Archives of Community and Family Medicine

ISSN: 2638-4787 | Volume 4, Issue 1, 2021

DOI: https://doi.org/10.22259/2638-4787.0401002

Community Medicine, Mental Illness and Social Control

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Abstract

This article explores the dualism of historic and contemporary rise and consolidation of Psychiatry and its relationship to the social construction of mental illness in Europe. It explores the emergent power dynamics that are inherent in how mental illness and disorder has been classified by the psychiatric profession. It does this in three processes. First, the article questions the historical rise of how 'madness' had and has been problematized as deviant and criminal for social order and is a form of hegemonic control and masculinity. Is psychiatric power about human development or discipline? Second, it introduces critical trajectories that provide a thorough underpinning of how and why certain acts of mental illness have been classified as an intensified threat to morality and society rather than out of concern. Finally, the article assesses the possibilities and problems for understanding mental illness for future concerns by stating that psychiatric power needs to be "un-masked" in allowing self-governance to be realised for those that have been at the centre of the clinicians' gaze and the rethinking of the medical profession itself. It is clear that bio-psychological paradigms have dominated discussion in relation to mental illness that underpins the knowledge base of Psychiatry and there is an urgent need to develop other explanatory frameworks because dominant frameworks have failed to identify underlying social structures, processes, attitudes and social practices which inter-combine to oppress and disadvantage people who are mentally ill whilst simultaneously reproducing negative aspects of hegemonic masculinity within psychiatric regimes. What opportunities are there for meaningful human agency in the light of this? This is a long enduring question.

Keywords: *power, psychiatry, social order, gender, hegemony, madness and mental illness*

Introduction

Medical and health languages have emerged as "master narratives" used to police the identities that people who have been defined as "mentally ill" adopt in contemporary society. Both contain continually changing technologies that function to mediate relations between people conceptualized as mentally ill and societal stereotypes. Medical and institutional discourses have been presented as reducing limitations associated with psychiatric disorders. This represents an increase in professional control that can be exerted on lifestyles of people who have been under the surveillance of psychiatry which extends to the governance of such people in institutional settings such as psychiatric secure wings. The process of treatment is to transform, discipline and "normalize" their behavior. In order to achieve normalization, coercive forms of treatment are invoked from informal social rules to the use and overuse of psychotropic drugs. Mentally disordered offenders are placed under the gaze of perpetual surveillance but, occasionally, find ways of negotiating, resisting, and subverting that gaze. Furthermore, this article illuminates how punishment on the body and the mobilization of the 'use of time' become other sources of punishment, which are pivotal to the institutional and structural organization of secure settings in the EU and elsewhere.

This paper is anunapologetic excursion on the rise and consolidation of psychiatric power and its control of individuals and populations who have become problematized and classified as mentally ill and madness throughout a long and enduring history of the present. For example, the acclaimed philosopher

Michel Foucault (1982) describes how the patient and madness are socially constructed through disciplinarian techniques, for example such as the "medical gaze" – the use and abuse of surveillance to control societal ills and give credibility to medical institutions and professional power as the instigator as the truthful arbiter of labelling mental illness (Porter, 1990). The fundamental aim of Foucault's point here has been "to create a history of the different modes by which, in our culture human beings are made subjects" (1982, p. 208). The history of how people are classified as subjects as having a medical disorder or mental illness is about revealing how psychiatry became embedded in occidental culture in particular to have the legitimacy and power to define people as problems of scientific knowledge sanctioned by its truth claims that were rarely contested (Scull, 1993).

Indeed, in path breaking work such as *Madness and Civilization* (1965), Foucault traces changes in the ways in which madness and mental illness was discussed which has obvious implications for psychiatry and the management of disorder and mental illness. Foucault utilizes the distinctive methodology of archaeology for these studies that aim to provide a "history of statements that claim the status of truth" (Davidson, 1986, p. 221).

In order to examine the emergence of legitimacy of professions of psychiatry, one has to understand the contextual backdrop of how it knowledge formation was legitimised by science so any attempt to sanction the definition, management and control of madness and mental illness was never challenged as if science was seen as the master narrative of 'truth', who can challenge or resist it? Once science become absorbed into professions, it moulds what those professions become and the difficulty for people who come into interaction with psychiatry, in particular, have found it difficult to resist the power and control of its profession and subsequent classification practices and processes of medicalisation (Scull, 1993; Foucault 1965).

This is an un-ashamedly a critical theory of psychiatric power and in understanding of how people become seen as a 'problem' which has consequences for those individuals who have been defined as mentally ill (Porter, 1990). The irony of course is in the rise of modernity, the more professions professed liberation and empowerment, the more they controlled. Furthermore, psychiatric power as Joe Sim (1990) has eloquently claimed, the more 'humane' it claims as its truth status, the more it controls and constructs the conditions of mental illness for powerless individuals and subjugated populations.

It becomes a surveillance technique used to classify and monitor the behaviour of 'mental disorder' of patients which uses deviancy conceptual dualities of normality/abnormality to simplistically characterise human behaviour which is more complex and open to historical and contemporary interpretation (Sim 1990). The article explores the historical emergence of asylums, Bedlam and the devastating implications it had in terms of treatment of individuals. We then explore psychiatric power and its relationship to mental illness which was seen as a subtle change to managing social and moral order. We move to evaluate some of the theoretical implications psychiatric power has if it is un-challenged in its hegemony of creating grand narratives of mental illness for powerless individuals and populations. We also track the current treatment structures of 'virtual asylums', hospitalisation and rise of community based services framed by contemporary political debates and gendered issues of psychiatric units. We finally assess the possibilities and challenges of resisting psychiatric power through opportunities for self-determination, self exploration and the rethinking of psychiatry itself.

Understanding the past is crucial in un-ravelling the emergent power of psychiatry in the present and implications and possibilities for the future in terms of resistance to dominant modes of power, surveillance and classification practices of mental illness and disorder and the consequences attached to it in terms of institutional confinement and the potential for 'meaningful' humanity. The reason is that this is contentious is that there is a taken for granted assumption that 'mentally ill' people are somehow violent. We can evaluate the relationship of mental illness and violence by asking three questions: Are the mentally ill violent? Are the mentally ill at increased risk of violence? Are the public at risk? Mental disorders are neither necessary nor sufficient causes of violence. Major determinants of violence continue to be socio-demographic and economic factors. Substance abuse is a major determinant of violence and this is true whether it occurs in the context of a concurrent mental illness or not (Foucault, 1977). Therefore, early identification and treatment of, for example,

substance abuse problems, and greater attention to the diagnosis and management of concurrent substance abuse disorders among seriously mentally ill, may be potential violence prevention strategies. Over time, there seems to have been a progressive convergence of mental illness and violence in day-to-day clinical practice. From early declarations disavowing the competence of mental health professionals to predict violence, there has been a growing willingness on the part of many mental health professionals to predict and manage violent behaviour amongst people who have been defined mentally ill. With the advent of actuarial risk assessment tools, violence risk assessments are increasingly promoted as core mental health skills: expected of mental health practitioners, prized in courts of law and correctional settings, and key aspects of socially responsible clinical management. This tells us nothing about the person and their biography but more about the use of nuanced language embedded through risk assessments by Psychiatrists.

Psychiatrists, however, exaggerate both the strength of the association between mental illness and violence and personal risk to the public. Finally, too little is known about the social contextual determinants of violence, but research supports the view that mentally ill people are more often victims than perpetrators of violence. Rather than there being a problem with mental illness, is there a problem with psychiatry?

Problematizing the History of Psychiatry

Exploring the historical development and consolidation of treatment of medical disorder and its relationship with its patients, uncovers the existence of a general consensus, that the treatment of the mentally ill has reflected how society conceptualized both mental illness and the mentally ill person at a biological and interpersonal level (Carron and Saad 2012). According to these authors, there exists documented evidence depicting on the one hand, cruel and inhumane acts, whilst on the other hand, the delivery of compassionate and benevolent care.

The origins of psychiatric services dates back to 1247 when a monastic priory The Priory of St Mary of Bethlehem, shortened to Bedlam, was founded by the church in London(Symonds 1995) and through its conversion to a hospital in 1357 became Europe's first insane asylum (Allderidge 1995). Bedlam has been housing the mentally ill, as in those described by the Stow's Survey of London (1720) as raving and furious and capable of cure; or, if not yet, are likely to do mischief to themselves or others; and are poor and cannot otherwise be provided for (Allderidge 1995).

Yet, for over six hundred years, its inmates have survived in conditions of inconceivable abuse and worst of all; their suffering became a source of entertainment for the rest of London (Allderidge 1995; Symonds 1995). For example, to increase its funding, the historical hospital was open to the public and the inmates were put on display and their bizarre behaviour and cruel treatment was considered to be a form of theatre (ibid). McMillan (1997) has demonstrated how patients, who suffered from illnesses now recognised as schizophrenia, dementia, depression, autism, and epilepsy to mention but a few, were confined in badly ventilated apartments and never discharged but by death.

As was true as much of medicine at this time, the treatment was rudimentary, often harsh, and generally ineffective (ibid). For example, 'the quiet', 'the noisy' and 'the violent' were all congregated together, a majority of which were chained to beds by their wrists or ankles and subjected to a range of treatments including immersion in icy water, starvation, bloodletting, purging, beating and spells in isolation (Clouette and DesLandes 1997). Some received a treatment known as rotation therapy which involved spinning the patient in a chair suspended from the ceiling until they vomited (ibid). Indeed, as McMillan (1997), Allderidge (1995) and Symonds (1995) note, many patients who may have survived their illness actually died from their therapy, and what became apparent for Davison (1997) was that the management of the 'insane' appeared more important than the medical procedures.

Linked to this, such increased medical treatment, therefore, was formed in the 'project of modernity' (Foucault, 1965; 1982) based on Enlightenment notions of progress and bringing social order to individuals lives.In modernity, asylums as a form of social control was characterized by theprocesses of normalization, discipline, and surveillance (Foucault, 1977) originally linked with the development of the modern prison but increasingly reflected in diffuse use of surveillance via new forms of knowledge (Foucault, 1977).

However, within the early nineteenth century concern for the wellbeing of patients suffering from mental illness gradually increased and at the recommendation of the House of Commons select committee, county asylums were set up in 1807 to probe into the state of lunatics (Hunter and MacAlpine 1974). Further legislation followed, including the Wynn's Act of (1808) advocating for the better care and maintenance of lunatics, being paupers or criminals and the Shaftesbury Acts of (1845), arguing for the better regulation of the care and treatment of lunatics (Hunter and MacAlpine 1974).

In a arguably more positive vein Bendiner (1981) illuminated how Pinel's Treatise on insanity (1806) within a Parisian 'madhouse' known as the Menagerie recognised that the mentally ill were suffering from a disease requiring differential diagnosis, prognosis and therapy. Pinel's revolutionary diagnosis and treatment therefore, promoted the removal of chains and shackles in a bid to provide more affectionate and supportive care in a more therapeutic setting (ibid). Importantly, Pinel's revolutionising work paved the way for recognising that the mentally ill were suffering an illness out of their control and by implementing the concept of 'moral treatment' a new philosophy emerged suggesting that mentally ill patients should be viewed with compassion and care and afforded their dignity as individual human beings (Davison 1997).

Throughout the nineteenth century, most asylums were built on the outskirts of major cities, and operated as self-sufficient communities with their own water supplies, farms, laundries and factories (Andrews *et al* 1997). Consequently, they were isolated from the local community and the psychiatrists working with them were isolated from their own colleagues and those in other medical specialties (Ibid). With the idea of self-sufficiency and emergence of 'moral therapy' around the turn of the nineteenth century, the idea of patient work became, according to Scull (1993: 102), "a major cornerstone" of treatment.

As described by Jeremy Bentham as cited in Porter (1990:131) work was an economic necessity and the workhouse for example, was: "a mill to grind rogues honest and idle men industrious". Alongside Pinel's Treatise on insanity (1806) The York Retreat emerged in Great Britain as the epitome of this kind of reformed regimen, whereby asylum superintendents and psychiatrists argued in favour of patient work to facilitate self-improvement through the patients acceptance of social morality, adoption of self-governance within a social community and retaining self-restraint during religious services (Carron and Saad 2012). However, this philosophy was abandoned in the latter part of the nineteenth century when the moral era took a different 'medical' turn.

From Controllingmental Illness to Psychiatric Benevolence or Malevolence?

It is possible to see that psychiatry was perceived progressively becoming more humane in its approach, as clinicians developed more effective treatments for the mentally ill (Beveridge 2014). Nevertheless, this philosophy was abandoned in the latter part of the nineteenth century when the moral era conceded to a more medically based paradigm of treatment for the mentally ill and this transition paved the way for what is known as the modern asylum, which lasted until the 1950s (Digby 1984).

In terms of admission criteria, and progression towards the establishment of a more modern asylum, the Lunacy Act (1890) set the parameters, providing a legal system in which a patient had to be certified as insane in order to be admitted to the asylum (Andrews *et al* 1997). During this period no psychiatric opinion was sought prior to admission, and thus medical officers in mental hospitals had no control whatsoever over the selection of the patients they were expected to treat, nor was there any opportunity to follow up upon discharge into the community (Rollin 1990).

There was no legislative provision for patients to be treated voluntarily in the asylum, yet, the situation remained somewhat different in registered hospitals such as the Bethlem where admissions continued to take place free from certification (Andrews *et al* 1997). For example, by 1900, only 3% of the patients admitted to Bethlem were certified, compared with 97% of the asylum population (ibid). Importantly, these differences in admission criteria contributed to an enormous rise in the asylum population, as demonstrated in the growth of the Colney Hatch Asylum, the largest in Europe, originally built to accommodate 1250 patients yet, was enlarged within 10 years to expand capacity to 2000. In 1937 (when it was renamed Friern Hospital), there were in excess of 2700 patients and the rise in population was due to a number of factors including: firstly, the admission of

many severely disabled patients who could never be discharged; secondly, patients were admitted with an increasing number of inadequately understood and untreatable conditions presenting with psychiatric symptoms such as metabolic disorders, lead poisoning, syphilis and intracranial tumours (Hunter and Mac Alpine 1974).

As noted by these authors once admitted to the asylum, medical officers classified patients as either curable or incurable and took into account other factors including the duration of their illness and the manifestation of any other complications including epilepsy and paralysis (ibid). In a bid to address the increase in the asylum population, the Mental Treatment Act (1930) was introduced to extend the voluntary admission procedure to asylums, which stimulated the establishment of outpatient departments. Here, applicants could be examined to ascertain their fitness for reception as voluntary patients into asylums and by 1935 there were 162 outpatient departments compared to just 25 in 1925 (Hunter and MacAlpine 1973). These were the origins of community psychiatric services that we have today (Andrews *et al* 1997).

The establishment of the National Health Service (1948), the introduction of phenothiazine drugs in the 1950s and the changing social and political climate around this time were all factors that influenced the gradual closure of the large Victorian institutions (Department of Health and Social Security DHSS 1957). Instead, it was envisaged that by keeping patients in hospital when they have recovered from the acute stage of illness, was an infringement of their human rights.

The Royal Commission (1957) on the Law Relating to Mental Illness and Mental Deficiency (DHSS 1957) recommended that no patient should be retained as a hospital inpatient when he or she has reached the stage at which he or she could go home. Here, the Mental Health Act (1959) was heralded as the first piece of mental health legislation providing clarification as to why an individual might need to be admitted to hospital and treated against their will (Fenton *et al* 1997). In doing so, this Act provided a distinction between voluntary and involuntary treatments, and provided a much clearer pathway especially in the form of compulsory assessment and treatment for the mentally ill when a 'failure of agency itself' is encountered (Greco 1993:357).

So far, according to Beveridge (1914), the history of psychiatry was written mainly *by* psychiatrists and was a rather benign progress facilitating change as brought about by the actions of eminent individuals at the expense of consideration afforded to exploring the wider social, cultural and political context. Indeed, this kind of history was seen by non-medical people as complacent, self-congratulatory and serving to legitimise psychiatry's present. However, this rather rosy view of psychiatry's past and the institutionalisation of psychiatric patients and their receipt of poor standards of care and quality of life was challenged by those outside the psychiatric profession.

Critical Interpretations of Psychiatric Power

Foucault (1965) using the York Retreat as an example, opened up the dialogue between the disciplines of psychiatry and philosophy to question if, and to what extent, psychiatrists of this period exerted power motivated by their compassion to work with disturbed and distressed patients with specific conditions, or on the other hand, were agents of the state and as a means of social control aided society in ridding it its debris – the so called 'mad'(Scull 1979).

In other words, Foucault (1965) argued that the mad enjoyed reasonable freedom until the arrival of the Enlightenment in the eighteenth century which saw the birth of psychiatry. This led to what Foucault called the 'great confinement' which as demonstrated above saw vast numbers of the mentally disturbed were herded into institutions. In doing so, for Foucault (1965) the voice of 'unreason' was silenced by the forces of 'reason', in the shape of the emerging lunacy profession, and thus psychiatrists helped manufacture madness within the asylum (Szasz 1970).

Although the philosophy in the moral era allowed for the more humane treatment of the mentally ill, Foucault (1965) argued that the self-improvement through an acceptance of social morality, adoption of self-governance within a social community, retaining self-restraint during religious services and of having a desire to work (Carron and Saad 2012), was highly repressive without losing sight of the potential of resistance. Foucault (1965) referred to this as "constraining power", through which the patient was

returned to "the order of God's commandments," succumbing "his liberty to the laws that are those of both morality and reality."(ibid: 247-8).

Consequently, In Psychiatric Power (1973) and in a lecture entitled The Punitive Society (1973:227) Foucault, declared that: 'it is now time to talk about power', which in Psychiatric Power (1973:4) was described as something that is not possessed but rather exists through 'dispersion, relays, networks' and 'reciprocal supports' that are 'rife with struggle, war, tactics, strategies' and 'microphysics' (ibid: 16). Techniques of surveillance are so sophisticated, argues Foucault, that "inspection functions ceaselessly. The gaze is everywhere" (1977, p. 195).

Foucault points here to the means through which power is exercised. He places the processes of discipline, surveillance, individualization, and normalization at the center of his analysis of psychiatry. These processes was part of a strategy that extended "control over minutiae of the conditions of life and conduct" (Cousins and Hussain, 1984, p. 146). Within this discourse the psychiatrist became "the great advisor and expert"(Rabinow, 1984, pp. 283–4) in the utilization of scientific-medico insights in constructing mental illness through its power.

For Foucault (1973:6-7), the history of psychiatric power as undoubtedly, one of struggle, of mastery and of the direction of others and as Foucault (1973:174) asserts, the mantra as threaded out in the clinic or asylum is: "I direct, I praise, reward, reprimand, command, constrain, threaten, and punish every day".

Indeed, if we set psychiatric power and its relationship with the patient within a wider context and within the large public asylums of the late 19th and early 20th centuries, we can locate evidence detailing institutional profiteering on the part of asylum staff, coercion of patients, withdrawal of food and rewards such as cigarettes or outings as punishment for noncompliance, intolerance to idleness and work as a default setting as opposed to choice for the purpose of self-improvement and its counter boundary with dangerousness (Szasz 1970). Part of the problem is the perception of "dangerousness". A central question is what constitutes 'dangerousness'? Themes of individual pathology influenced by a wider familial environment has been the dominant framework which explained gendered dangerousness and this is highlighted by the use of milieu therapy. However, it would seem that the policy of secure specialised provision for the 'dangerous' mentally ill is based upon unfounded yet taken for granted assumptions. 'Dangerousness' is not such a clear and well conceptualised term. Hence, 'dangerousness' is not a constant, fixed personal characteristic. Rather, mentally illness may pose a 'risk' at certain times and in response to certain situations but not in others; for example, highly vulnerable people can be 'disruptive' than very 'dangerous' in terms of behaviour. Such labels become constructed and applied via complex processes of negotiation, classification and rapport between patients and professionals.

Hence, there is a need to transcend images of dangerousness and locate the institutional mechanisms by which people in such psychiatric regimes are manipulated to facilitate perceptions of legitimated social control, masculinity and power. However, admission to a secure institution is a self-fulfilling prophecy; patients come to be regarded as 'dangerous', otherwise why would they be there. It is important to recognise that all people in secure settings are not fearless, manipulative and violent. Behind the walls of the special hospital, medical personnel including psychiatrists, psychologists as well as psychiatric social workers test, probe and hypothesise about women constructing and re-constructing quantifiable profiles of the bio-psychological and narrowly conceptualised sociological factors deemed to be lying at the root of their 'instability'. Such individualised responses generates intervention into people's lives and reinforces the view that it is their problem rather than the pressurised structures and policies of the psychiatric hospitals which are at fault.

Utilising a concept such as 'hegemony' from Connell (1987) is particularly useful in recognising the relationship between domination and disempowerment. Alternative definitions of realities and ways of behaving are not simply obliterated by power networks. Thus, while physical and psychological violence might be a cornerstone of mental illness confinement which support dominant cultural patterns and ideologies, they are utilised within a balance of forces in which there is an everyday contestation of power and where there is always the possibility for individual, social and historical change (Connell 1987: 184. Domination is emphasised at the expense of contradiction, challenge and change both

at the level individual identities and social formations (staff/regimes). This position is particularly relevant for the study of women in special hospitals for despite the domineering brutalisation/disempowerment/ infantilisation which underpins and reinforces the culture of masculinity inside, this culture has often been undercut by individualist and collective strategies of dissent that have provided a glimpse of the possibility for constructing social arrangements which are not built on violence and domination in such regimes of power.

The 'hegemonic masculinity' (Connell 1987) and the controlled use of violence which prevails in psychiatric hospitals with its population exemplifies a broad pattern of physical violence, psychological intimidation which provides a stark yet chilling context in which everyday decisions are made, lives controlled and bodies and minds broken. The process of normalization and routinization underpins and gives meaning to the self-perception of the individual and the perceptions of the significant others in the power networks of the institution. As a comparison to the prison system, prisons sustain, reproduce and indeed intensify the most negative aspect of masculinity, moulding and re-moulding identities and behavioural patterns whose destructive manifestations are not left behind the walls when the prisoner (or even patient) is released. Disempowerment on the inside it seems can be mirrored on the outside.

A more nuanced gendered reading of the social order and hierarchies of power moves therefore beyond bio-psychological models and organisational imperatives or individualised profiles. What we need to point to is how the maintenance of order/security both reflects and reinforces the pervasive and deeply embedded discourses around particular forms of masculinity.

The mortification which people who are mentally ill undoubtedly experience in their daily lives does nothing to alleviate the problems that the majority will face on their release into the community. Rather in its very celebration of masculinity, the psychiatric unit, like other state institutions such as prisons like hospitals, materially and symbolically reproduces a vision of order in which 'madness' remains problematic, the template for constructing everyday social relationships between prisoners/patients/ professionals working with them.

Illustrating this point Erving Goffman (1961) in his work on *Asylum* examines the social situation of hospitalised mental patients arguing that total institutions such as the hospital or asylum are spaces where immersion is complete, where inmate's roles are defined, where relationships are inhibited by the culture, and where its inhabitants become what the institution needs them to become.

Goffman (1961) speaks about the mortification of the self, encompassing how the self changes and how, over time, personal identity is substituted by organisational identity to the degree that a completely new role emerges, that is, the role of the patient. Eventually, for Goffman, after a period of time, post mortification, everyone within a total institution starts to submit to the definition of the self that the organization enforces on them and thus the positive aspects of mental illness became somewhat forgotten. For example, through the usual range of physical treatments such as 'the carrot and the stick', patients begin speaking the language of the organisation, reiterating the goals of the organisation, and tolerating the authority and set rules of the organisation, as in being reprimanded for any misdemeanours and symptomatic behaviour, fixed with the ever surveying eye and placed under physical restraint (Freebody 2016). In time, Goffman (1961) argues that the patients become aware that their very survival depends on understanding the political, the social, psychological, and economic nuances of their environment and are thus, compelled to construct a new self and a new vision focused on surviving and succeeding within the asylum.

Yet, what happens when patients leave an institution, as in the very place in which they have learned to survive and possibly thrive? Can those who have been admitted for too long, successfully move on when their sense of self has been totally defined by the institution and have become professional patients? Revisiting Durkheim's work on the production of individuality Foucault (1973:57) begs the question is there any 'individual beneath power relations who can be freed' when institutions impose a morel rule, a limitation of liberty, a submission to order, an engagement of responsibility in order to desalinate the mind? In other words, is it possible that both Foucault (1965) and Goffman (1961) have over-emphasised the repressive nature of treatments received within the asylum?

Is subordination to routine, the acceptance of discipline and maintenance of concentration important in

preparing the patient for re-entry outside the asylum? For Goffman (1961) the ideal situation for patients is to obtain these benefits of treatment and leave before they have lost a sense of self by becoming enmeshed in the asylum's culture and values (Goffman 1961).

Contemporary Issues in the Hospitalisation of Mental Illness

Enoch Powell's (1961) Water Tower speech further fuelled a political and social movement supporting the disbanding of the asylums and in 1962 the Hospital Plan for England and Wales projected a closure of half of all mental beds by 1975 (Ministry of Health 1962). From 1971 onwards there followed a dramatic change in the facilitation of psychiatric provision. A Government paper on 'Hospital Services for the Mentally ill (DHSS 1972) proposed the complete abolition of the mental hospital system with all services being delivered by district general hospitals with close liaison with general practitioners and social services. This model promoted the re-organisation of psychiatric services mirroring other hospital disciplines, namely the impatient and outpatient facilities within a hospital building (ibid). As a result, outpatient clinics became a vital part of psychiatric service provision and moved from having a triage function to becoming a resource for both assessment and follow-up.

Alongside these developments, there was also a shift towards the provision of other community-based services for people with mental illnesses, such as day services, supported housing and community-based mental health nurses and social workers. This was referred to as community care and was supported by many government policies such as Better Services for the Mentally Ill (DHSS 1975) Care in the Community (DHSS 1981) and Community Care with Special Reference to Mentally Ill and Mentally Handicapped people (House of Commons Social Services Committee Department of Health and Social Security 1985). However, the community service provision for individuals who had previously resided in an asylum has been subject to much debate over the last 40-50 years, particularly due to the reported incidences of inadequacies. For example, one of the accomplishments of community care has been the provision of a diversity of supported housing supplied by non-statutory organisations (Poole *et al* 2002). Here, the majority of people who have transitioned from the asylum to the community, even with the most complex needs, have increased their social networks, gained independent living skills, improved their quality of life and have not required re-admission (Tanzman 1993).

However, the private provision of long term inpatient care for patients referred to by Mann and Cree (1972) as the 'new long stay' is more problematic due to the reduction in psychiatric inpatient beds since the 1950s. Indeed, Poole *et al* (2002) have exposed how and why a sheer lack of NHS resources and associated costs for patients with more challenging behaviours or who have unusual psychiatric needs has provided a market opportunity for large and small businesses to exploit the situation. Here, Poole *et al* (2002: 325) illustrate how:

> "private facilities have developed at a distance from purchasers and without a policy framework for the protection of patients' long term interests. Patients dislike isolation from family and friends and are vulnerable to changes in the institution's niche in the market. But these detained users of private services have little influence over their circumstances. The network is a "virtual asylum," dispersed, invisible, and inadequately regulated"

Patients often arrive in the 'virtual asylum' when discharged from lengthy unproductive spells in acute psychiatric wards, from prisons, special hospitals, NHS secure units and some have been shunted from institution to institution since childhood (Poole *et al* 2002) Many have a chequered reputation with local NHS services, who have lost the capacity to deal with them and thus, in the absence of any appropriate NHS provision, these patients are placed in the private sector (ibid). Of course, a variability of care is widespread in the NHS, yet, it is possible to measure the quality of care.

However, within the 'virtual asylum', lessons from our past continue to be ignored when the accruing evidence exposes how care tends to be basic, patients are subjected to little purposeful activity and depending on the size of the establishment, there is a disparity in terms of qualified staff available (Poole *et al* 2002). Like Goffman's (1961) work on *Asylum* the inmates in the 'virtual asylum' are likely to receive rehabilitation, albeit this is once again focused on the absorption of the culture with little or no monitoring of quality of individual care (Poole *et al* 2002). Nursing home

inspection teams coupled with the Mental Health Act Commission can monitor legal requirements, but fail to sufficiently supervise individual care within a 'virtual asylum' (ibid). Reverting back to the 1970's it is possible to see how incidents of moral panic concerning mental health patients has continued to govern the development of mental health policy in the UK. For example, concerns about the neglect and abuse in mental hospitals yielded to the perceived dangers associated with mentally ill people living in the community during the 1990's. For example, the high profile case of a schitzophrenic Christopher Clunis, who murdered Jonathan Zito in an unprovoked attack at Finsbury Park station in London (Ritchie *et al* 1994), highlighted the potential for community patients living a transitory lifestyle to possibly detach from mental health services. Consequently, for Poole *et al* (2002) this has produced some badly thought out policies which has made the 'virtual asylum' vulnerable to a destructive moral panic, which predominantly apportions blame on service users, psychiatrists, clinicians and purchasers.

As Priebe et al (2005) notes, if the private sector provision of the 'virtual asylum' was to suffer from disrepute, the costs of re providing services in the NHS would make the idea of reinstitutionalisation appear more lucrative and this appears to be already taking place elsewhere in Europe. As this historical backcloth demonstrates, the main victims of this situation will inevitably be the patients and their families as opposed to the politicians and policy makers who unintentionally created the 'virtual asylum' (Poole *et al* 2002). These authors suggest that what is required is the formation of a partnership between the public and private sector with receipt of clearly defined and agreed agenda's for the private sector so that there exists suitable systems to develop, manage and monitor the interface between both sectors. This takes time, reorganisation, better thought out policy initiatives and more conjoined methods of thinking. As Poole *et al* (2002:350) strongly assert:

> "If these basic requirements cannot be achieved for mental health, with its long history of cooperation with non-statutory services, then an overarching NHS policy of public-private partnership has little credibility for other healthcare sectors".

Psychiatric units in the NHS are also gendered in the private-public healthcare landscape. Powell and Taylor (2015) have illustrated that women in psychiatric secure units as ignored, lack any control over their own situations/lives and have few role models. They have pointed to psychiatric secure units as anti-therapeutic and as adding to the social control and disciplination to which women feel adding to powerlessness. As Powell and Taylor point out (2015: 141):

"Psychiatric secure units act as a structure of symbolic violence which is part of the system of domination of female patients, while at the same time a measure of its imperfection. If the hierarchy were actually legitimate, symbolic violence would not be necessary to maintain it."

Conclusion

Psychiatric professionals who refuse to work within the bounds of accepted practices organised around discourses of power, authority and domination which underline, underpin and give meaning to the working lives of the majority of such professionals both on the ground and within the bureaucracy of the State. Ideologies, dominant discourses and behaviour which legitimises disempowerment can be tied to issues of masculinity (Connell, 1987). Attempting to step outside a swamping disciplinary culture results in alienation and disempowerment. In those parts of the psychiatric establishment where care is most emphasized, rather than regimen and control, particularly in psychiatry, there seems to be a potential resistance on the provision of care based on a rigorous emphasis on the patient's own subjective experience outside of the medical gaze (Benner 1995). In these patient care contexts, substantial attention has been devoted to the ethical implications of various medical definitions. Specifically, the discussion also focuses on how language shapes the response to illness, and to how definitions and paradigmatic models impact communication between psychiatric professionals and patients (Rosenberg and Golden 1992).

Significant work has demonstrated how the *lived body* is experienced in altered form and how taken for granted routines are disrupted, invoking new action recipes (Rosenberg and Golden (1992).Thus, an alternative approach to social control seeks to offer a corrective to the seeming dominant emphasis on bio-medical conceptualizations of mental illness; it excavates how we problematize disorder at a surface level by digging underneath such surfaces to reveal

meanings and subjective sense of self that have been historically silenced by rigid historical models of psychiatric power. Hence, more qualitative methods that illuminate the human meanings of social life that brings to life issues associated with understanding their own identity rather than having it imposed on them is an important issue of self governance and resistance to disciplination (Settersten 1999). This is a difficult task given the cultural domination psychiatry. Yet, the opportunities for meaningful human agency should never be lost sight of without simultaneously never losing sight of the threats that power and social control can have for human beings with human rights.

This article has provided an historical and contemporary focus to how mental illness was treated by institutions and professions such as psychiatry (Foucault, 1965). Rethinking psychiatry is a huge task in modern society that illuminates an understanding of the relationship between states of individual mental health and classification practices and confinement. As an approach applied to understanding mental illness, psychiatry could alternatively seek to reveal how human rights awareness is implicated in the production of *social* action, social situations and social worlds of people not as 'cases' but as person centred. Therefore, it is both inadequate and insensitive for psychiatrists to view *people* only as objects. People who interact with psychiatrists are subjects with sentient experience. Psychiatry could focus on the investigation of *social* products as humanly meaningful acts. The meaning contexts applied by the psychiatrist explicates the points of view of individuals. It also expresses their life world and gives impetus that people with mental illness are people first which is a healthy corrective to the hegemony of psychiatric power. How better way to empower people with mental illness by giving them a voice as a vehicle to challenge the existing moral order and recognise we are all human beings with human rights.

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Citation: **Jason Powell**. *Community Medicine, Mental Illness and Social Control. Archives of Community and Family Medicine. 2021; 4(1): 08-19. DOI: https://doi.org/10.22259/2638-4787.0401002*