# CHAPTER 5

## GOVERNMENTALITY, RISK AND THE LEGITIMISATION OF PSYCHIATRY

> Governmentality and the techniques of government have become the only political issue, the only real space for political struggle and contestation (Foucault, 1991b: 103).

The previous chapter identified how the law is utilised in mental health to authorise involuntary treatment through the coupling of 'serious mental illness' with 'dangerousness'. This means that immediate medical intervention in the form of certification, medication and seclusion is considered legitimate. The result is a paradox of legally authorised coercive medical services devoid of therapeutic value. This paradox it is argued in this chapter, is a product of the role of government attempting to protect 'public safety' through coercive interventions in the face of a perceived 'danger', 'threat' or 'risk'. The reliance on the distinction between public safety and risk to legitimise coercive interventions has become more acute since deinstitutionalisation. The extent of this problem has become one that fulfills Touraines (1978: 85) last condition for a social movement: that it is a concern of the whole society. The interventionist logic discussed in terms of 'governmentality' is defined as the logic of government.

## 1. A Population at Risk

The government's view of the subject Foucault suggests is implicit in government techniques or 'Governmentality'. 'Governmentality' refers to the rationalisation of programs and strategies to justify acting upon others' actions to achieve certain ends (Foucault, 1982; Foucault, 1991b; Rose, 1996). Rose urges that psychiatry is best understood by recognising its role in social regulation, which explains the intersection with human rights abuses and raises the problems of political and ethical issues. Rose suggests that in general, such disciplines are:

> best understood when their very existence is first of all treated as a problem to be explained and where their functioning is understood in relation to a wider field of systems of social regulation, political domination and ethical judgments (Rose, 1988: 183).

In the context of social control, the government's choice of what services to provide is not necessarily rational or neutral. Foucault (1991) considers claims of neutrality, which hide the specific interests that have produced knowledge, a political violence. This needs to be revealed in order to be opposed. The political task according to Foucault:

> is to criticise the workings of institutions which appear to be both neutral and independent: to criticise them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked, so that we can fight them (Rabinow, 1991: 6).

Foucault (1991b) states that policies, projects and laws of governance are used to control, subdue, discipline and normalise the conduct of individuals. Therefore the collection and use of 'information' is important in justifying what services are provided. Foucault (1991b)

declares that it is these techniques, procedures, methods and practices of government that determine, maintain, construct and transform identity. 'Governmentality' then, is central to the construction of subjectivity. This raises the question of the concept of the subject in government.

According to Foucault (1991b) the subject of government is not an individual objective entity but a population. The first priority of this population is the maintenance of security. In other words, from the point of view of the administration of government, the protection of the population is of primary importance. As a primary concern, a threat to this subject is a concern for which evidence is sought. From this point of view, mental health patients are perceived in terms of their potential 'dangerousness'. It is not that people considered to be 'mentally ill' are actually dangerous (Holloway et al., 2000; Rabinowitz & Garelik-Wyler, 1999), but that this is a major concern from the point of view of governance. Hence, it is from this primary concern that a threat to the safety of the population becomes a problem.

## Systems for evaluating and regulating risk

The government's conceptualisation of the subject as population renders people who present themselves distressed to services or in the community, in terms of 'risks' to this primary concern. This primary concern with threat has given rise to a whole new range of tactics and techniques, as Castel (1991), Rose (1988) and others (Samson, 1995)

have identified as to do with the management of 'risk'. The emphasis on regulation of risk 'dissolves the notion of the subject or a concrete individual and puts in its place factors of risk' (Castel, 1991: 281), or 'risk factors'. That is to say there is a move from a focus on the individual to the prevention of undesirable events such as deviant behaviour that puts the population 'at risk'. This denotes the transition from a clinic of the subject to that of epidemiology (Castel, 1991: 109).

Castel (1991: 28) highlights 'there is in fact no longer a relation of immediacy with a subject because *there is no longer a subject*', but rather factors of risk. The government's conceptualisation of the subject as population therefore requires strategies to detect 'risks'. The potential risks factors in populations are 'based on the collation of a range of abstract factors deemed liable to produce risk' (Castel, 1991: 281). It is in the context the statistical collation of this entity—population—which is not an objective reality, but a construction around which factors of risk associated with this 'population', that factors of risk can be assessed, prescribed, and determined. This has resulted in an increased reliance on experts to detect 'risks'. Castel (1991) goes so far as to claim experts have constructed risks in order to create new sites of intervention. This new preventative strategy of social administration, Castel maintains, provides a subtle mode of population regulation and multiplies the sites for intervention.

Risk is the effect of a combination of factors. Risks are not things as such but predictions that are socially defined and constructed. The

dispute over risks' definition is because what is at stake is the social, economic and political consequences of these definitions. Calculations of risk can be made on the basis of biological facts or through scientific means that fail to take into account the social and cultural concerns. The failure to take into account these concerns amount to, '*a loss of social thinking*' (Beck, 1986: 25). The focus on a biological definition of risk at the expense of what is meaningful, means that 'dealing with a multitude of troubling, troubled and troublesome individuals' (Rose, 1998: 181) becomes a paradoxical management issue.

It is paradoxical in that the coercive techniques used to subdue patients who are considered mentally ill, 'risky' or at risk of violence, is justified as needed in the interests of the safety of the population. This coercive treatment creates a vicious cycle of violence. The use of violence to deal with the distressed patient, perceived as dangerous, is a violation of the patient's person. Involuntary detention of a person, who is already distressed, overrides their rights to protection of his/her personal safety. It is the coercive and disrespectful techniques that are utilised in response to 'risks' that the consumer/survivor movement have identified and experienced as problematic.

Yet the literature on risk has identified the conceptualisation of risk as inherently subjective:

> Risk does not exist 'out there' independent of our minds and cultures, waiting to be measured. Human beings have invented 'risk' to help them understand and cope with the dangers and uncertainties of life. There is no such thing as real risk or objective risk (Slovic, 1992: 119).

Beck (1986: 26) also points out that the concept of the risk carries a very negative logic of 'disposition, avoidance, denial and reinterpretation'. Though a qualified expert is required to determine risk 'objectively', risks are neither visible nor perceptible. What this results in is the abandonment of 'victims completely to the judgments, mistakes and controversies of experts while subjecting them to psychological stressors' (Beck, 1986: 27). The reliance on the language of risk, Castel (1991: 181) contends, subordinates specialists to executants of managerial forces.

In the field of mental health, the task of risk management is delegated to psychiatrists who are considered authorities in identifying 'dangerousness' or 'riskiness'. To achieve this task, these medical professionals are also empowered with the legal authority to remove or threaten to remove the liberties of those considered to pose a threat. These same professionals then, authorised with State authority, arbitrate over who is to be subject to carceral 'treatment'. The authorisation of medical experts with legal authority in mental health services is an attempt to justify and legitimise the coercive administration of State power.

Psychiatrists' diagnostic expertise then is a tool used to serve the interests and purposes of government to maintain social order. The authorisation of the psychiatrist through the *Mental Health Act 1986* (Victoria, 1998) with State power achieves the governments' primary

objective: protection of the population. Castel (1991) outlines that psychiatric patients carry a certain threat, the realisation of which is somewhat unpredictable as noted in the last chapter. The rational schemas of hospital treatment, he states, are about programmed prescriptions of the regulation of behaviour. Psychiatry has provided a system of rationalisation for practices and technologies utilised to legitimise and authorise coercive practices in the governing of conduct.

However, the difficulty of predicting dangerousness understood as an internal pathological quality of person, and the unreliable, inaccurate and over-diagnosis of its assessment has not provided an adequate basis for intervention. Rather, the concept of risk offers the mental health professionals the ability to think in probabilistic terms. This risk thinking has resulted in an important shift from legal to administrative decision making and as Rose (1998: 178) points out, has had great significance for 'our way of understanding and responding to mental health problems'. The task of psychiatry is now 'less therapeutic than administrative: administering problematic persons on this complex terrain in an attempt to control future conduct' (Rose, 1998: 179). The concept of risk now extends into the community with ongoing assessments of people's 'riskiness'.

The logic of risk prediction, then, has been superimposed on the logic of diagnosis. The role of the mental health professional has become one of risk assessment. The 'risk assessment' is a defense if something goes

wrong. This form of professional practice is what Rose (1998: 190) describes as a new mode of regulation of professional judgment.

> Professional practice is governed through enwrapping professionals in a bureaucratic nexus of reports, forms, monitoring, evaluation and audit, under the shadow of the law, thus governing them according to the logics which are not their own, in the interests of community protection (Rose, 1998: 192).

The concept of risk has inextricably linked care and control. It is part of 'a new style of control' (Rose, 1998: 181). It is concerned with the management of dangerousness. The change in the practices of control, the management of mental health and mental health professionals Rose makes clear, does not mean that psychiatry does not continue to perform its clinical or legal functions. Rather, the concept of risk has reshaped, but not replaced, medical and legal logic. Risk strategies are an attempt to 'identify, classify, and if possible, neutralise the riskiness of the individual pathological person' (Rose, 1998: 181).

The role of the psychiatrist is now to do with the assessment of risk. This responsibility involves:

> the continuous and unending management of permanently problematic persons in the name of community safety. It is here that the clinical language of diagnosis and treatment is increasingly replaced with the probabilistic language of risk assessment. And it is here that the professional vocation of therapy is replaced with that of administration (Rose, 1998: 183).

The coercive measures used in psychiatry result in a reaction of fear by the patient who is not understood but restrained by a variety of coercive means: chemical, physical, electrical and often with long lasting and detrimental results. The coercive measures used on the wards, as has

been established so far in this thesis and as Quirk (Quirk & Lelliot, 2001) and many other studies have identified (Allen et al., 1999; Victoria's Mental Health Service, 1996a), introduces another set of traumas for the patients. This contradiction of control and care is central to the current crisis in psychiatry internationally.

The role of mental health professionals has been transformed by the demands of risk assessment and risk management. Risk assessment is an attempt to objectify decision making in response to a prediction of violence. It is the attempt to increase the capacity of clinicians to make objective decisions 'in a climate of doubt and criticism from those outside the field of knowledge itself' (Rose, 1998: 187). The push for risk assessment is:

> to help sustain the bureaucratic and political assertion of the mental health professional that, potentially at least, they have the capacity to make objective, impersonal and unbiased assessments (Rose, 1998: 187).

Risk classifications then become the means by which professionals justify their decisions. This means clinical decision making is 'formatted by the demands and objectives of non-clinical authorities' (Rose, 1998: 187). This means that the system of risk calculation has authority over the clinicians, subordinate to expert systems. Control agencies become connected through 'circuits of surveillance', 'designed to minimise the riskiness of the most risky', within a 'regime of perpetual surveillance' (Rose, 1998: 187). The logic of risk, is that these assessments constitute individuals as actually or potentially risky.

## 2. Medical legitimacy

In the field of mental health, risk assessment requires clinical assessment. The responsibility for assessing and managing this 'risk' is delegated to social control experts—psychiatrists—who medicalise deviant behaviour. As demonstrated in chapter two, the failure to understand psychosis or to recognise patients' accounts of their needs as legitimate, leads professionals to rely on medical explanatory discourses. The medicalisation of people's distress objectifies and alienates the person subject to treatment. Denied other sources of understanding, becomes a source of identity. This *diagnostic-identity* constitutes a profile with a trajectory of ongoing assessment. The claim for diagnostic control adds an additional dimension to the analysis of risk so far laid down by Rose. This additional dimension is the claim for legitimacy by psychiatric professionals themselves.

The question of the legitimacy of the powerful authorisation of medical professionals is discussed by Willis (1990) in *Medical Dominance*. Willis claims that the alliance between doctors and the State is at the root of the dominance of medicine (Willis, 1990: 27). The autonomy and authority of medicine he claims, is a product of a legally created monopoly 'to penetrate the body…physically, chemically or with drugs' (Willis, 1990: 2). Thus, medical 'sovereignty' is claimed by the medical profession, which includes psychiatry, on the basis that it contains the knowledge on which healing is based. In contrast, Willis argues, that medical domination is a result of its control within the field of mental

health generally, which is 'sustained at three levels: over its own work; over the work of others; and in the wider health sphere' (Willis, 1990: 2).

Medicine's powerful position involves it having control by demarcating territorial boundaries of other health occupations. Moreover, medicine's position of authority denies an evaluation of it by others. This 'ideology of expertise' informs the 'hierarchical division of labour' so that those who claim to be the 'experts are the obvious controllers of the division of labour' in health care (Willis, 1990: 25). The equation of professional authority with expertise, Willis (1990: 25) claims, 'legitimises the health division of labour' and the authoring of medical professionals with power.

Furthermore, medicine's dominance has been secured by the rise of science as a form of legitimacy. This buttressing of psychiatry's claims by science has meant that an attack on one is seen as an attack on the other. Until recently, the lack of scrutiny within medicine had been unquestioned by a belief that doctors act in the interests of their patients. However, this belief has been undermined by evidence that doctors act in their own interests, evidenced by excessive pathology testing and surgical intervention (Bates & Linder-Pelz, 1990: 175-177).

Although Willis' work is an analysis of the medical profession more generally, his work also applies to the medical specialty of psychiatry. In psychiatry, behaviour previously considered 'wrong' is considered an 'illness' that requires treatment. This medical rationalisation of social

life encourages scientific explanations for a wide range of problems (Zola, 1972: 487). For instance, Szasz (1961: 204-220) suggests that this replacement overlays deviance or riskiness with medical terminology. Szasz claims that the myth of mental illness obscures difficulties actually located in social relationships.

Other critics argue that psychiatry is used as a form of social control to depoliticise social problems [Kleinman, 1988; Fulford, 1994; Foucault, 1991; Willis, 1990]. Foucault highlights how the clinical gaze enables a redefinition of reality in terms of disorder (Foucault, 1975). Psychiatry became a medical discourse as a product of what Foucault (1991c) described as 'effective history': the political and economic forces resulting in the domination of the medical perspective. Psychiatry depends upon medical discourse for its power, status, and professional legitimacy, which is attributed to scientific discourse (Foucault, 1991c; Willis, 1990).

Foucault (Rabinow 1991: 73, 162-166) argues the medicalisation of the subject in psychiatry is not because of a logical progression of thought within medical knowledge as is assumed. It is because of what has been referred to as, 'the politics of truth', that is, 'the political, economic, institutional regime of the production of truth' that is internal to medicine's claim for legitimacy [Rabinow, 1991: 74-75). Likewise, Willis suggests that legitimacy is established not through 'truth value', but through a political process whereby a practice is accepted as authoritative and therefore the practices associated with it are justified.

Freidson (1970: 139) in an analysis of the professional dominance of medicine considers the question of how 'professional practices contribute to the unhappy experiences of the patient?' He suggests, as this thesis does, that a patient is unhappy when 'treated *as if* he were an object' (Freidson, 1970: 139). That is, as if there were no capacity for understanding. This indicates a failure of communication based on the one-sided power of medical knowledge. Freidson states

> if the staff do not communicate to the patient the meaning of and justification for what is done to him, it in essence refuses him the status of a responsible adult or of a person in the full sense of the word (Freidson, 1970: 139).

In contrast an 'explanation by the staff constitutes acknowledgement of the client's status as a responsible adult capable of intelligent choice and self-control' (Freidson, 1970: 140).

The question of this failure to communicate to the patient in hospital Freidson suggests does not lie in the:

> financing, understaffing or bureaucratisation. Rather it lies in the professional organisation of the hospital and in the professional's conception of his relation to his clients (Freidson, 1970: 141).

The professional dominance of medicine is, as outlined according to Willis, is a product of medicine's control of information. Other health occupations are not permitted to divulge any medical information. But as Freidson states 'while he (the doctor) does not want anyone else to give information to the patient, neither is he himself inclined to do so' (Freidson, 1970: 141).

As Freidson argues, the reason professionals do not want to communicate to their patients 'is based on characteristically professional assumptions about the nature of their clients' (Freidson, 1970: 142). The patient is assumed to be:

> too ignorant to be able to comprehend what information he gets and is in any case too upset at being ill to be able to use the information he does get in a manner that is rational and responsible (Freidson, 1970: 142).

The result of this is that providing information to the patient is considered to create problems of management. Thus: the patient is not given information and viewed as responsible but treated as a child.

The failure to provide explanation then, Freidson points out, puts the expectation on the client to have faith in the professional. Failure to have faith results in denial of service. The insistence on faith in the service provided 'constitutes insistence that the client give up his role as an independent adult', which also functions to maintain the 'profession's institutionalised authority' (Freidson, 1970: 143). This kind of domination makes clear that the source of a patient's alienation is not bureaucratisation but professionalism. The medical profession alienates other occupations through this kind of dominance. This is in contrast to the meaning and identity that the dominant profession offers its own members.

The authority and dominance of medicine has resulted in medicine having authority over the planning and financing of services. This servicing involves a self-enclosed circularity. What professions offer is

limited to what defines a profession and services are defined in the terms of a profession. Medicine can only offer healing in its own terms. Professionalism is:

> constituted by commitment to occupationally defined knowledge and technique and occupationally defined public service, to a particular occupation's view of correct knowledge and ethicality (Freidson, 1970: 153).

The medical profession has a professional pride and imperialistic attitude over the value of this knowledge, which is jealously guarded. Medical professionals, through their proud identity with their work, are committed to the institutions within which they work. This professional approach has inherent weaknesses which Freidson (1970: 156) notes, because it is inherent to the profession itself, cannot be rectified from within.

Further, the distribution of health resources is also organised according to the medical profession, which is totalitarian in that it limits other discourses. This totalitarianism is not 'automatically self-correcting'. Quite the contrary, 'expertise establishes office and hierarchy analogous to that of bureaucracy', such that 'ideology and technology combine to produce bureaucracy-like consequences' (Freidson, 1970: 157).

The problem with the autonomy of the medical profession is that it is not bound by rules outside its profession. This avoidance of accountability results in the failure to communicate with patients, which patients experience as objectifying. The objectification of patients through bureaucratic practices are subject to appeal, but professional

practices, imputed to have 'unquestioned objectivity of expertise and scientific truth' and so are 'not routinely subject to higher review or change by virtue of outside appeal' (Freidson, 1970: 159). But as has been demonstrated, experts' knowledge is not neutral. 'It is the practice of a knowledge organised socially and serving as the focus for the practitioner's commitment' (Freidson, 1970: 159-160).

Freidson identifies that the weakness of professions is not due to the lack of resources, but is a consequence of the demands of professionalism. In this context the medical professional becomes committed not only to the ideals of the profession, but moreover 'to a concrete career and to concrete, historically located institutions' (Freidson, 1970: 155). This limits the problems a professional can perceive as they also have a sense of great pride about their work. The combination of ideals, career and features of professionalism then become a source of the weakness of the profession itself.

Freidson's (1970: 170) analysis of medicine identifies the depersonalisation of the client, central to service provision, as most marked 'when the client is most helpless'. That is, 'when the choice and arrangement of services are an exclusive prerogative of management' (Freidson, 1970: 170). This is especially the case for mental health patients, though there has been a shift in recent times in service delivery from that of therapy to: 'an activity of expertise which serves to label an individual, to constitute him or her a profile which will place him or her on a career' (Castel, 1991: 290).

The dovetailing of medical knowledge and dominance and the newer language of risk in the field of acute public psychiatry entails that there is no longer a function of care but only of identification of risk through diagnosis. Treatment is replaced by the practice of 'administrative assignation' (Castel, 1991: 290) on the basis of the diagnosis of mental illness. These diagnoses can only function through an expertise. This expertise eliminates the problem of care while increasing control through the 'autonomised management of populations' (Castel, 1991: 291).

As has been discussed in this chapter, the organisation of relationships between patients and staff are structured by the administrative and professional view of the patient. The involuntary or coerced position of the patient depersonalises and denotes him/her as incompetent and unable to enter into negotiations (Freidson, 1970: 177). It is argued here that the organisational aspects of institutions stem from the profession's practice of expertise, as well as administration as such: 'the social establishment of expertise permits the organisation of services around its authority independently of purely administrative organisation' (Freidson, 1970: 181). This type of administrative control in acute mental health services is a major source of discontent, as it entails a failure to treat people with respect.

Although there has been an attempt by government to improve quality assurance through the institution of interventions such as outcome measures, this attempt has re-established the problem by relying on

clinical methodology, rather than an independent and external evaluation of practices. To avoid the influence of the demands of administration that conflict with those of the client and the professional, evaluation by users needs to be strengthened, so that services are responsive to the 'immediate human needs of the patient' (Freidson, 1970: 212). This requires building in to the process mechanisms whereby there is direct feedback from users.

As has been argued above, governments bestow psychiatrists with the authority to incarcerate people considered 'dangerous' or 'risky' as 'ill' and 'incompetent'. That commitment carries a responsibility of care. But the current mode of intervention with coercive 'medical treatment' does not fulfill its 'duty of care' but rather, produces trauma. Furthermore, the government's alliance with, and authorisation of medical sovereignty, means that the problems or limitations of the approach are not recognised but denied.  The consumer/survivor movement claims that services fail to meet needs, and are traumatizing. These reports are not taken seriously and are considered further evidence of pathology. Instead of responding to peoples needs with face-to-face interviews, current practice offers incarceration and the examination of the patient's record.

## 3. Problems with Governmentality: Risk and Medical Legitimacy

The conception of the role of psychiatry as that of community protector fails to conceptualise the obligation to protect those with mental health problems from the 'actual and symbolic violence they face at the hand of the community' (Rose, 1998: 183). This failure is a failure to empower those who use services and replicates the logic that 'equates difference with danger' (Rose, 1998: 183). The result is that the rationale for confinement is security. Yet the coercive methods used against consumer/survivors are not considered a violation of human rights because this action is considered a legitimate use of power in the interest of the safety of the population.

Action taken against those defined as 'mentally ill' is justified through the legalisation of coercion in mental health law, as the example from the *Mental Health Act 1986* (Victoria, 1998) has demonstrated. The identity of the patient is forfeited in the interests of the protection of society from risk. The diagnosis of mental illness authorises the imposition of violent and coercive practices, under legal protection. The imposition of 'treatment' under the pretence of medical care is incongruous with the negative effects such coercive methods have on the patient's already traumatised sense of identity and subjectivity. As Castel (1991: 289) has noted, there has not been 'a trace of reflection on the social and human cost of this new witch-hunt' for risk factors. Castel (1991: 202) argues that the focus on the case record has

highlighted a 'shift from presence to memory, from the gaze to the objective accumulation of facts'. The focus is on factors that produce risk and not the person. This means that the aim of intervention is that:

> which, at other times or in other circumstances might be considered intrusive, oppressive, discriminatory or paternalistic, can be justified as being for the protection of the 'at risk' individual and ultimately of benefit to 'society' as a whole (Peterson, 1996: 56).

Meanwhile people detained in an acute public psychiatric hospital are then subject to further 'risks', as indicated in the introduction: violence, sexual abuse and drug and alcohol use (Quirk & Lelliot, 2001). The problems experienced by the patient with coercive routines in mental health services, do not result in time allocated to consultation, but as noted in chapter 4, in 'ceremonial chemistry' (Szasz, 2000). Castel (1991: 202) also states the resulting situation might be called 'a crisis of clinical medicine, a crisis affecting the personalised relation between professional and client' which 'supplants the old doctor-patient relation' with a 'clinic of the subject to an epidemiological clinic', marking a transformation in medical practice.

This shift from individualised clinical practice is also noted by Willis (1990) and Illich (1975) and is evident in the more recent changes in health, whereby health services are run on a corporate model. This involves the psychiatrist's role being subordinate to that of a manager (Castel, 1991) dealing with reduced resources (in terms of bed numbers and length of stay). This has meant that psychiatrists can offer only crisis and emergency management in an acute psychiatric admission.

Nonetheless, admission is the only available resource to respond to acute crises.

Rose (1998: 190-192) makes three points about the shift toward the management of risk in mental health services. The first point is that risk management shapes the role of mental health professionals. The fear of prosecution by patients, victims and families is the driving force behind the risk-based technologies. Participation in the 'ideology of risk' however makes a priority of public protection, at the expense of the duty of care owed to patients, and 'to the myth that risk-based practice will actually enhance public safety' (Rose, 1998: 190).

Secondly, Rose points out that significant ethical consideration is bypassed in the assessment of risk around the issue of the moral and social judgment of what does and does not count as dangerous and the uncritical acceptance of the 'objectivity' of such scales. Thirdly, Rose points to the way the debate has been structured in terms of the rights and security of the general public as potential victims and the demand for protection. Psychiatry has been forced to satisfy the public and political demand to identify 'the potentially dangerous' in the name of community safety because of the proposed danger. The intervention of incarceration does not involve reform. The concept of risk transforms the responsibilities of psychiatry and its roles and responsibilities to that of coercively managing risky individuals (Rose, 1998: 192).

The government's conceptualisation of the subject as population means that risk to the population is of primary concern. Clinical epidemiology combines medicine and governmentality to evaluate risk in the population. It is an evaluation of the incidence of health problems in the community in order to provide government services. Though clinical epidemiology provides information about the incidence of mental illness in the population, that level of evaluation is inadequate as a means to understand these problems and therefore is an inadequate means by which to establish a response to these problems. The problem is that analysis at the level of clinical epidemiology as Koegel (1992: 1) asserts, provides an incomplete and even 'distorted perception' of problems.

Moreover, the language of risk and the language of 'population', when tied to clinical epidemiology provide little understanding about 'what patients think, what their beliefs and values are, and what meaning they impute to their existence' (Koegel, 1992: 4). Koegel (1992: 4) goes on to say, that what is worse is that there seems to be little notion that the attitudes and values in mental health services affect how people considered mentally ill behave, and 'even less of a notion that such people have something important to say about their own lives'.

Koegel, for one, states what is needed is a framework for understanding behaviour that otherwise would seem bizarre. This requires finding out about the meanings people have of their lives and what is meaningful to people. He (Koegel, 1992: 4) points out that the preoccupation with 'pathology, disintegration and disaffiliation' has also brought attention

to what is wrong with people without knowledge of 'what may be *right*', that is the strengths and creativity that enable people to survive. The conception of the subject as population by government means the identity of the patient is forfeited in the interests of dealing with risk factors, a task delegated to psychiatrists. It also explains the use of community treatment orders and the rise in the use of antipsychotics and preventative mechanisms of surveillance directed towards children in a 'system of systemic predetection' (Turner, 1995: 227).

An example of the limitations of the epidemiological and clinical approach is that the only attempts to understand the 'homeless mentally ill' have been through a reliance on epidemiological and clinical perspectives (Koegel, 1992: 2). Research into understanding how these people live their lives and make sense of them is missing. Koegel's (1992: 8) study of the 'homeless mentally ill' identified that behaviour labeled 'psychotic' made sense when considered in context and 'may even be adaptive'. Understanding requires studying behaviour in context. [1]

> While clinicians and epidemiologists direct little of their attention to the structural and economic influences that define the framework in which individuals live their lives, the fact remains that these

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[1] This need for understanding of the context and meaning of symptoms was what was found to be missing from psychiatry in chapter two in Jaspers phenomenology, and identified as centrally important in Goffman's analysis in chapter three.

> influences shape the options available to people, the choices they make and the behaviour we observe (Koegel, 1992: 7).

Link and Phelan (1995: 80) question the current emphasis on risk factors and argue that 'greater attention must be paid to basic social conditions if health reform is to have its maximum effect'. This claim is made on the basis that risk factors must be contextualised to understand what 'puts people at risk of risks' (Link & Phelan, 1995: 80). Further, they argue that social factors are fundamental causes of disease through multiple mechanisms. Medicalising patients' problems as risk factors has implications for both those who provide and those who receive mental health services. The authorising of professionals by the State with legal authority to enforce coercive 'treatment' has implications for the identity and subjectivity of both the patient and the professional.

Moreover, the subjectivity of the psychiatrist is just as much taxed in the encounter or in the distribution of these techniques as the patients themselves. To identify the role of coercive practices in the construction of the subject is to recognise the political nature and responsibility of what is authorised. The conflicting responsibilities to patients and families that institutions of government require of psychiatrists, disregards the ethical dilemma this produces for professionals in this 'hierarchy of coercive power' (Thomas, 2001).

The coercive regime of treatment services and instruction for trainees, results in psychiatrists leaving public mental health services in

preference for private psychiatry (McKay & Associates, 1996). The National Mental Health Strategy, *Optimum Supply and Effective Use of Psychiatry* (McKay & Associates, 1996) indicates that this movement of psychiatrists to private practice is explained by a number of factors. Psychiatrists are disempowered in public mental health services whose managerial roles have been taken over by managers and other health professionals. The negative image and relative lack of status have also been cited as factors as well as the responsibilities, coercive nature of treatments and relative isolation of registrars and the stress this induces. The taxing nature of the engagement between patients and psychiatrists has led practicing psychiatrists to avoid personal involvement especially with public patients. The failure to provide patients with a personal level of support denies satisfaction for both parties.

Furthermore, this study (*Optimum Supply and Effective Use of Psychiatry,* (McKay & Associates, 1996)) identified that the determinants of access to mental health services were socio-economic factors not clinical ones. Even though those in the public mental health system are generally of a lower economic status, those experiencing some form of serious mental illness such as psychosis, need specialist psychiatric care. However, as the report identifies, few specialists stay in the public mental health services, preferring the more lucrative and more rewarding practices of private treatment. From this perspective, admission of public psychiatric patients is not a function of 'illness' but

of a lack of social, emotional and economic resources. In other words, socio-demographic factors may predict health service use better than diagnosis (Kisely, Preston & Rooney, 2000).

In a retrospective analysis of diagnostic related groups and outcome, Faulkner (1994) found that the length of stay of hospital admission was related to social variables rather than diagnosis. Likewise Goldney (1998) found that problems with daily living rather than a specific diagnosis was related to depression. Rather than provide housing, and other supports as the study *People Living with Psychotic Illness: An Australian Study 1997-98* (Jablensky et al., 1999a) identified as needed, people identified as mentally ill are considered dangerous and admitted for lack of alternative resources.

Since the introduction of Medicare in 1983 the use of private psychiatry has been rising (McKay & Associates, 1996). Forty-five percent of private practitioners provide long-term psychotherapy for people in the other high status professional occupations, while only five percent of the lowest socioeconomic group received the same therapy, though these have been the group identified with the most serious mental illness. Utilisation rates parallel the socio-economics status, as those who use private psychiatry are privately insured (McKay & Associates, 1996).

What this amounts to is an economically driven service: people in the highest socio-economic brackets get specialist therapy on Medicare

while those most disabled are channeled into the hospital system that offers little support. Notably, between 1984 and 1993 there has been a 44 per cent increase in the number of registered psychiatrists (McKay & Associates, 1996) and Victoria has the highest per capita level of consultations by consultant psychiatrists, 25 percent above the national average (Commonwealth Department of Health and Aged Care, 1996: 156). Importantly, the programs and practices offered have real effects in the lives of those completely subjected to those with authority.

## Contesting Governmentality: Risk and Psychiatric Legitimacy

People subject to services are invalidated, without rights or a voice, completely disempowered and without means to establish the legitimacy of their own experience. Expressing concerns carries with it the fear of an increase in coercive psychiatric treatments. The rationality used to justify practices utilised in mental health services has not taken the implications for user and provider subjectivity into account. This failure leaves services unaccountable for the negative outcomes for which it is responsible. What discussions about risk make clear is the 'fissures and gaps between scientific and social rationality in dealing with the potentially hazardous potential for civilisation. The two sides talk past each other' (Beck, 1986: 30). It is left up to new social movements to 'raise questions that are not answered by risk technicians' (Beck, 1986:

30). New social movements highlight the varied interests of the current political terrain.

As a new social movement, the consumer/survivor movement contests the techniques and knowledge's that authorise the processes that are imposed on them. The consumer/survivor movement is an attempt to impact on policy and break the vicious cycle of the conceptualisation of people with 'mental health' problems as dangerous, and the enforcement of coercive practices in the interests of 'security' as: the treatment of human beings in public mental health services has grave results for those so subjected. Failure to recognise the effects in terms of costs for the personal subjectivity of those that currently practice in them or are subject to them is a failure of government to be accountable for the very practices it endorses. The consumer/survivor movement contests the use of force against them, because of the negative subjective consequences. As the authorising body, the negative effects are the responsibility of government.

According to Touraine (1978), the reason this discontent has not been taken seriously is because those in power oppose whatever restricts their action, while disowning this power. He argues that the powerful are only prepared to replace the system of historical action with a system of corresponding interests. As has been shown above, this is the case with the mental health system. The conflict in mental health services is over the legitimacy of social, cultural, political and legal decision making in the treatment of the 'mentally ill' by those working

in the mental health system. The positioning of psychiatrists in the system works to defend professionals through the use of the law, and protect them through claims to knowledge and truth, which limits the possibilities for social transformation. Professional stakeholders are able to maintain power by manipulating society's needs while rejecting the autonomy of participants and other professionals. Mental health consumer/survivors are in conflict with professionals who control the social and cultural organisation of practices' political and legal decisions.

However, perhaps the incommensurability between the stakeholders' perspectives can be addressed. People using services have identified the most important factor of their experience was that they felt that they were not respected or treated as human beings. A theory of the subject is required that conceptualises patients as legitimate subjects within acute psychiatric services. This would provide the means for those who use services to acknowledge their needs as they identify them. This would require the availability of methodologies that access consumer/survivor narrative knowledges, which requires 'know how, knowing how to speak and knowing how to hear' (Lyotard, 1984): that is, tools that recognise the subjectivity of the patient, as person is required.

The practices prescribed and enforced in the mental health services construct the subjectivity of mental health users as risky, threatening and dangerous. This conception is responded to with the authoritative

and coercive force of the law, which has negative implications for the subjectivity of patients and providers. The consumer/survivor movement as a new social movement is directed at the level of the system of action, challenging the social definition of the roles of politics and the social order. This is in opposition with the dominant cultural model that coincides with the economic interests.

The actors in a social movement want both to create and control a system by overcoming an adversary who is preventing them from doing so, thus challenging the traditional system of social and economic relationships. The system is maintained on the basis of what is practical. A strong new social movement is a struggle against a practice, which is counter-productive for the wellbeing of those subject to it. Even though economic arguments are used to defend the current problems in mental health services, this defense is inadequate to defend a call to address the important moral and political issues raised by uses of these services. In an attempt to respond to this call, alternative conceptions of the subject that could be utilised in acute psychiatric services will be considered in the next two chapters.

The next chapter is a detailed analysis of RD Laing's reconceptualisation of problems experienced by acute public psychiatric patients. This counter paradigm to the medical conception of problems is important, as the conceptualisation of patient's problems has implications for treatment in a double sense. Laing's reconceptualisation of psychiatric problems in the light of a person's

biography, not only makes psychiatric problems understandable, but also offers a conceptualisation of the subject as one who is comprehensible in terms of their biography. This alternative conceptualisation raises the question of the way patients are treated at two levels: the question of the appropriateness of biological treatments; and the question of ethics in the way people are treated in acute public psychiatric services in general.