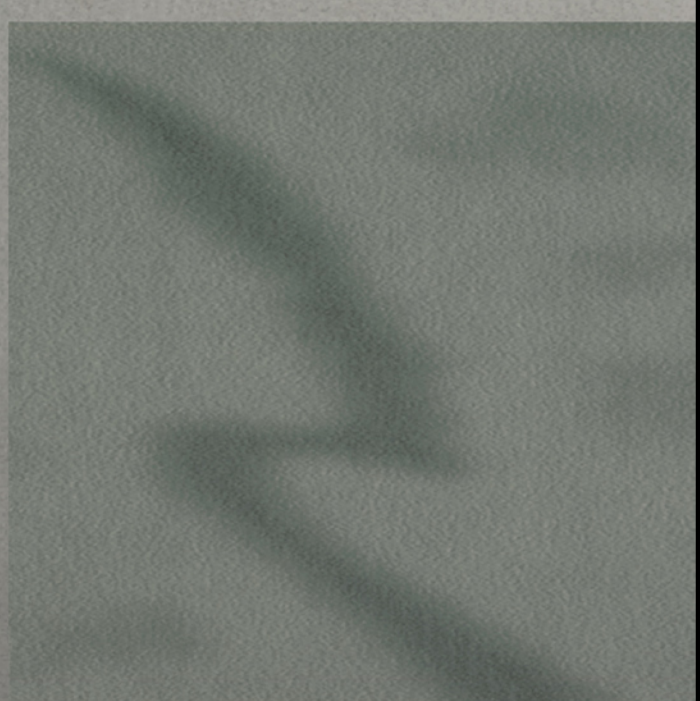
Asylum in the Community

Edited by
John Carrier and Dylan Tomlinson



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In this century psychiatric hospitals have often come to be seen as places of incarceration rather than of true asylum for the mentally ill. At the same time there is a belief that community care policies have brought about a decline in the provision of asylum for some of the patients whose needs were previously met by the psychiatric hospital. This book opens up the debate about how far these views are accurate.

Based on an empirical examination of psychiatric care in the past and the present with an international focus, *Asylum in the Community* critically assesses the concept of asylum and shows how it can be operationalised for services outside the hospital. Drawing on work in the USA, Belgium, Spain, Ireland and England, contributors analyse such services from both user and provider perspectives. From these analyses the editors establish the key elements of asylum that should be considered in developing contemporary community services for the mentally ill.

Asylum in the Community offers a multidisciplinary approach to new directions in psychiatric care. It provides a balanced assessment of a controversial, topical issue for managers and providers of mental health services and those teaching or training in the mental health services.

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This book is dedicated to the memories of Geoff Bromley, whose main concerns were those contained here, and whose contribution to the field was immense, and to Joanne Snooks, desk
editor at Routledge, whose commitment saw the book through to publication.

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Introduction

Dylan Tomlinson and John Carrier

Few would defend the mass-produced care of the large mental hospital, and it is government policy in Europe and America for residential care to be provided on a smaller scale in community care settings. Community care, however, has, of late, been subjected to ever more critical scrutiny. This has led to 'Scull's dilemma' being posed (Jones, 1982). This is the dilemma of those who see institutional neglect being succeeded by community neglect and who thus look in vain for an alternative. Scull suggests in this volume that the dilemma is the dilemma of society at large rather than of mental health care analysts. But whoever it is that faces the dilemma, its existence calls for a reappraisal of the role of the mental hospital in giving asylum, in its truest sense. This book attempts such a reappraisal, from a variety of perspectives, and assesses whether 'true' asylum can be provided in the community.

True asylum as retreat or refuge is a concept that is surprisingly ill-defined. Reparation and even relief from poverty have been argued to lie within its compass. The rather general and often sweeping definitions of true asylum that have been offered in relation to the functions of the mental hospital have tended to lack evidence to support them. To some extent it has been taken as an unquestioned assumption that there has always been, and continues to be, provision of asylum in the psychiatric hospital. A major concern we share with our contributors is therefore to address the lack of evidence to support this claim.

The book begins with an examination of the objectives of asylum for nineteenth-century founders of the 'asylum movement'. It moves on to analysis of case notes and archival material to assess the ways in which the founders' objectives were met, if at all, during succeeding historical periods. In focusing on true asylum we are not primarily concerned with the issues of violence, unpredictability and dangerousness in relation to mental illness. These issues, and their significance for mental health,

have been thoroughly debated in both popular and academic forums elsewhere.

We are raising several key questions in this appraisal of mental hospitals and asylum. Is the gift of asylum disappearing as mental hospitals close down? If so, can asylum be given in non-hospital settings without the institutionalism, neglect and abuse of patients that have tended to occur in mental hospitals? Do users/survivors believe that the concept of asylum has any relevance to their care and well-being?

At the risk of some crudeness in interpreting the chapters of the contributors concerned, we can highlight a very significant debate presented in the book at this point about the perceived loss of asylum presented by mental hospital closures.

REAL OR ARTEFACTUAL LOSS OF ASYLUM?

In Chapter One, Scull provides a succinct account of the decline of the 'retreat' as the form of asylum which early mental hospitals found themselves unable to sustain, under pressure of large numbers of apparently incurable cases. Where humane intentions underpinned the development of these retreats, with benevolence towards the mad a key element in their treatment, such intentions, in Scull's view, do not underpin the contemporary shift of mental hospital care to community care. He considers that community care fails the sufferers of chronic psychosis in particular. This is on account of the social indifference and political liberalism which are associated with a poor development of community care infrastructure.

Scull's account has a familiar feel in its focus on the shortcomings of community care. Raftery's account, on the other hand, has no such familiarity about it. In his view, the idea that there has been any radical shift away from institutional care, and therefore from asylum in that sense, is quite mistaken. Whether social indifference or political liberalism has been responsible for the promotion of community care or not, the situation is quite to the contrary of that suggested by Scull. At least in the British context, the gift of asylum is being used to an unparalleled extent to offer hospital-based shelter and care to the mentally ill, including those with long-term or recurrent disabilities. This has been made possible by continued real increases in the level of funding of mental health services. Scull's argument in this respect, of a community care era having replaced an asylum era, creates a false

impression. Historically, in relation to hospital beds, our contemporary governors are being as generous in their provision and at least as humane as their Victorian forebears. For Raftery, what needs to be explained instead is the rise in asylum provision which took place in the first half of the twentieth century, with provision falling back to more 'natural' levels thereafter, when the rush to community care is popularly held to have taken place. Scull and others have created an artificial polarity between institutional and community care, and this needs to be addressed.

Up to this point, as the reader may be aware, we have assumed that true asylum is synonymous with the retreat aspect of mental hospital care, or the care given in the discrete psychiatric units of general hospitals. But is it? In our own research we could find no commonly accepted definition of asylum. The frequent association of the concept with the mental hospital has of course led to it having taken on very negative connotations in the contemporary period. So often analysts of the mental hospital, especially social scientists, have seen it to be performing a primarily social control function, with retreat being of little, if any consequence. Those who suggest, as we do, that the hospitals provided relief from suffering and a place of safety for some of their residents run the risk of ridicule from such quarters.

The closures of mental hospitals taking place on an international scale have led some psychiatrists and prominent voluntary organisations to argue that true asylum is being lost in the process of large institutions being removed from the mental health care landscape. They argue, as Furlong does in her contribution to this book, that there are beneficial aspects of mental hospital care which can only be provided in discrete campus facilities. Mindful of this argument we asked our contributors to consider whether true asylum, where those experiencing acute mental distress had appealed to physicians, policemen, Justices of the Peace and others for relief by admission to the mental hospital, had been a significant phenomenon in the history of these hospitals, and if so to consider its nature.

In relation to this question we are presenting in this book some instructive contrasts in relation to the history of mental hospitals in Spain, where true asylum does not appear to have been significant, and the history of mental hospitals in Ireland and England, where such asylum does appear to have been so. Martínez Azumendi shows the way in which the religious and political injunctions placed upon the family to care for the chronically sick in Spain have led to mental hospitals being seen less commonly as places for asylum to be sought. The moral

treatment associated with the 'retreat' movement did not affect the Spanish hospitals and families in Spain have tended to experience extreme feelings of guilt if they did not care for relatives suffering long-term illnesses at home. In the post Civil War period, the Franquist dictatorship maintained this pressure on the family to care for their chronically sick at home, and in some respects Spain is an extreme example of this familialism in a western context.

Finnane and Prior, in examining the Irish institutions, which, if only in respect of religious injunctions on the family to care, one would expect to show a relative lack of true asylum giving, find that, quite to the contrary, mental hospitals in Ireland seem to have been popular places of relief-seeking for the mentally ill and their families. Finnane illuminates processes hidden from us by the development of Irish asylums as institutions ostensibly for the compulsory admission and care of what were termed 'Dangerous Lunatics' for the period from the mid-nineteenth to the mid-twentieth century. This legal framework for admitting patients in Ireland indicates that, in theory, most mental hospital residents were placed there because they were dangerous. The framework would thus seem to have ruled out any significant degree of true asylum being given. In practice the law relating to Dangerous Lunatics was subverted to enable the admission of large numbers of the not-so-dangerous. The relationships between society, administrative processes for hospital admissions, and the legal framework for committal allowed for a negotiated refuge to be sought which confounds the received wisdom of Irish patients being primarily 'put away'. Prior's contribution provides some support for Finanne's views. He considers that the social control thesis does not work when applied to the Irish context, where patients appeared to have been entering hospital from a cross-section of society rather than being drawn from a stratum of social undesirables or failures.

In examining the English case we also find case notes evidence of true asylum being a feature of mental hospitals (Chapter Six). We suggest that there were plenty of reasons why terrified and traumatised people who were experiencing severe mental distress would want to be placed in a mental hospital. As Hobbs notes, the East End of London, where most of the patients whose notes we studied came from, had become a metaphor for crime and depravity by the beginning of the twentieth century, with fighting and stealing for bread, work or property commonplace (Hobbs, 1989:105–108). This may go some way towards explaining why a minority of patients requested to be admitted to

hospital while others felt 'fatuously happy' at an early stage in their admission.

We also discuss the issue of whether true asylum is something specific to the mental hospital in our analysis. We suggest that perhaps the key distinguishing feature of mental hospital asylum is that patients are able to remain 'unaccounted for' for extended periods of time. The reason for our using this phrase will be apparent from reading Chapter Six. By it we mean that mental hospital staff allowed patients to remain under their care for as long as they could not present themselves as coherent individuals having some volition in life. In our view this attribute of asylum can be provided outside the mental hospital, and we explore the possibilities of such provision in the conclusion to the book.

The question of whether the concept of asylum can have any meaning or relevance to contemporary users or survivors of services is addressed by Wallcraft. She suggests that users are seeking to reclaim the concept from the clutches of psychiatry so that its 'general meaning' of a place of safety may be reinstated. She argues that the concept can be decoupled from hospital or hospital-like care and be applied constructively to the development of community asylum. Such asylum would not only offer places of safety but also offer a significant degree of control over the administration and evaluation of such places to their users.

Wallcraft's vision is very much at odds with the proposals of Furlong for the provision of asylum in 'havens'—complexes of sheltered accommodation and day care. The Haven concept, first mooted in 1986, has been widely debated. In Chapter Seven, Furlong has re-evaluated the need for such complexes in the light of detailed study of individual long-stay patients' clinical needs for asylum in Friern Hospital. She argues that the placement outcomes for a group of patients who were to have been placed in Haven homes suited to their particular clinical needs, but who were instead resettled in a variety of alternative forms of care not designed for their particular needs, support her original view that provision of separate greenfield care facilities for such patients is required.

While we have made much of Ireland in this introduction, we have not so far mentioned colonialism or racism, which are of obvious importance in relation to mental health issues. The African Caribbean Mental Health Association (ACMHA) has established a sanctuary for those experiencing not only profound emotional crises but also, as a result of their skin pigmentation, being vulnerable to racist treatment and lack of social support. Huka's chapter reviews the development of

this project as a form of asylum in the community intended to counter the racism and isolation which have been well documented as a feature of the mental health experience of African-Caribbean people. Like Wallcraft's community asylum the ACMHA sanctuary is not intended to provide indefinite asylum. This is an issue to which we return in the conclusion.

In that our contributors include not only psychiatrists and sociologists but a survivor of psychiatric services, a health economist, a legal historian, and a psychologist, we feel that this book offers a thorough inspection of the possibilities for asylum in the community. By deploying this interdisciplinary range of contributions we have also been able to take an international view of this issue, through our focus on Ireland, Spain and England. We hope, with our contributors, to have made a modest contribution to the securing of asylum in the community.

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Chapter 1
Asylums
Utopias and realities

Andrew Scull

INTRODUCTION

This chapter provides a series of historically informed reflections on the vicissitudes of the term 'asylum'. The concept has, it turns out, undergone striking changes in meaning over the course of the past two centuries. Originally associated at the outset of the nineteenth-century lunacy reform movement with Utopian visions of institutions that would serve as humane and creative retreats, to which the mad would repair for rehabilitation, the concept acquired darker overtones in the Victorian age, as initial expectations met with disappointment, and what were intended as philanthropic foundations degenerated into more or less welltended cemeteries for the still breathing. In the second half of our own century, such 'loony bins' have come under sustained ideological assault, and the once positive associations of the term asylum have been transformed, via the writing of the sociologist Erving Goffman and others, into something with sinister overtones of the concentration camp. Most recently of all, however, the failure of community neglect masquerading as community care has created renewed interest in the relevance of the more positive meanings that can be attached to the notion of 'asylum'.

IMAGES OF THE ASYLUM

For much of the twentieth-century, institutional psychiatrists have shied away from the term 'asylum'. Even a hundred years ago, the concept's associations with what Ernest Jones called the 'Chubb lock era' in psychiatry were an embarrassment for professionals desperate to escape their public image as little more than custodians of the degenerate and defective, and concerned to emphasise their links with the more

respectable sectors of the medical profession. Hence the eagerness with which alienists sought in those years to relabel their establishments as mental hospitals and themselves as expert practitioners of psychological medicine. In the half century since the Second World War, the reluctance to make use of the older terminology has become even more pronounced. A generation of sociological studies critical of the mental hospital's therapeutic pretensions culminated in Goffman's (1961) denunciation of such places as fundamentally and irremediably flawed. *Asylums,* his book of that title, proclaimed, stigmatised, dehumanised, and systematically disabled the inmates they purported to cure. They were 'total institutions' that, in crucial respects, resembled nothing so much as concentration camps. With institutional care for the mentally ill rapidly falling into disfavour in political circles during the same period, as policy-makers rushed to embrace the mythical vision of a community anxious to re-embrace the mentally ill, the asylum's fate seemed sealed on still another front. Its paymasters increasingly dismissed it as a well-meaning experiment gone wrong, an expensive irrelevance now thankfully to be relegated to the dustbin of history.

In view of its ignominious end, it is difficult to recall how differently the founders of the asylum era expected their creation to turn out. The lunacy reform movement of the early nineteenth century was driven forward, in substantial measure, by a Utopian vision of the possibilities of asylum life. So, far from being 'a moral lazar house' (Coombe, 1950: 376) wherein the deranged were hidden and hope and humanity abandoned, the asylum in the imagination of its proponents was transmuted into the 'moral machinery' through which the mind was to be strengthened and reason restored.

To be sure, the moral outrage that gave energy and urgency to the reformers' efforts was periodically refuelled by trade in lunacy. A series of parliamentary inquiries appeared to provide lurid confirmation of the public's worst gothic nightmares about what transpired behind the high walls and barred windows of the madhouse. The reports of the Select Committees themselves, and the books and pamphlets produced by those agitating for lunacy reform, contained a compelling amalgam of sex, madness, maltreatment, and murder, mixed together in a fashion guaranteed at once to titillate and repel: patients bled and drugged into insensibility; their public display, 'like animals in a menagerie'; unregarded deaths from botched force-feeding and the brutality of uncaring attendants; the corrupt confinement of the sane, amidst the shrieks and raving of the mad; the placing of even those madwomen who retained some semblance of 'innate' female purity and

modesty at the disposal of the lascivious ruffians who served as madhouse attendants; and the ingenious array of 'bolts, bars, chains, muffs, collars, and strait-jackets' madhouse proprietors had devised to coerce a measure of order from recalcitrant raw materials.

At least as vital to the achievement of lunacy reform, however, was the construction of a positive image for the reformed asylum. Here, if its proponents were to be believed, were 'miniature worlds, whence all the disagreeable alloys of modern life are as much as possible excluded, and the more pleasing portions carefully cultivated' (Anon., 1836–1837: 697). Most famously realised by Tuke and Jepson at a Quaker institution, the York Retreat, this novel version of a haven for the mentally ill presented a very different scene to those with occasion to view it.

The asylum was now to be a home, where the patient was to be known and treated as an individual, where his/her mind was to be constantly stimulated and encouraged to return to its natural state. Mental patients required dedicated and unremitting care, which could not be administered on a mass basis, but, rather, must be flexible and adopted to the needs and progress of each case. Such a regime demanded kindness and an unusual degree of forbearance on the part of the staff. If the ideal were to be successfully realised, the attendants would have to be taught to keep constantly in mind the idea that 'the patient is really under the influence of a disease, which deprives him of responsibility, and frequently leads him into expressions and conduct the most opposite to his character and natural dispositions' (Tuke, 1813: 175). Crucial, too, was the moral influence of the asylum's governor. By paying 'minute attention' to all aspects of the day-to-day conduct of the institution, by always setting, through his own example, a high standard for subordinates to emulate in their dealings with the inmates, by observing the patients daily, sometimes hourly, he could foster the kind of intimate and benevolent familial environment in which acts of violence would become rare. Indeed, as the autocratic guiding spirit of the whole curative apparatus, the superior moral and intellectual character of the medical superintendent was an essential precondition for success.

Classification, separation, and employment, all central features of Tuke's version of moral treatment, were to be combined with careful attention to the architecture and physical setting of the asylum. Since it was recognised that the insane were very sensitive to their surroundings, buildings ought to emphasise as little as possible the idea of imprisonment or confinement. Indeed, spacious and attractive

accommodation could make its own contribution to the inmates' 'moral training', and to replacing 'their morbid feelings…[with] healthy trains of thought' (Browne, 1837:191). Treatment could thus be individualised and adapted to the peculiarities of the particular case, and interaction managed and controlled within carefully constructed communities of the mad.

Here was an ideological vision of extraordinary resonance and surpassing attractiveness, of a social universe constituting an organic, harmonious whole wherein even the rage of madness could be reigned in without whips, chains, or corporal punishment, amidst the comforts of domesticity and the invisible yet infinitely potent fetters of 'the desire for esteem' (Tuke, 1837:157). Men like William Tuke, William Alexander Francis Browne, and John Conolly insisted, moreover, that theirs was a 'description…not…of a theorist, or of an enthusiast, but of… practical [men] long accustomed to the management of lunatics' (Conolly, 1838: 74). It was, said Browne (1837:231), 'a faithful picture of what may been seen in many institutions, and of what might be seen in all, were asylums conducted as they ought to be'. Within the controlled confines of the institution, even the irrational and the raving could be reduced to docility and cured of their madness, and by moral suasion and self-sacrifice, rather than by force. With all the fervour of a new convert, John Conolly (1847:143) delivered a panegyric to the new asylum, the place where

> calmness will come; hope will revive; satisfaction will prevail. Some unmanageable tempers, some violent or sullen patients, there must always be; but much of the violence, much of the ill-humour, almost all the disposition to meditate mischievous or fatal revenge, or self-destruction will disappear… Cleanliness and decency will be maintained or restored; and despair itself will sometimes be found to give place to cheerfulness or secure tranquillity. [The asylum is the place] where humanity, if anywhere on earth, shall reign supreme.

VICTORIAN MUSEUMS OF MADNESS

The small, intimate institution which allowed even a remote approximation to this idyll did not survive for long. The influx of a horde of pauper lunatics brought the demise of the notion that the asylum should be a substitute household. Instead, local magistrates insisted on taking advantage of presumed economies of scale, and until

well into the twentieth century, the average size of county asylums grew almost yearly. The degree of regimentation needed to administer institutions of 500, 1,000, and more ensured that such asylums would be the virtual antithesis of their supposed inspiration, the York Retreat. To Tuke, moral treatment had meant the creation of a stimulating environment where routine could be sacrificed to the needs of the individual. Here the same term disguised a monotonous reality in which the needs of the patients were necessarily subordinated to those of the institution; indeed, where a patient's needs were unlikely even to find expression. Hence John Arlidge's trenchant conclusion (1859:102) that 'a gigantic asylum is a gigantic evil'.

At the margin, among those newly admitted to an asylum, turnover remained reasonably rapid, with between a quarter and two-fifths being discharged within a year or so of their arrival. Each year, however, a very substantial fraction remained behind to swell the population of chronic, long-stay patients, and as the size of county asylums grew remorselessly, annual admissions formed a smaller and smaller fraction of the whole. An over-whelming and growing proportion of the asylum population thus came to be composed of patients who lingered year after year; and it was this spectre of chronicity, this horde of the hopeless, which was to haunt the popular imagination, to constitute the public identity of the asylums, and to dominate Victorian and Edwardian psychiatric theorising and practice. Despairingly, W.A.F.Browne viewed the collapse of the vision he had once propagated of the asylum as a curative establishment under the weight of 'a vast assemblage of incurable cases' (Crighton Royal Asylum, 1857: 8). Their numbers ensured, he said, that

> The community becomes unwieldy; the cares are beyond the capacity of the medical officers; personal intimacy is impossible; recent cases are lost, and overlooked in the mass; and patients are treated in groups and classes. An unhealthy moral atmosphere is created; a mental epidemic arises, where delusion, and debility, and extravagance are propagated from individual to individual, and the intellect is dwarfed and enfeebled by monotony, routine, and subjection.
>
> (ibid.)

As asylums silted up with the chronically crazy, those Browne dubbed 'the waifs and strays, the weak and wayward of our race',[1] so Victorian psychiatry moved steadily towards a grim determinism, a view of

madness as the irreversible product of a process of mental degeneration and decay. The madman, as Maudsley put it, 'is the necessary organic consequent of certain organic antecedents: and it is impossible he should escape the tyranny of his organization' (Maudsley, 1879:88). Insanity constituted nothing less than a form of phylogenetic regression —which accounted, of course, for its social location and for the lunatic's loss of civilised standards of behaviour and regression to the status of a brute. Maudsley rhetorically asked,

> Whence came the savage snarl, the destructive disposition, the obscene language, the wild howl, the offensive habits displayed by some of the sane? Why should a human being deprived of his reason ever become so brutal in character as some do, unless he has the brute nature within him?
>
> (Maudsley, 1870:53)

Employing ever harsher language which combined a physiological account of madness with 'the look and tone of moral condemnation', (Turner, 1988:179) psychiatric discourse now exhibited a barely disguised contempt for those 'tainted persons' (Straham, 1890:337) whom it sequestered on society's behalf. And within such a world-view, given that the notion of mass sterilisation never acquired the status of a serious option in Britain,[2] the asylum was naturally accorded a wholly new significance in the battle to contain social pathology and to defend the social order.

Local authorities were always reluctant to spend 'extravagant' sums of money on the poor, and the funds for a predominantly custodial operation were predictably scarce, rarely more than what was needed to supply a bare minimum of care. Occasionally, indeed, the cheeseparing went too far, as in Buckinghamshire between 1916 and 1918, when the official dietary tables for St John's Hospital suggest that a male patient's daily food allowance provided only 40 grams of protein and 750 calories a day (which may be compared with what is now estimated to be a minimum requirement for a sedentary man of 60 grams of protein and 2,100 calories). Female patients received even less. With a deliberate policy of semi-starvation carried to this extreme, the result (as J.L. Crammer, 1991:76–77, 113, 126–127, has noted) was a very sharp increase in asylum mortality rates, till in 1918, a third of the asylum population died in the space of twelve months, a denouement which finally shamed the authorities into action and led to limited improvements in the patients' diet.