well being.[88]

The advancement of human wellbeing, however, is a formidable task. This is especially so when the area of public health struggles to develop and articulate a conceptual framework, or as the late Jonathan Mann wrote, 'a vocabulary with which to speak about and identify commonalties among health problems experienced by very different populations'.[89] The term 'mental health' remains particularly ambiguous, being virtually impossible to measure. Nonetheless, it has come to be understood as more than just the absence of mental disorder.[90] Australian policy makers adopted Canada's definition of 'mental health' because it 'appropriately identifies mental health as a multi-dimensional, dynamic and interactive phenomenon'.[91] Mental health is:

> the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimum development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality.[92]

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[86] World Health Organisation, 'Constitution' in *Basic Documents* (36th ed, 1946).

[87] See Jonathan Mann et al, 'Health and Human Rights' (1994) 1 *Health and Human Rights* 7; Sylvia Bell, 'Rationing the Right to Health' (1998) 6 *Journal of Law and Medicine* 83; Ian Freckelton and Bebe Loff, 'Health Law and Human Rights' in David Kinley (ed) *Human Rights in Australian Law* (1998) 290.

[88] Article 25(1).

[89] Jonathan Mann, 'Medicine and Public Health, Ethics and Human Rights' *Hastings Center Report* (1997) (May-June) 8.

[90] Basil Hetzel, *Health and Australian Society* (1974) 16-18; Gordon Edlin and Eric Golanty, *Health and Wellness: A Holistic Approach* (1988) 4; L J Donaldson and R J Donaldson, *Essential Public Health* (1993) 320.

[91] Commonwealth Department of Human Services and Health, *Mental Health in Australia: A Review of Current Activities and Future Directions* (1994) xii.

[92] Ibid 3 (citing the Canadian Department of National Health and Welfare (1988)).

Despite ambiguities about the meaning of mental health or its assessment, psychiatric institutions were criticised as the wrong vehicle for providing health and community services.[93] An appreciation of the history of institutional care that emphasised control, confinement and exclusion from mainstream community life through a regime of surveillance, silence and brutality provides a useful context for understanding the strength of the criticism against it. 'Large', 'overcrowded' and 'inhumane' are the stock attributes synonymous with nineteenth and twentieth century state asylums and with large psychiatric hospitals in general. Influential critics such as Goffman[94], human rights advocacy groups, lobby groups, families and friends were instrumental in achieving the ensuing shift to community care for particular client groups like those with physical or mental disabilities.

C *Deinstitutionalisation Movement*

As it had been for the creation of asylums, expert opinion was an important factor in the mid-twentieth century in influencing the deinstitutionalisation movement. Advocates of the initiative optimistically embraced the experts' reform rhetoric. Economists, for instance, calculated the costs of institutional care and compared them with the lower anticipated community mental health care costs. These calculations provided credible support of official rhetoric that assured the public that funds formerly allocated to institutions would not only be redirected towards the community mental health project, but would be more cost-effective. What was not stressed was that much of the burden would be shouldered by families. Alternatively, the burden would fall on the shoulders of those least able to bear it—the mentally ill themselves, resulting in their suffering and exclusion.

Scientists and large private pharmaceutical companies further supported the movement. New psychotropic drugs were created reassuring the public on safety. The new drugs were promoted as fundamental to managing the symptoms of some mental illnesses, allowing many of the formerly institutionalised to 'safely' return to their lives in the community. Of course the most severe and acute cases were to remain under the close surveillance of the state mental health services. Changes in mental health legislation allowed for supervised and community care orders to develop

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[93] David Mechanic and Linda Aiken, 'Improving the care of patients with chronic mental illness' (1987) 317 *New England Journal of Medicine* 1634-1638.

[94] Erving Goffman, *Asylums: essays on the social situation of mental patients and other inmates* (first published 1961, Penguin Books 1991) 17.

as the new tools to facilitate the process.[95] The level of supervision and control over a person's freedom to pursue his or her aspirations in the community was to be determined by officials able to accurately weigh the risk of 'harm' to both the individual and to the public.

Particularly in light of the expanding list of disclosed scandals and publicly reported failures under the state institutional model in Australia[96], as with all other welfare states, the lure of the community mental health proposals proved irresistible for most political decision makers. Growing pressure for economic savings fuelled by neo-liberal[97] reform policies for downsizing the public services sector emerging in most advanced capitalist states sealed the shift.

D *The Market State Revolution and the Community Care Project*

The latter decades of the twentieth century are marked by the transformation of the state. It is a period when the state changed its form from the 'safety state' (also known as the post war Keynesian Welfare State) to the 'market/contract state'. The safety state was based on promises of security in the form of welfare provided by state institutions, science and technology. The state's transformation into the market state brought new economic rationalist reform policies.

The market or contract state is characterised by the ever-growing use of the 'language and practice of contract' in the organisation of social and

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[95] For instance, in each jurisdiction in Australia, legislation provides for the compulsory treatment of people with mental illness while living in the community. See *Mental Health (Treatment and Care) Act 1994* (ACT) s 29; *Mental Health and Related Services Act 2002* (NT) s 45; *Mental Health Act 1990* (NSW) s 131; *Mental Health Act 2000* (Qld) s 109; *Mental Health Act 1996* (Tas) s 40; *Mental Health Act 1993* (SA) s 17; *Mental Health Act 1986* (Vic) s 14; *Mental Health Act* 1996 (WA) s 67.

[96] For instance, in Australia the highly controversial and publicised inquiries and subsequent closures of the Chelmsford Hospital in Sydney and Ward 10B in Townsville. See New South Wales, Royal Commission Into Deep Sleep Therapy, *Report* (1990); Queensland, Commission of Inquiry into the Care and Treatment of Patients in the Psychiatric Unit of the Townsville General Hospital Between 2nd March 1975 and 20th February 1988, *Report* (1991).

[97] For a meaning of 'neo-liberal' see, eg, Nikolas Rose, 'Governing "Advanced" Liberal Democracies' in Andrew Barry, Thomas Osborne and Nikolas Rose (eds) *Foucault and Political Reason: Liberalism, Neo-Liberalism and Rationalities of Government* (1996) 37-65.

political life.[98] It is a period of transformation and change in which the individual citizen of the 'welfare state' has come to be transformed into the individual citizen-client, citizen-producer or citizen-consumer in the 'contract (ing out) state'[99], or 'brokerage state'[100] of late modernity. For Havemann, this period exemplifies 'the movement from simple modernization to reflexive modernization'.[101]

The process of decommissioning large institutions is now a *fact* in most market societies. Common to the process has been a series of programmatic shifts that led to a change in the locus of care for people with mental illness from institutions to the community.[102] One such shift is the mainstreaming' or centralisation of mental health services.[103] The ideological sources of mainstreaming are diverse.[104] For the purposes of this discussion, mainstreaming is the policy concept that co-locates mental health services with general health services (leaving some specialised mental health services to ensure the continuity of clinical management of the most severe cases).[105]

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[98] Whereas previously, the use of contract was more confined to areas of commercial law and liberal political theory, different versions of the concept are now applied to the management of a wide range of social problems. B Sullivan, 'Mapping Contract' in G Davis, B Sullivan and A Yeatman (eds) *The New Contractualism?* (1997) 1-13.

[99] P Havemann, 'Social Citizenship, Re-commodification and the Contract State' in E Christodoulidis (ed) *Communitarianism and Citizenship* (1998) 134.

[100] Terry Carney and Gaby Ramia, 'Contractualism and Citizenship: Rivals or Bedfellows?' (2001) 18(2) *Law in Context* 8, 15-16.

[101] Havemann provides a comprehensive list of the diverse 'emancipatory "goods" and 'apocalyptic "bads", drawn in part from the literature, that characterise the contradictory and complimentary dimensions of 'reflexive modernisation'. See Havemann, above n 99, 135.

[102] For an insightful account of the US experience see Leona Bachrach, 'What We Know About Homelessness Among Mentally Ill Persons: An Analytical Review and Commentary' (1992) 43 *Hospital and Community Psychiatry* 453.

[103] Service integration became a major focus of the *First National Mental Health Plan* in Australia and by June 2000, all States and Territories had transferred the management of public mental health services to the mainstream health system.

[104] To make full sense of the neo-liberal movement, it is necessary to understand how tendencies from the anarchist 'Leftists' of the 1960s such as the anti-psychiatry movement impelled by Ken Kesey and RD Laing for instance, came a distrust of all large institutions; and from the libertarians on the Right, came a distrust of all governmental bureaucracy and a desire to shrink government sector in all areas re-enforced one another. But properly speaking, only the latter can be called 'neo-liberal'.

[105] NSW Parliamentary Library Research Service, 'The Burdekin Report – Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness', Briefing Paper No 004 (1993) 11 cited in

One of the tangible ill-effects of deinstitutionalisation of mental health services has been a reduction in beds in psychiatric institutions. In Australia, for example, it is estimated that between 1992 (when the National Mental Health Strategy was accepted by all Australian Ministers) and June 2000, the number of beds in stand-alone psychiatric institutions fell by 3,097 or 53%.[106] Over the life of the Strategy, it has been estimated that resources released through institutional downsizing were transferred to fund 44% of the total growth in community based and general hospital services.[107] This involved a 68% increase in the number of beds in 24-hour staffed community residential units designed to replace psychiatric institutions. But, as in most other jurisdictions that engaged in this reform strategy, mainstreaming soon produced a crisis in the availability of beds.

E Concerns about Availability of Care

Presently, the lack of available beds for people in acute crisis situations is a lethal problem of growing concern to professionals and community organisations.[108] The rise of 'double-diagnosis' patients, due to the increasing availability of 'street' drugs, has exacerbated the acute care needs. The old 'warehousing' role of mental hospitals was cruel, wasteful and served no social purpose. But the lack of 'acute' beds is a different issue. People with serious mental illness, now living in the community, experience a crisis of extreme human suffering. Such crisis of suffering is not from the physical and mental trauma of being incarcerated but from their exclusion from appropriate housing and support services, including access to hospitalisation during acute phases of illness.[109] This represents the outcome of the latest failed 'lunacy reform enterprise' I have discussed.

New South Wales, Legislative Council Select Committee on Mental Health, *Inquiry Into Mental Health Services in New South Wales Final Report* (December 2002) 38.

[106] Commonwealth Department of Health and Aged Care, *The National Mental Health Report 2002 Mental Health and Special Programs Branch* 3.

[107] Ibid 4.

[108] Submission by the National Association of Practicing Psychiatrists to NSW Legislative Council Select Committee on Mental Health, above n 105, 41-43; Commonwealth Department of Health and Aged Care, above n 106, 4.

[109] See the latest national report by the Mental Health Council of Australia, *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia* (2005) Mental Health Council of Australia.

Potentially, mainstreaming can create an inequity of access problem. For instance, to receive mental health treatment and care, people may prefer to present themselves at the emergency department of a public hospital rather than undergo the stigmatisation of having to go to a psychiatric institution. But the lack of mental health units within some public hospitals translates into inequitable distribution. Health planners often fail to accurately assess the demand for hospital beds. When they use 'theoretical' or 'average' provisions formulae, such assessments tend to inadequately reflect needs in areas where the 'occupancy and demand for long stay and rehabilitation beds are above average', or where there is 'no hospital accommodation available on a state-wide basis'.[110] In such situations, mainstreaming does not produce an equitable distribution and subverts a key ideal of the community treatment approach.

F Criticisms of the Community Care Enterprise

As with earlier reform initiatives, deinstitutionalisation has drawn criticism. Much of the criticism targets the diversity in standards of organisation and planning for the after care of patients with serious mental illness discharged into the community. The low quality support for these people after discharge, the inappropriate housing and the lack of adequate long-term community residential facilities are core concerns.[111] Upon closer scrutiny, deinstitutionalisation and mainstreaming strategies have failed to address the problems and hardship experienced by people with chronic serious mental illnesses.

G Mental Health Care and Control in the Community

Some critics ardently contend that community based mental health care has exacerbated the plight of chronic patients leaving them worse off than institutionalisation.[112] In most modern market societies, de/non-

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[110] NSW Legislative Council Select Committee on Mental Health, above n 105, 43-44.

[111] H Richard Lamb, 'Lessons Learned from deinstitutionalisation in the US' (1993) 162 *British Journal of Psychiatry* 587; Carl Cohen and Kenneth Thompson, 'Homeless mentally ill or mentally ill homeless?' (1992) 149 *American Journal of Psychiatry* 816; D Double and T Wong, 'What's Happened to Patients from Long-Stay Psychiatric Wards?' (1991) 15 *Psychiatric Bulletin* 735.

[112] Morrissey and Goldman, above n 6, 789; John Zadolinny and Karen Zadolinny, 'Deinstitutionalisation of Mental Health Services' (1991) 1(4) *Australian Journal of Mental Health Nursing* 1; Ellen Bassuk and J Gerson, 'Deinstitutionalization and mental health services (1978) 238(2) *Scientific American* 46; E Gruendberg and J Archer, 'Abandonment of responsibility for

institutionalisation has been associated with the rise of homelessness, social exclusion, extreme human suffering and traumas experienced by people with mental illness, all of which escalate in seriousness for those whose illness is more severe.[113] Yet, opinions in the literature differ on the extent to which homelessness and substance abuse are really products of the deinstitutionalisation process itself.

For some, that process is responsible, at least in part, for people with mental health problems being forced to live in unsatisfactory circumstances.[114] Others blame the individuals themselves for somehow 'causing' their own mental illness and hence their homelessness, particularly where the person is doubly stigmatised because of an accompanying substance abuse disorder.[115] The National Coalition for the Homeless blames the rise in homelessness since the mid 1980's largely on two trends: the growing shortage of affordable rental housing and a

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the seriously mentally ill' (1979) 57 *Milbank Memorial Fund Quarterly* 485; Peter Braun et al, 'Overview: Deinstitutionalization of Psychiatric Patients, a critical review of outcome studies' (1981) 138 *American Journal of Psychiatry* 736.

[113] Virginia Hiday et al, 'Victimization: A link between mental illness and violence?' (2001) 24 *International Journal of Law and Psychiatry* 559; L Frency, 'Victimisation of the Mentally Ill: An Unintended Consequence of Deinstitutionalisation' (1987) 32 *Journal of Social Work* 502; H Richard Lamb, 'Will we save the homeless mentally ill?' (1990) 147 *American Journal of Psychiatry* 649; D Dennis et al, 'A Decade of research and services for homeless mentally ill persons: where do we stand?' (1991) 46 *American Psychologist* 1129; Ronald Kessler et al, 'The epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilisation' (1996) 66 *American Journal of Orthopsychiatry* 17; Nancy Wolff, "New public" management of mentally disordered offenders: Part I. A cautionary tale' (2002) 25 *International Journal of Law and Psychiatry* 15. In a recent Australian study of the cost of psychosis, 18% of the participants reported having been a victim of violence and 10% having been arrested during the 12 months prior to interview. See Commonwealth Department of Health and Ageing, *The National Survey of Mental Health and Wellbeing, Bulletin 2 Cost of Psychosis in Urban Australia 2002 Low Prevalence (Psychotic) Disorders Study* 21; Neil Buhrich and Maree Teeson 'Homelessness in Australia' (1990) 41 *Hospital and Community Psychiatry* 331.

[114] See the Centre for Addiction and Mental Health, *Housing Discussion Paper* (Spring 2002) 2 <http:// www.camh.net/best_advice/housing_paper_camh2002.html> at 12 September 2002.

[115] Wesley Mission, Strategic Planning & Development Unit Report, *The Faces of Homelessness* (2001) 6.

simultaneous increase in 'new' poverty[116]—both issues squarely within the federal government's portfolios.

The sheer breadth of the problem of homelessness in societies that have embraced the de/non-institutionalisation movement suggests that political leaders failed to anticipate, or at least to accurately appreciate, the extent of the shortage of appropriate low-cost housing in the community prior to implementing the process.

However, in some jurisdictions, like England, where the movement toward community-based care and services[117] has for over half a century been characterised by continuous incremental development rather than by a 'single stage introduction of a wide ranging policy of reform',[118] homelessness for people with mental illness has not been specifically associated with the closure of psychiatric hospitals.[119] This may be explained by the slower than originally envisaged closure of large asylums in the United Kingdom despite government policy to do so since the 1960s. The United Kingdom also has a stronger tradition of socialised medicine than either the United States or Australia. Problems of crime and vagrancy among former long-stay in-patients placed in the community have also been fewer than in the United States and elsewhere.[120]

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[116] 'New' poverty refers to the postmodern disarray and despair associated with poverty and social insecurity at the end of the 20th century. Despite a century of rhetoric about improving the lives of low socio economic families, the rise in unemployment as a result of the transformation of the labour market and growth in social security policies has done little to address the risk of being poor. See for instance, David Cheal, *New Poverty: Families in Postmodern Society* (1999); National Coalition for the Homeless, 'Why are People Homeless?' Fact Sheet 1 (June 1999) 1 at <http://www.nationalhomeless.org/mental.html> at 9 November 2002.

[117] Organised community care being provided in particular regions where there has been extensive evaluation of the process (by the Team for the Assessment of Psychiatric Services TAPS, for example). See Julian Leff, 'Evaluating the transfer of care from psychiatric hospitals to district-based services' (1993) 162 (Suppl 19) *British Journal of Psychiatry* 6; Catherine O'Driscoll and Julian Leff, 'The TAPS Project 8 design of the research study on the long-stay patients' (1993) 162 (Suppl 19) *British Journal of Psychiatry* 18.

[118] Sonia Johnson, M Zinkler and Stephan Priebe 'Mental Health Service Provision in England' (2001) 104(Suppl 410) *Acta Psychiatrica Scandinavica* 47.

[119] Double and Wong, above n 111; Noam Trieman, Julian Leff and Gyles Glover, 'Outcomes of long stay psychiatric patients resettled in the community: prospective cohort study' (1999) 319 *British Medical Journal* 13.

[120] Johnson, Zinkler and Priebe, above n 118.

Critics of England's community mental health care system tend to be concerned with the excessive diversity of patterns of service delivery and support made available to severe chronic mentally ill patients in various localities. Mental health services providers have also been criticised for failing to seize the opportunity presented at the point of discharge from hospital or prison to intervene and ensure the person remains connected to services and does not become homeless.[121] As in Australia, strategies and policies linking former patients of particular institutions to community mental health services, public housing services, and the social welfare service system have not been established and implemented equally in all localities, or within similar time frames or to the same extent. Yet in fairness to the institutions involved, the ever-shrinking resources for assisting an ever-expanding clientele to successfully make the transition to community life, is the explanation. Financial cutbacks under neo-liberal economic reform policies have seriously impaired the availability of community services and trained discharge planners. Shrinking resources remain an obstacle to achieving improvements in the performance of these duties. Reducing the large regional variations in the availability of services has driven the United Kingdom government's implementation of its *National Service Framework for Mental Health*[122] and *National Health Service Plan*[123].

In the absence of integrated management, what remains is a mosaic of fractured public and private services that cannot meaningfully cater to the needs of today's homeless chronic mentally ill populations and their transient lifestyles. This is now obvious to policy makers and social commentators alike. As Rosen and Teeson point out, despite the diverse health service structures in countries like the USA, the UK and Australia, problems of under-funding leading to the neglect of individuals with chronic mental illness and co-morbidities, and of homelessness persist.[124] These problems are closely linked to a lack of unified or integrated system of de-institutionalisation. The need for appropriate discharge planning, for community services, for adequate funding, for appropriate accommodation, for access to social and support services, for continuity of care and evaluative research has all since been stressed in the literature and

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[121] Luke Birmingham, 'Between Prison and the Community, The "revolving door psychiatric patient" of the nineties' (1999) 174 *British Journal of Psychiatry* 378.

[122] Department of Health, *National Service Framework for Mental Health – modern standards and service models* (1999) London.

[123] Department of Health, *The National Health Service Plan* (2000) London.

[124] Alan Rosen and Maree Teeson, 'Does case management work? The evidence and the abuse of evidence-based medicine' (2001) 35 *Australian and New Zealand Journal of Psychiatry* 731, 732.

official reports as crucial for the success of community care programs.[125] Indeed, Brian Pezzuti, Chair of the most recent New South Wales Parliamentary Inquiry into mental health services, describes the lack of adequate community services following the deinstitutionalisation process as responsible for the emergence of yet another form of institutionalisation: 'homelessness and imprisonment'.[126]

More recently, the 'new generation' of chronically mentally ill persons, adolescents and young adults, may well pose the greatest challenge to the deinstitutionalisation project. They present the most difficult clinical problems in community treatment because they lack insight into their illnesses and consequently deny their need for mental health treatment including psychotropic medication.[127] Of great concern is the presence of accompanying primary substance-abuse disorders and the practice of self-medication with 'street' drugs. There is growing evidence that chronic adolescent patients have 'swelled the ranks of the homeless mentally ill and the mentally ill in goal'.[128] Prisons, immigration detention centres and the streets are all present-day sites of exclusion for people with serious mental illness.[129]

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[125] Catherine Robinson, 'Understanding iterative homelessness: the case of people with mental disorders' (July 2003) for the Australian Housing and Urban Research Institute; Buhrich and Teeson, above n 113; G Andrews et al., 'Follow-up of community placement of the chronic mentally ill in New South Wales' (1990) 41 *Hospital and Community Psychiatry* 184; John Talbot, 'Deinstistutionalisation: Avoiding the Disasters of the Past' (1979) 30 *Hospital and Community Psychiatry* 621; Mental Health Council of Australia, above n 109; Commonwealth Department of Health and Aged Care, above n 106; Social Exclusion Unit, 'Mental Health and Social Exclusion' Consultations Document (May 2003) Office of the Deputy Prime Minister.

[126] NSW Legislative Council Select Committee on Mental Health, above n 105, xv.

[127] Lamb, above n 111, 588; Beverley Raphael, *Promoting the Mental Health and Wellbeing of Children and Young People*, Discussion Paper, National Community Mental Health Working Group and National Community Child Health Council (2000) 22-23.

[128] C Widom, 'Childhood victimization: early adversity and subsequent psychopathology' in Bruce Dohrenwend (ed) *Adversity, Stress and Psychopathology* (1998) 81; Lamb, above n 111, 588. Misuse of drugs is also considered as the most potent cause of criminal activity among young mentally ill patients in the UK. See Trieman, Leff and Glover, above n 119. In Australia see for instance, NSW Legislative Council Select Committee on Mental Health, above n 105, Chapter 13; Raphael, above n 127, 22-23.

[129] Lynda Crowley-Cyr, 'Contractualism, Exclusion and 'Madness' in Australia's Outsourced Wastelands (2005) *Macquarie Law Review* (in print).

The homeless disabled with serious mental illness represent paradigm subjects whose continued suffering, through their exclusion, exemplifies the limits of modernisation. The modern social world in which these people live has not altered in such a way as to significantly improve their quality of life by alleviating their suffering, despite the promises of modernising interventions like de/non-institutionalisation.

H Serious Mental Illness and Social Exclusion

The process of 'othering'[130] is one way of explaining why some members of the population experience more extensive and intensive forms of exclusion than others. Othering is a process that defines 'who is in'/ who is 'out', the 'civilized'/ the 'uncivilized' and the 'normal'/ the 'abnormal'. In a sense, the process is associated with intolerance and the atomizing of society. It is also part of the social exclusion imbroglio that further characterizes epochal changes associated with waste making modernisation.

The fracturing and transformation of economic and social structures over the latter part of the twentieth century onwards has increased the sense of insecurity felt by people about their place in society. According to some sociologists, like Erving Goffman, some deal with this insecurity by stigmatising others perceived as weaker and less able to defend themselves.[131] People with mental illness have long been the targets of stigma and somehow trigger fear and resentment in others. In the process, the mentally ill are 'dehumanised' and treated as 'other' than those who have a right to respect.

Othering is thus a process that can lead to a loss of 'mutual identification' in society',[132] allowing some sections of the population to be persecuted, discriminated against, oppressed or even killed, while the central features

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[130] 'Otherness' is a term that originated in the writings of Hegel (1770-1831). Howard Becker developed his theory of labelling in the 1963 book *Outsiders: Studies in the Sociology of Deviance.* Many have presented their own approach to labelling theory such as Edwin Schur, *Labelling Deviant Behaviour* (1971).

[131] Erving Goffman, *Stigma. Notes on the Management of Spoiled Identity* (1963).

[132] Robert Van Krieken, 'The Barbarism of Civilization: cultural genocide and the 'stolen generations' or Elias in the Antipodes' (Paper presented at the Norbert Elias Centenary Conference 'Organized Violence: The Formation and Breakdown of Monopolies of Force - Conditions and Consequences', Amsterdam,18-20 December 1997). Van Krieken comments on the work of Norbert Elias in his discussion of history of colonialism and 'cultural' genocide in Australia.

of 'civilization' appear to remain intact.[133] History tends to suggest that this has been the case for homeless people and for those we know as mentally ill—at least since the division between reason and madness, back beyond the mid-seventeenth century.[134] And yet, despite the acquisition of new knowledge and truths during the 'Enlightenment' and the 'Golden Age' of science and 'quantum leaps' in science and technology during the nineteenth and twentieth centuries, the horrors that have been perpetrated on these people their suffering and exclusion to continue to be documented.

Over the span of a few centuries this group of vulnerable individuals came to be revered as divine beings, perceived as harmless jesters or fools, or else feared as instruments of evil. The traumas that they have had to face include starvation, brutalisation and torture, and eventually exclusion and confinement, through the theft of their freedom and dignity by various means and to different extents. Today, issues of stigmatisation, victimisation, labelling and exclusion are more common focus of concern.[135]

'Asylum' in the Asylums: Reconceptualising Asylums as 'Safe' Places

Despite their shortcomings, having no psychiatric hospitals would be a far worse alternative to living with the admittedly unsettling, and at times horrific, conditions found in them. Asylums have and continue to provide minimum levels of care without which, many individuals could not survive present-day modernity. Secure shelter during periods of acute phases of mental illness is a life saving necessity that must be considered when discussing community based mental health care for poor people with severe mental illness. Much support can be found in the literature for providing *asylum,* a place of refuge for people vulnerable because of their mental illness. In this sense, hospitals, large or small, if sufficiently resourced, can offer nourishing food, dress and shelter from the vagaries of climate.[136] Studies conducted in the late 1980s and early 1990s found that

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[133] Ibid.

[134] Alan Sheridan, *Michel Foucault The Will To Truth* (1980) 16.

[135] See for instance, the work of the Social Exclusion Unit, above n 125 and in Australia, of the Australian Housing and Urban Research Institute at http://www.ahuri.edu.au.

[136] Robert E Drake, Michael Wallach and J Schuyler Hoffman, 'Housing Instability and Homelessness Among Aftercare Patients of an Urban State Hospital' (1989) 40 *Hospital and Community Psychiatry* 46, 50; Isaac Marks, 'Innovations in Mental Health Care Delivery' (1992) 160 *British Journal of Psychiatry* 589.

some chronically mentally ill people absolutely require highly supportive living arrangements rather than improvised and temporary shelters because 'there is a bed-rock of illness which will always need in-patient care however comprehensive the community resources'.[137]

The value of hospital care for some people with severe mental illness is based on the fact that a hospital is seen as 'a living alternative that provides basic amenities rather than as a treatment facility'.[138] All of their diverse service needs can be met under one roof rather than from different sites in the community.[139] This perspective is supported by many contemporary mental health reform policy documents and inquiries into mental health services.[140] The call is for an increase in psychiatric beds as a place of asylum not just crisis treatment.

IV CONCLUSION

Both interventions, the institutionalisation and subsequent deinstitutionalisation of people with mental illness, constitute responses to the social problem of where to warehouse the state's mentally ill citizens. Learning from the past includes acknowledging that values such as humanitarianism, welfarism and egalitarianism (theories of the old welfare state) have failed to protect the interests and rights of vulnerable, dependent and marginalised individuals. Such techniques failed because they were incremental in their design, ad hoc in their approach and misfocused in their object.[141] There is also no denying that for many, community mental health care works well. But for those others who are located at the margins of society, it is questionable whether in the transition from *welfare state* to *market state,* their life choices and life chances have improved. Promises that the de/non-institutionalisation reforms would improve opportunities and life choices for everyone are unfulfilled. Inexorably, vulnerable mentally ill citizens have suffered marginalisation and distress through seemingly benign, cost cutting measures.

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[137] Drake, Wallach and Shuyler Hoffman, above n 136; RE Lawrence, JB Copas and PW Cooper, 'Community Care: Does it Reduce the Need for Psychiatric Beds? A Comparison of Two Different Styles of Service in Three Hospitals' (1991) 159 *British Journal of Psychiatry* 334.

[138] Ibid.

[139] Marks, 136, 592.

[140] NSW Legislative Council Select Committee on Mental Health, above n 105, Chapter 4; Mayor's Homelessness Action Task Force, *Taking Responsibility for Homelessness: An Action Plan for Toronto* (1999) 115.

[141] Wolff, above n 113, 25.

The community care model of the market-state has led to negative consequences through the structured disempowerment of such people by placing them in a sometimes worse position than under the previous, highly criticised, 'social democratic' welfare state model. It is through deinstitutionalisation that the dialectical process exposed by the contradictions and tensions between the two conflicting forces of social control and social protection has culminated into a state of total exclusion of such people from health care, housing, employment and social life.

In part, the failures of the past have been based on insufficient and inadequate understanding of the complex, multi-dimensional processes that trigger social exclusion. Such processes are influenced by an obsession with reducing funding levels associated with neo-liberal market fundamentalism.

The deficiencies in present day mental health reform enterprises and practices must be overcome. History's warning is that a different approach must be sought in these uncertain times. This encompasses change in the way we perceive others. To do otherwise, risks twenty-first century mental health reforms also being labelled as failures by future historians.