Managed Detours: The Strategic Organization and Management of Social Problems

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The impetus for this piece came about as I was completing social historical research on mental illness in Northern Ontario for my doctoral thesis. I had undertaken research in the archives of Ontario and had included in my thesis a critical ethnographic study wherein I interviewed fifteen people who had been diagnosed with or experienced a period of mental illness. I also interviewed fifteen people who had worked with, cared for, or delivered services to those considered to experience various mental health conditions. One of the most interesting ruptures I found was in the understandings of what mental illness is from each of these perspectives. The phenomenology of mental illness or madness, when considered from the experiences of people who identify or who have been identified with mental disorders, or as having mental illness, continues to raise interesting questions about human experience and meaning production. As well, what has been called mental illness, when considered within social historical contexts, calls for a thoughtful and critical analysis of the ways in which people have historically been separated, quarantined and ostracized from their societies, both geographically and socially. Indeed, in the contemporary moment, a diagnosis of what is called schizophrenia often comes with a prognosis of social isolation

and frequent hospitalizations, even for those so diagnosed who have good family and social support. I include in this piece excerpts from a person so diagnosed. Many of the people I interviewed spoke of the place of drugs or alcohol in either ameliorating or exacerbating the experience of mental illness, some to the extent that addiction to alcohol or drugs had become a secondary or concurrent diagnosable illness. I use the terms madness and mental illness and other descriptors as people, in my experience, generally self describe using a variety of terms.

The main point I want to focus on in this paper is that to live with what is called mental illness in post-modern society is to live also within the echo of a historically misunderstood phenomenon, a phenomenon that has also been the focus of science, charity and most recently, an industry of mental health. To this end I will discuss some attempts and successes of social reformers in 19th century to scientifically categorize and classify prisoners, habitual drunkards and those considered deviant. I will open up also an exploration of the latest classification system which considers consumers, survivors and addict/alcoholics under the same system of delivery of services.[1] The 19th century social reformist strategy and the current provincial integration of services strategies have relied on ideas of normal, moral and functional behavior which can be explored through a post-structuralist lens of power / knowledge relations. I have done this to some extent in other works.[2] In this paper, I will limit the discussion to the parallels of social reform in 19th century Ontario and the evolution of the consumer

[1]Ontario's Local Health Integration Networks, *Highlights of the Local Health System Integration Act, (2006),* Retrieved 11 March 2012 from ‹http://www.lhins.on.ca/legislation.aspx›.
[2]Moira Ferguson, "*Tracing Paths: A Critical Ethnographic Study of Mental Illness in Northern Ontario*," Comprehensive Examination paper (Sudbury, Ontario: 2009).

model of health service delivery at the end of the 20th century in Ontario, with a focus on disrupting the discourse of mental illness.

The Search for Madness

Michel Foucault writes in *History of Madness* that, "In the midst of the serene world of mental illness, modern man no longer communicates with the madman: on the one hand is the man of reason, who delegates madness to the doctor, thereby authorizing no relation other than through the abstract universality of illness; and on the other is the man of madness, who only communicates with the other through the intermediary of a reason that is no less abstract, which is order, physical and moral constraint, the anonymous pressure of the group, the demand for conformity."[3] Foucault points to a parting of the way, in terms of conversation, between the madman and the man of reason; a space wherein the voice of psychiatry may step in and clarify what is madness and what isn't. "The language of psychiatry," he suggests "…is a monologue by reason *about* madness."[4]

The rupture in conversation between the madman and the man of reason, to which Foucault directs us, began in Ontario with the physical separation of one from the other and the creation of spaces specifically built to house those people called old, feeble-minded, imbecilic, and lunatics. Certainly the treatment of many of these people within their communities cannot be said to have been kind or humane, but their removal from society, often far from their communities, began the silence, curiosity and myth making that surrounded many institutions.

[3]Michel Foucault, *History of Madness* (Routledge: NY, 2009), p. xxviii.
[4]*Idem*

Indeed, as Foucault suggests, psychiatry claimed its voice in these times and madness began to be talked about with authority rather than 'common sense'. One's neighbor was no longer described as 'not right in the head' or as 'having fits'. There was language for these conditions and a place for treatment. Ontario's first of many hospitals for the reception of the insane opened in 1841 at a temporary location in Toronto's York jail; in 1850, it was moved to 999 Queen street and was known from then until 1871 as the Provincial Lunatic Asylum.[5] This asylum became known as 999 Queen Street and is known infamously by this name by many, despite its having been renamed as 1001 Queen Street. In 1846, and until 1905, all such institutions were known as lunatic asylums. These institutions were under the management of a superintendent and were regularly inspected by the Inspector of Hospitals for the Insane.

In Ontario, from the 19th century institution building phase to the present, mental illness has been dealt with as a social problem at worst and as a curiosity at best. Insanity and lunacy had long been the subjects of morbid fascination. An 1848 Globe and Mail column reports on the Annual Lunatic Asylum Ball. Attendees, in letters to the editor describe the events of the social evening. On February, 23rd, 1848, 'Spectator' writes of receiving his much anticipated invitation to the Ball and his subsequent visit to the Insane Asylum. "About 9 o'clock", he writes, "the lunatics withdrew to partake of some refreshments, and the visitors having got over the feeling of sadness, which naturally pervades the mind in contemplating such a number of shattered intellects, enjoyed themselves in a set of quadrilles. Wishing to see

[5]Archives of Ontario, retrieved in 2009 from ‹www.archives.gov.on.ca/english/collections/index.aspx›.

as much as possible of the insane, we accompanied them down stairs, and watched their movements with tolerable closeness."[6]

The tone of pity in 'spectator's' letter, however condescending, is reflective of many of the public and political speeches that bolstered the agendas of social reformists. The insane lunatic and the imbecile were, for spectators and others, pitiable creatures. Whether motivated by compassion, the appearance of compassion, or concern for the soul, the lunatic presented a body upon which one could find repentance, political opportunities and the demonstration of reasonable and rational process as well as charity.[7] Lunacy appeared as a subject to be discussed through the establishment of laws and through constructions of what constituted good and rational behavior, often read as moral and functional behaviour.

One of the more vocal and successful reformists of the nineteenth century was John Langmuir. Langmuir was a gifted rhetorician who wrote successful proposals year after year. Richard Splane, professor emeritus in the School of Social Work at the University of British Columbia, Vancouver, credits Langmuir with widespread social reform. "Year after year" writes Splane, "during his fourteen years as inspector, Langmuir presented superbly prepared proposals that won governmental acceptance for new or enhanced programs in corrections and mental health, new facilities for the deaf and blind, and support and direction for a wide range of voluntary social welfare and health services under the Charity Aid Act."[8]

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[6]*Globe and Mail* Feb. 23rd, 1848 Canada's Heritage from 1844, retrieved from Laurentian University, (2009).

[7]For more on the theory of redemption through care, see Guenter Risse, "*Mending Bodies: Saving Souls*" (New York: Oxford University Press, 1999).

[8] Francis J. Turner, *Encyclopedia of Canadian Social Work* (Waterloo: Wilfred Laurier University Press, 2005), p. 210.

Langmuir began his long career with the intention of building a facility to house habitual drunkards. *The Fifth Annual Report of the Inspector of Asylums, Prisons & Charities* discusses the establishment of 'Inebriate Asylums'. Langmuir was most successful in both helping to establish a classification system by which to sort out society's institutionalized population and in maintaining institutional systems for the whole time of his tenure and beyond. One of the goals of reformists such as Langmuir was to determine a more humane and rational approach to the treatment and management of people, whether the fault was determined to lay in their genes or in their habits. Page 35 of the 5th Annual Report begins "…the statements and opinions which have been cited here are sufficient to prove that the plan of treating drunkenness as a *disease,* and of establishing hospitals for its cure or amelioration is not chimerical or impracticable…." The author continues in his case for such an institution:

> "And last of all the establishment and maintenance of an Asylum of this character falls within the true sphere and work of the Government. It would be pre-eminently an institution of *public utility*, as the evil against which it would contend is pre-eminently a public burden and calamity. The degree of disease, idiocy, insanity and crime directly and indirectly caused by drunkenness, and the extent of the pecuniary expenditure out of the public funds together with the decrease and limitation of the general wealth thus occasioned are simply incalculable."[9]

Consequently, a committee, named the Select Committee appointed to enquire into the development of a Plan for the Control and Management of Habitual Drunkards, considered and agreed to a lengthy study at this time. Among these agreed to items was that 'the great evil of drunkenness' could be attributed to 'higher wages and shortened

[9]Fifth annual report of Asylums, Prisons &c., for the province of Ontario, 1871-1872 printed by order of the legislative assembly. Toronto: Hunter, Rose & CO., 1873, p. 35.

hours of labour' (pg35 ibid.). It is also noted and agreed to in this Report that the problem of habitual drunkenness does not seem to be as prevalent in agricultural districts."[10]

One of Ontario's first inspectors, Langmuir made it his life's work to scientifically and rigorously study the nature of vice to better understand how to manage and classify the ever growing asylum population. Early eugenicists as well as mental health reformers sought the solution to what were considered emerging social and moral problems in classification and rehabilitation. Langmuir was at the tide of this wave, and can be read as standing on the moral/pragmatic side of reform. The underlying ethic was one of early to bed, early to rise philosophy which saw idleness as a breeding ground for 'vicious' behavior. In his attempts to classify the many types of people held in the provinces asylums, prisons and charitable institutions, and to suggest various effective methods of rehabilitation for each, Langmuir set up a committee to inquire into the nature of vice.[11] Much attention was given in this study to the types and reasons for crime; the idleness associated with shorter work weeks and the move from agricultural to industrial communities were cited as contributing to the general depravity of those with a propensity for vicious behavior. Among the contributors to Langmuir's and his Commissioners' study was Havelock Ellis author of *The Criminal* (1891) who suggested that there were classes of criminals, those being political criminals, (the victim of a despotic government), criminals by passion, insane criminals, instinctive criminals, and occasional criminals.[12] Of these, the instinctive criminal and the insane criminal

[10] *Idem*

[11] Report of the Commissioners Appointed to Enquire into the Prison and Reformatory System of the Province of Ontario, Toronto 8th April 1891, Ontario Sessional Papers Vol. 23, Vic. 54, (no. 18) - 1891 Warwick and Sons, Toronto, 1891) p. 35..

[12] *Idem*

received the most colourful and speculative analysis. The instinctive criminals, for Ellis, "in their fully developed form are moral monsters in whom the absence of guiding or inhibiting social instincts is accompanied by unusual development of the sensual and self-seeking impulses…."[13] The insane criminals, suggests Ellis, "being in a condition of recognizable mental alienation perform some flagrantly anti-social acts…."[14]

Langmuir was not without the ability to think critically and must be read within both the political and social contexts of that time. However he can also be read as a particularly pragmatic and strategic liberalist in his distribution of funds and his plan to sort out first the classes of people, in relation to the greater society, and then the treatment of people, according to available institutions. His plans for the specific use of institutions were not always immediately successful. His report of 1877 indicates that a building constructed to house inebriates was actually used to take in the overflow of "chronic cases of insanity of a mild type, to be drawn from the Asylums at Toronto, London and Kingston."[15] Langmuir's social reform and his excellent ability to write persuasive proposals, although not always successful went some way in fortifying the use of the institutional spaces in such a way as to demonstrate their usefulness. Why let people (bad people) idle away when they could be put to practical use in institutions and could provide a profit for the province (good, hardworking people)?

The Report of the Commissioners also complemented the prevailing ideology of punishment as discipline. Prison wardens report almost

[13] *Idem*
[14] *Idem*
[15] Langmuir, J.W. 10th Annual Report of the Inspector of Asylums, Prisons and Public Charities for the Province of Ontario, 1877, Toronto: Hunter, Rose & Co., 1878), p. 6.

gleefully on the availability of rock piles to be hammered down by inmates. Once the institutions were built they now had to be kept. Finally, Langmuir situates the causes of insanity, and of criminality in the person, not an unusual philosophy for his time. He wanted to ensure that the institutions were being used for their intended and specific purposes, having gone to great lengths to ensure that people were sent to the institution which would provide them with a scientifically calculated treatment; rest and discipline for the habitual drunkard and toil and discipline for the pauper and the criminal. He cautions against the practice by some people of handing family members over to the care of the province when it was not warranted. Langmuir described a process wherein the cause of insanity was ascertained by information given by witnesses such as family, a process which is hindered, as Langmuir saw it, by the commitment of lunatic's under the warrant of the Lieutenant Governor.[16] A person guilty of nothing more than outrageous behavior such as spending or promiscuity, as well as those who had become a financial burden could be sent to institutions with enough pressure from family members or, as was often the case, dissatisfied husbands.[17] Langmuir believed that it was too easy to obtain the Lieutenant Governor's Warrant and for the sake of humanity and prudence, the process should be changed to avoid the abuse of the institutions. This was, in part, why Langmuir wanted more control of the classification system. The method he proposed, a rigorous and rational inquiry calling on known experts in the treatment

[16]Report of the Commissioners Appointed to Enquire into the Prison and Reformatory System of the Province of Ontario, Toronto 8th April 1891, Ontario Sessional Papers Vol. 23, Vic. 54, (no.18)- 1891 Warwick and Sons, Toronto, 1891) p. 35.

[17]For more on this explanation, see Thierry Nootens, "*To be quiet, orderly, obedient and industrious: La normalité dans le district judiciaire de Saint-François entre 1880 et 1920 d'après l'interdiction des "malades mentaux"* (Québec : 1997).

of criminals and insane persons, would go some way toward establishing a system of classification, management and control.

In discussing the nature and genesis of crime, the Commissioners suggest that "these vices however, are in many cases the roots or germs of the greater offences called crime."[18] It is here that Ellis submits his thoughts on the causes of crime, and brings the focus back to the weakness of character present, in varying degree, in each of the classes of criminals. Ellis is quoted extensively in this document, the Commissioners explain because he "…expresses the views of a large and important section of those who make the causes of crime a special study."[19] One of the witnesses, in addressing the question as to the causes of crime, the Report explains, suggested that " …the tendency to cause crime is hereditary as are the formation of the body…"[20] This witness, a 'specialist of considerable observation and experience' , theorized that "…mankind as a whole is steadily progressing, that each generation adds to the stock of general knowledge and thus contributes to the improvement of the race, but that some do not keep pace with the march of civilization."[21] As to the prevalence of children of criminals who lead 'honest, virtuous lives' this witness suggested that it was only a matter of time until these committed some crime. This unnamed witness states that "…the only effectual mode of repressing or reducing crime was to shut up all the criminals, so that they could do no further mischief and could not propagate

[18]Report of the Commissioners Appointed to Enquire into the Prison and Reformatory System of the Province of Ontario, Toronto 8th April 1891, Ontario Sessional Papers Vol. 23, Vic. 54, (no. 18)- 1891 Warwick and Sons, Toronto, 1891) p. 35.
[19]*Idem*
[20]*Ibid.*, p. 37.
[21]*Ibid.*, p. 37.

their kind."[22] Clearly, a eugenic philosophy was at the heart of the inquiry in much the same way that prevailing philosophies, about work, about functional roles, about quality of life, about class, lie at the heart of even the most pragmatic of policy decisions in the present time.

By the time of the 1891 Report of the Commissioners, Langmuir already had a well-developed career in social reform. He continued his efforts to establish a social science of the classification of types of people ending up in institutions. In the case of the causes of insanity, which was also discussed in the 1877 10th Annual Report of the Inspector, a 'scientific' approach, again based on eugenics was used. A number of studies are used in these reports which point to the presence of insanity in the families of criminals. The family of Margaret Jukes is offered as an example of the worst case of hereditary criminality and insanity. The Jukes-Edward case was cited often in the early days of the eugenics movement. Margaret Jukes is said in the Report to have been responsible for '200 descendants who were criminals, besides great numbers of idiots, drunkards, lunatics, paupers and prostitutes."[23]

The method used was to trace the family history for evidence of insanity, drunkenness, prostitution, idiocy or lunacy. ``The Jukes: A Study in Crime, Pauperism, Disease and Heredity", written by Richard Dugdale and published in 1877, was written for the Prison Association of New York, and was the result of inquiries into county jails and state prisons. The study was used to strengthen the case for degeneration theory and to stress the necessity of classification, institutions and moral

[22] *Ibid.*, p. 37.
[23] Langmuir, J.W. 10th Annual Report of the Inspector of Asylums, Prisons and Public Charities for the Province of Ontario, 1877, Toronto: Hunter, Rose & Co., 1878), p. 6.

reform. Mr. Vaux, another `well-known student of criminal science` is quoted from the report of the inspectors of the State Penitentiary of Pennsylvania, 1887. Vaux is quoted as saying, ``… inherited crime cause and a crime class, the result of hereditary taint, are already demonstrated. The statement given (a statistical table), proves that many persons are criminals by reason of transmitted moral defects of character peculiar to families and traceable to transmitted conditions."[24] Eugenic theory was used extensively in sorting out the likelihood of both criminality and insanity. Of course, there was no Margaret Jukes. She and her offspring were born in eugenic imagination. We can picture her though, as an apt description has been provided of her behavior. She is slovenly, toothless, and either too fat or too thin. She is surrounded by wailing children, clinging to her stained dress while she clutches a bottle of liquor with one hand and grasps the belt buckle of a rough looking male companion with the other. This person cannot be allowed to breed. This person must be locked up and her brood must soon follow.

Langmuir reflects darkness in his writing of this period. He writes, with provincial pride, of the new asylums that have been erected. Asylums continued to be built or added to during this period largely due to the belief, commonly held and substantiated, at least in sheer numbers, that there had long been a need for institutions to which families could send their blind, deaf, dumb, elderly or insane relatives. The buildings were always full to capacity so it is hard to argue that families were at the mercy of a great plan of institutionalization carried out by an oppressive and overly zealous provincial leadership. As soon as they were built, they were rapidly filled. The physical structures erected during this time were ominous and foreboding. Beyond this, they

[24] *Idem*

soon generated webs of myth and stories of the sheer terror of madness. This part of the discourse of madness, perhaps unreason taking its voice, is very much part of our cultural and social present.

The Mental Health Consumer and the Psychiatric Survivor

Despite the stigma attached to mental illness, the consumer/survivor movement continues to flourish. Consumer/survivor initiatives or CSIs struggle to define themselves and their *raison d'être*. CSIs are usually run by and for people with lived experience of mental illness. These organizations offer a place for people with lived experience of mental illness to volunteer, work or in other ways participate with others who have similar lived experiences within the mental health system. They stress the need for consumer/survivors to have their own places and their own voices. They offer an alternative to the medical system. Like complementary medicine, which stands somewhere between allopathic medical practice and naturopathy, CSIs strike a philosophical bargain between a strictly medical model of mental illness and a social construction model of mental illness. In essence, CSIs make an argument for social inclusion for those with mental illness and for the reduction of barriers to society for people with lived experience of disability.

Still, it is hard to join up. It is hard to 'come out' as mentally ill or as alcoholic or addicted, even though these categories are medically sanctioned. The paradigm that joins 'consumer' and 'survivor' suggests an easy and natural relationship but it actually erases the separate trajectories of each movement. To some, perhaps to Don Weitz and others who identify strongly as psychiatric survivors of the system, consumer/survivor might roll off the tongue about as smoothly as

sandpaper.[25] In other cases, the consumer model as a movement has learned to make peace with the psychiatric system, adopting some of its language, some of its ideologies, some of its policy decisions and accepting some re-channeled funding.

Historically, psychiatric survivors vehemently refused funding. Somewhere, the survivor movement acquiesced and became part of the new health delivery service model. It is an interesting history of social outrage, social justice and compromise. The survivor and the consumer and the alcoholic are three separate entities. Once upon a time, all deviants, the compliant and the non-compliant, the lunatic and the drunkard were housed together, the idea being that society must be defended in the same way against all public nuisances and immoral influences. At present, mental health and addictions agencies are funded under the same governing and policy making body. In this relatively new political framework, people who use mental health services take up and either resist or internalize the ideology of the dominant discourse. In Ontario, the reforming of categories in the newest model began approximately 30 years ago, with the restructuring of health care delivery services focused on indentifying gaps in the delivery of health services. [26] A provincial policy analysis paper outlines the challenge for the government between the late nineteen fifties and the late nineteen seventies:

> "Between 1959 and 1979, the province of Ontario closed 7,000 of its 11,000 provincial psychiatric hospital beds. Since that time the mental health policy debate has revolved around what to do with the remaining provincial hospital beds and the hospitals themselves, general hospital psychiatric programs and community mental health programs. Often

[25]For more on Don Weitz, see "Call me Antipsychiatry Activist- not 'Consumer'", *Radical Psychology*, Spring, 2002 (online: http://www.radicalpsychology.org/vol3-1/don.html)
[26]Robert Graham, "Building Community: A Plan for Mental Health Reform in Ontario" Ontario: 1988.

> referred to as the three solitudes, these components of what should be a mental health system have historically not been well connected."[27]

Public service announcements claim that we are all affected by mental illness in some way, that there is nothing to hide. However, in more subtle ways, through the media, through dominant ideologies which reward competition, the message is implanted; if you are not achieving success, in relationships, at work, in your cycles of sleep and rest, the error, weakness or misfiring neuron is in you. This individualization subtly points the lens of surveillance toward the self and away from the socially constructed environment. We would perhaps do well to take seriously the fear and bewilderment that defines the present. Psychiatry, still cloaked in mystery and esoteric language and often experienced as coerced obedience, offers solutions for sleeplessness, impotence, sadness, and existential musing gone a step too far. The new discourse of mental illness rewards consumption especially as the consumption of mental health services maintains a flourishing industry.

When one enters the mental health system, one becomes part of a system that thrives on maintenance rather than cure. At the top of this hierarchical system, at least if understood in terms of power, money and access to knowledge are psychiatrists, administrators, social scientists, policy makers, pharmacists and funding bodies. Somewhere in the middle layers are social workers, counsellors, occupational therapists, rehabilitation specialists, and most recently methadone counsellors or addiction specialists. Nearer the bottom of this hierarchy are the 'troubled people' of what Joseph Gusfield has called the troubled person's industry.[28]

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[27]Steve Lurie, "Comparative Mental Health Policy: Are there Lessons to be Learned", ‹http://www.toronto.cmha.ca/ct_PDFs/articles/sl_comparative_mental_health_policy.pdf› retrieved 2010.

[28]Joseph Gusfield, "Deviance in the welfare state: the alcoholism profession and the entitlements

As the brief history of the search for madness and consequent treatment of those deemed to be mad shows, ideas about mental illness are tethered to historical frameworks which create binary relationships between moral traits and vicious traits, between good genes and bad genes. What has come to be called mental illness came into the social world as a problem to be solved and quickly became conflated with deviance and viciousness. What was built up or conceptualized to promote or at least to work in tandem with the eugenicist goals of a new world served also to differentiate normal from pathological, and to 'rigorously' classify one from the other. In Canada, this dichotomous relationship thrives in the contemporary moment on an ideology in which to be healthy means to contribute to the process of producing and consuming. Historically, social reform as a project in Ontario conceptualized mental illness through a discourse of deviance, wickedness and immorality. The contemporary corollary of this discourse serves to maintain and create a binary system of mental health consumer and expert advocator in a multi-layered system of surveillance and self surveillance. *Non-compliant* has replaced *wicked* and terms such as schizophrenia continue to suggest deviance and unreason. I include here an excerpt from a recent ethnographic interview, wherein a person describes the experience of living with a diagnosis of schizophrenia:

> Morag: And then the next diagnosis… treatment was ten years later, '94 I had a span of no treatment for anything but the doctor at the uhh…. it was another psychiatric referral and she gave me a diagnosis of schizo-affective disorder and once again a treatment of anti-psychotic and antidepressant both… yeah that was in'94
>
> M: Did you have any ideas about that term, schizo affective, did it mean anything to you?

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of stigma", in *Research in Social Problems and Public Policy*, vol. 2, (1982), p. 1-20.

Morag: Well it was a disconcerting diagnosis because as she explained it to me I had a delusion of reference… I was incorporating events around me into a central play that was psychotic….. so I didn't like it… I tried the medication for a while and I don't know it made me stupid dumbed me down which I guess is the idea of the anti-psychotic to get rid of those higher end thoughts

M: Okay and so do you have any idea about what that word meant to other people… how did your family react?

Morag: No. They didn't know. I was single at the time and I didn't really tell anybody… I didn't like the word schizo ……. sounds like psycho

M: Tell me a bit more about that….. those words…. guess that's what I m trying to get at… where these words come from and what they mean to us

Morag: Well for a person with a mental illness diagnosis anything with the SKZ in it… sound ….is offensive like schizophrenic or schizoaffective

M: How it that… what is that experience of having that diagnosis?

Morag: It's because they're hard it's like an axe an … an axe has been blunted into your personality that says you got an skz …..it's not a happy diagnosis ….. but the bi-polar as opposed to the manic- depressive that's a nice soft diagnosis… it's not offensive

M: Oh geez……okay

Morag: But anyway the bipolar diagnosis came two years after the schizo-affective diagnosis… the company doctor at ****sent me to the psychiatric consultant they had at **** … Dr. **** ….and together they came up with the diagnosis…… bi-polar based on the pressure of speech presentation I was giving… rapid talking … many high end manic events associated with the bi-polar high.

M: Okay….. And how was that….. I don't know if I've ever heard such a good description…..like the one was like an axe it's a good description…how is the bi-polar diagnosis softer

Morag: Well that BP is just a nice sound it's like British Petroleum …. a trusted gas station…….hmm? …..a trusted gas station…. It's a trusted….it's a trusted diagnosis

M: Trusted? The diagnosis is trusted or the person with the diagnosis?

Morag: Well the person who receives that diagnosis *can* be trusted but if you have an SKZ you *can't* be trusted….bi-polar is more of an intellectual fragmentation…..instead of like….an SKZ always implies a dangerous personality ….the…. so intellectual fragmentation is easier with the bp… um…yeah so I like that

M: Okay….how about the MD?

Morag: The MD? The Manic Depressive?

M: Is it the same as bi-polar or different … a different sound? Different meaning?

Morag: No as long as it's got that …like AK or SK ….

M: AK?

Morag: Formulation manAK … Depressive…. it's just umm……it sounds dangerous again like a manic depressive sounds……. and people perceive that as… mania….. manic ……. Maniac……maniac and psycho…if you get those two connotations out of the lingo it's easier on the person with the diagnosis to make it all soft….it's easier to wear that badge…

M: Okay…okay

W: Although if you have a bi-polar illness and you have a long period of unmedicated activity it can be dangerous in that you come up with very complicated schemes to fit your hypo-mania … so a soft um a softer diagnosis but it's one that's easier to hide into if you're up to something

M: Okay….it makes sense

Morag: Not really …it's psychotic but….. in the thinking of the mental illness so

M: So with these diagnoses….um you have your own perception about what they meant….yes….does it matter …you said it's easier to wear that badge but why is it easier if no one knows you have it

Morag: Well word gets out your family and friends who do find out they tell other people and what happens is you do become socially isolated because people think 'geez buddy's got a mental illness there and he could snap…. there could be a bad scene or we might have to share the burden of something untoward or illogical even devious in our social milieu' so you do become socially isolated because people are afraid….. with any one of those the…. a soft one or a hard one people are afraid

M: Do you think it's just a physical thing or what else do you think people are afraid of?

Morag: Every so often you read in a newspaper that a SKZ or BP does kill someone out of either an unmedicated rage scenario or a mental deviation ….that's what people are afraid of is that there's something there that is unexpected and unpredictable and cannot be trusted …….. do not associate with openly because it is dangerous….in the percentile….. like people….. as soon as you get a diagnosis there is a danger for other people on a percentage basis…like you just can't be trusted[29]

The Survivor Movement

The psychiatric survivor movement had a radically different origin than that of the consumer movement. In some ways, the consumer movement came out of the need to share funding and to close identified gaps in services during the nineteen eighties.

[29] Personal Interview, 2009.

Among funding issues that came about during the Harris government's social spending cuts of the nineteen seventies in Ontario were the duplication of services and gaps in services.[30] It was thought that the community mental health model could address these issues by collecting the identified needs of mental health consumers (even if they preferred to be called survivors) and those with addictions. In Northern Ontario this model now sees mental health and addictions services under the auspices of 14 Local Integrated Health Networks or LHINs. In terms of funding, LHINs provide the same kinds of services to the same kinds of consumers. One may enter this system by way of a health or a mental health crisis, and may then be channeled through a series of community service programs which ensure long term involvement and dependence on the health care system. The main point of analysis of this paper is the subsuming of the very different and radical goals of psychiatric survivors, self support groups and other truly independent movements under the rubric of "consumer" and all that term implies. Consuming in the community mental health model can be indicative of compliance. The consumption of medicine, of definitions, of ideologies, of therapy, of services is often perceived as "getting better" or actively participating in one's recovery.

The term "consumer" as it has been applied to consumers of mental health services or users of mental health services came out of the collective activism of the nineteen sixties and nineteen seventies, consumer advocacy as a social movement and the "needs assessment" projects of the nineteen eighties. Human rights activism in the nineteen sixties and nineteen seventies in Canada saw black people and people of

[30]Steve Lurie, "Comparative Mental Health Policy: Are there Lessons to be Learned," ‹www.toronto.cmha.ca/ct_PDFs/articles/sl_comparative_mental_health_policy.pdf› retrieved 2010.

colour, lesbian, gay, transgender and bisexual people, and queer people, women and "disabled" people collectively demanding Human Rights.[31] Around this time, ex- patients or self described ex-inmates of psychiatric prisons[32] began to tell their stories and to self describe as psychiatric survivors. This was not the first time in Canadian history that people confined against their will had told their stories. Clifford Beers in *A Mind That Found Itself* [33] described the cruel treatment he underwent at the hands of attendants of a New Haven mental hospital. Beers established in America the National Committee on Mental Hygiene which later partnered with the Canadian Mental Health Agency.

Sally Clay, one of the first consumer advocates, writes of her first experiences doing consumer advocacy work with the Alliance for the Mentally Ill (a group of family members of consumers) and the Consumer Coalition. Clay writes of being invited to speak at the public hearing of the Office of Mental Health. Given a copy of the rights and regulations included in a document said to spell out the rights of patients confined to state hospitals, Clay was outraged to find in the document rules of behaviour for staff when faced with clients who would not comply with what was asked of them. There was, writes Clay, no mention of rights for patients.[34]

[31]Bonnie Burstow open interview on AIDS/Gays/Lesbians on CKLN (audiotape 75) Psychiatric survivor archives ‹www.psychiatricsurvivorarchives.com/ 1989›.

[32]Don Weitz, "Notes of a Schizophrenic Shitdisturber" (audiotape 92) Psychiatric survivor archives ‹www.psychiatricsurvivorarchives.com/›

[33]Clifford Beers, *A Mind That Found Itself: An Autobiography* (Pittsburgh: University of Pittsburgh Press, 1980).

[34]Sally Clay, "A Personal History of the Consumer Movement" (no pagination).

There are critical distinctions to be made in the motivations and trajectories of the first organized groups of ex-patients. They did not call themselves consumers but survivors and they refused any government funding. In the United States, these activists called themselves, among other group names, the Insane Liberation Front, Mental Patients Liberation Front, Network Against Psychiatric Assault, Project Acceptance, and Mental Patients Alliance.[35] After years of protesting, these early activists, at least in the United States, writes Clay, eventually began to organize around offering services, rather than protesting treatment of psychiatric patients. Certainly, anti-psychiatry movements and conferences continue to critique and challenge the discourse of psychiatry, often now with a focus on pharmaceutical interventions. Historically, acts of nonviolent civil disobedience were acts of resistance against specific intrusive psychiatric treatments such as bed-strapping, confinement and electroshock treatment. A conference in Syracuse, New York saw psychiatric survivors block the doors of Benjamin Rush Psychiatric Center as an act of resistance against shock treatment.[36] This was, in America at least, the day the music died. From here on in, and by no means taking a straight path to complacency, those protesting the treatment of people said to be mentally ill continued to organize and to hold conferences and protests, but as the movement became more service oriented, consumer/ survivor initiatives and drop in centers became the focus for many people who had 'lived experience' with the mental health system. Even Clifford Beers had recognized the wisdom in recognizing that he who pays the piper calls the tune. Still radical psychiatric survivors such as Don Weitz continue to speak out. Indeed, anti-psychiatry is the focus of the Psychiatric Survivors Archives

[35] *Idem*

[36] May 23-24 Tribunal -11th Annual International Conference for Human Rights and Against Psychiatric Oppression (Syracuse NY, 1983).

of Toronto, a grassroots organization which collects and maintains artifacts, interviews and all information pertaining to the period of psychiatrization in Canada from the institutional period to the present.

Time and again, movements, and attempts by ex-psychiatric survivors to band together to provide non-professional support and help in transitioning from hospital to community have been co-opted or taken over by professionals. In essence, when the troubled and disturbed mentally ill attempted to make sense of their lived and shared personal experiences and their lived and shared mad and psychiatric history (some caring more or less about the latter) they often found only funded organizations (of diverse mandates). These often relied, among therapies, on psycho-social rehabilitation, a technique born out of the recognized need to reintroduce institutionalized people back into the communities from which they had been removed. Psycho-social rehabilitation, and rehabilitative therapy more broadly understood often highlight the psychological (or physical) as problematic and erase the social as problematic, contending that the person in need of service needs to learn how to get along.

The consumer as a political entity began to take shape in the late nineteen eighties when "the three solitudes" of psychiatric services, beds and community services were attempting to better utilize resources.[37] After decades of protesting treatment at the hands of psychiatry, ex patients in Canada and in the United States were now demanding to be heard. The demand of ex-patients to participate in their own treatment decisions and the identified needs of the government to use most

[37]Steve Lurie, "Comparative Mental Health Policy: Are there Lessons to be Learned," ‹www.toronto.cmha.ca/ct_PDFs/articles/sl_comparative_mental_health_policy.pdf› (retrieved 2010).

prudently and efficiently the resources they had could be said to represent a happy coincidence. A more critical analysis recognizes the turn from psychiatry as an industry to mental health as an industry. Psychiatry had acquired a long list of indictments by the end of the nineteenth century and well into the present, with charges of wide scale institutionalization, physical and mental experimentation, torture and abuse. One therapeutic intervention of psychiatry in particular, psychoanalysis, was taken up by mainstream pop psychology. Talk therapy is widely known as the therapeutic tool of the hippie generation which embraced transactional analysis and free for all psycho-social encounters. This move from the psychiatrist's couch to the encounter with self and existence, could have represented a pivotal moment in the history of mental illness, had it not been for the professionalization of even one's encounter with one's self; social work, social service and psychology took over where psychiatry left off, asserting that human beings, especially disturbed human beings, were not to be left to themselves.

One could perhaps liken the late nineteen seventies and eighties to a trade show for the mental health industry, with professional bodies of various strata claiming expertise and ownership of mental illness. Mental illness as a product was proving to be lucrative indeed. Psychiatric survivors went as far as to claim that their own experiences with mental illness or madness had been manipulated and exploited. How could this moment fail to have been realized; a moment when mentally ill human beings would claim their own experience, without professional rephrasing and analysis and from there decide what treatment they would have? The moment is not yet over, but it is a question that will not be answered here. In some ways, the radical notions of patients, survivors or ex-psychiatric inmates, along with those who identified as mental health consumers were linked to the recovery movement.

Consumers and some survivors saw the commonality of their experiences and some of the sting was then naturally taken out of the angry activism of the survivor. Tethered to the consumer, who saw a need for the mental health services and quite compliantly consumed medicine, services and ideas, the survivor was tamed to a great extent.

The term consumer starts to be readily found in mental health policy papers around the time that community programs are being funded. In fact, outside of policy papers, the term just starts to appear. One would assume that the term has come out of the social activism of the nineteen seventies mentioned earlier.

The consumer, the survivor and the chemical substance abuser share a common social and historical past. Once seen as one and the same, the lunatic and the habitual drunkard were the subject of many public and private discussions. This is the institutional and ideological history from which the consumer, the survivor and the chemical substance abuser or addict/alcoholic emerge. Certainly, the move toward community involvement can be said to have benefits and perhaps even to promote and enhance mental health. The challenge is in recognizing that the concept of mental health is a moving target, historically defined from a concept of normality which has an equally tainted history in eugenics. The happy move to community mental health should not be had at the cost of the erasure of the historical trajectory which saw anything outside of normal as deviant and in need of repair of rehabilitation.

As recently as 1988, the human mind or the brain provoked imagery of esotericism, secrecy and even Mad Scientists. David Reville and Kathryn Church, writing of user involvement in mental health services, re-capture for us the image on the cover of Maclean's magazine in

1988, *The Scientists Who Are Unlocking the Brain's Mysteries.* Reville and Church suggest that this might be "reflective of a general trend in medicine toward specialized, high-cost, technological solutions…" wherein mental disorder was "… a scientific problem to be solved primarily by engineers and equipment."[38]

Church's and Reville's analysis of user involvement in mental health services situates the first of ex-inmate writings around the end of the nineteen seventies. *Phoenix Rising*, a distinctly antipsychiatry publication was among the first of the antipsychiatry publications. The quarterly was founded and published by a Toronto self help group called On Our Own.[39]

At about the same time that self-described ex-psychiatric patients began to form groups and to write about their experiences in the psychiatric system, there was a backlash in the media and a return to the practice of vilifying those involved in crimes whenever it was known that they had a history of using the services of the psychiatric system. Church and Reville, writing in 1988, describe the image of the psychiatric patient or user of mental health services.[40] The psychiatric patient is frightening and unreasonable and should not be legally allowed to make decisions concerning his or her treatment. The user of mental health services, while not quite conjuring up images of a mad man frothing at the mouth, shot gun in hand should, it is subtly suggested in nineteen eightie's news stories, be treated with caution and should certainly not be given any position of authority or leadership.

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[38]Kathryn Church & David Reville "User Involvement in Mental Health Services in Canada: A Work in Progress," University of Sussex, International Conference on User Involvement in Mental Health Services, 1988.

[39]*Idem*

[40]*Idem*

Historically, the discourse of mental illness included the use of words and images meant to conjure up fear when more institutions were wanted. This discourse was powerful and persuasive enough to be grounds for many, who were diagnosed as mentally ill, to be denied the right to determine their own course of treatment, and for many to be sent to spend the remainder of their lives in over-crowded institutions. The insurgence against psychiatric power in the nineteen eighties sought to dislocate the dominant discourse, which having taken on a distinctly medicalized lexicon, effectively shut out the voices of all but those taking pleasure in authority. Critical investigations of both the discourse of mental illness and the social relations involved in the mental health industry disrupt these images created by words and ask what, and for whom, they are being created.[41]

[41] Some of the ideas and themes from this piece appear in my upcoming thesis, titled "Tracing Paths: A Social Historical Ethnography of 'Mental Illness' in Ontario".