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Scull's Dilemma

KATHLEEN JONES

Few psychiatrists now take a lively interest in the social sciences, and few social scientists listen to what psychiatrists have to say. For the handful who do, the widening gap between the two fields of knowledge is regrettable, for we have much to learn from each other. The gap seems to have grown for two reasons: psychiatrists, increasingly occupied with pharmacotherapy, have drawn closer to general medicine, and there is comparatively little interest in the social therapies which seemed to offer so much promise back in the 1950s. The open-door system was a success, and so was the idea of community care, even if the practice left much to be desired. Incidentally, these developments destroyed many of the interesting experiments in group dynamics which were at one time a feature of mental hospital life. Social workers, once seen as allies, went off on their own in the new, powerful and largely incomprehensible Social Services Departments, where they had many other tasks to occupy them. Sociologists became shrill and hostile. Many psychiatrists ceased to read sociology after the publication of Goffman's *Asylums* (Goffman, 1961) because it seemed that sociology was off on some kind of ego-trip which was deeply antithetical to their own professional experience. People who talked about "madness" instead of "mental illness", rejected diagnosis as labelling, and regarded mental patients as victims of a capitalist plot were (and are) difficult to talk to. One of the distinguishing features of mental health reform over the past 200 years has been its apolitical nature—people of all political views could agree on what seemed essentially a matter of common humanity. Suddenly it became highly politicized, both in theoretical terms, since the new analysis was basically neo-Marxist, and in the action of pressure groups in the Civil Liberties lobby. Confused by the Right to Treatment, the Right to Refuse Treatment, the Right to Information and the Right to Confidentiality, most psychiatrists have (wisely in the circumstances) kept their heads down and got on with the job.

What has all this to do with Scull, who is Scull, and what is his dilemma? That is quickly told. Andrew Scull is an associate professor of sociology in the University of California, San Diego campus, and the latest in a line of radical sociologists who have studied the mental health services, or, as they would prefer to put it, the social control of madness. He has written two books with rather tendentious titles—*Decarceration*, published in 1977, and *Museums of Madness*, published in 1979. The first marshalls the evidence about the inadequacies of community care in Britain and the United States, looking at both prisons and mental hospitals. The second deals with the evils of institutional care in British asylums in the nineteenth century; and the dilemma, which he does not make explicit, but which one can only hope will be the subject of another book, is simply this: if it is wrong to get patients out of the mental hospital, and wrong to keep them in, what are we to do with them?

Scull expresses the problem twice, once in a nineteenth century setting when he notes that "those who sought to improve the lot of the pauper insane, but who were dubious about the merits of the asylum, were in an impossible bind" (Scull, 1979a); and once when he writes, in connection with present-day problems:—"One can, indeed I think must—be deeply sceptical about claims made on the mental hospital's behalf; yet one must not fall prey to equally groundless fantasies and illusions about the available alternatives" (Scull, 1979b).

Scull's significance in the present context is that he is the only scholar who has made a thorough study of the literature of the mental hospital, both the building up of the system in the nineteenth century and its partial destruction in the twentieth, since the publication of *A History of the Mental Health Service* (Jones, 1972) and since this was based largely on earlier work, (Jones, 1955, 1960) he is a whole generation later. He has been over many of the same sources, but of course has had access to more up-to-date ones as well; and because he is a sociologist rather than a historian, and developed his trade in the strident seventies rather than the liberal fifties, he writes in a different tradition.

Vieda Skultans, in *English Madness* (Skultans, 1979) takes the view that we are on the opposite sides of a great intellectual divide and attempts to reconcile us. This is scarcely necessary. While, on the whole, the

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History of the Mental Health Services stresses the fact that the lunacy reform movement of the nineteenth century involved benevolent emotions and altruistic action, it is also clearly stated that much of social policy is dictated by the less admirable motives of social control or saving money (Jones, 1972). Scull, as a revisionist, puts these factors first, but he is not unaware that human beings do have humane and compassionate impulses (Scull, 1979c). Only the emphasis and the language are different.

This paper has two purposes: first, to examine the kind of critique which Scull and his contemporaries are offering, and how far, behind the somewhat excessive language, there is a serious argument; and second, to put that argument into perspective with other kinds of policy writing about psychiatric practice. We shall not resolve the dilemma—there are no technological or administrative rabbits to be pulled out of the hat which can achieve this—but interpretation and marshalling of the issues connected with settings for psychiatric care may at least lead to a better quality of discussion.

The first hurdle to get over is the curious and sometimes offensive terminology of the radical sociologists. Why do they talk about "decarceration" when other people talk about "community care"? Why do they say "madness" instead of "mental illness"? Why do they keep emphasising "social control" when most psychiatrists are concerned with care and treatment? Is this just a matter of a trendy, in-group terminology, or does it have meaning?

The term "decarceration" means the opposite of "incarceration"—getting people out of prison or prison-like institutions. The term is Scull's, but the thought behind it comes from Michel Foucault, the French philosopher, who has greatly influenced sociology in the past two decades. You will not find "decarceration" in the Oxford English Dictionary. Foucault's second major study of institutions, *Surveiller et Punir* (the English version is called *Discipline and Punish*) is largely about prison régimes, but by implication about other kinds of institutional life as well (Foucault, 1975). Foucault uses the verb "*décarcérer*" and he describes the prison as "*la cité carcérale*". Neither of these words appears in my French dictionary, either. In sociology, the use of "decarceration" has three merits: it shows that one has read Foucault; it shows that one is a radical; and it expresses a belief that what the official view calls "community care" is merely a matter of getting people out, not of providing an adequate service for them. Scull describes it as ". . . shorthand for a state-sponsored policy of closing down the asylums, prisons and reformatories. Mad people, criminals and delinquents are being discharged or refused admission to the dumps in which they have traditionally been housed . . ." (Scull, 1973a).

Elsewhere he quotes with approval from Gary Wills' *The Human Sewer*. Many patients live "in our culture's human sewer, clogged and unworkable with human waste . . ." (Scull, 1973b).

Scull calls this "forceful and brilliant writing", and that is a matter of taste. Perhaps it seems less excessive if we remember that the reference is to the decaying inner cities of the United States, where conditions are immeasurably worse than anything one can find in Britain. One of the confusing things about the radical sociologists is that they also borrow from Lévi-Strauss—in the "synchronic" tradition, material from different cultures, different periods of history and different countries is juxtaposed in order to shock and to reveal new features of similarity (Sheridan, 1980a). So the Atlantic, which some of us find quite a wide stretch of water, shrinks to the size of a puddle.

This "synchronic" tendency provides a partial explanation of why the radical sociologists talk about "madness"—the changes which have taken place in the care of the mentally ill mean far less to them than the similarities; and "mentally ill" or "mental illness" is taken to imply two things: a mealy-mouthed, woolly liberal failure to look reality in the face, and an acceptance of the medical model of treatment.

I would like to add one other factor which I think is less frequently recognized. Goffman never uses "mad" or "madness"—he writes about "mental patients", "persons labelled as mental patients", "mental hospitals". The use of "mad" or "madness" seems to be consequent on the publication in 1961 of the English translation of Foucault's *Folie et déraison: histoire de la folie a l'age classique*, as *Madness and Civilisation*—the translator having chosen to render "folie" as "madness" rather than as "folly" or "foolishness".

But when all allowances have been made, the language of Scull and the radical sociologists is still excessive. It seeks to jolt us out of our alleged liberal complacency by being arresting: it often ends by being merely off-putting. For instance, Scull writes "A *state-sponsored* effort to *de-institutionalize* populations has become a central element in the *social control practices* of . . . *advanced capitalist societies*" (Scull, 1973c).

"State-sponsored" shows that he is suspicious of Government and its intentions, "de-institutionalize" shows that he is writing about the American scene, "social control" shows that he is a radical non-interventionist and "advanced capitalist societies" that he is on nodding terms with the neo-Marxist critique. Had he written "*Public efforts* to develop *community care* have been a central element in the

social policies of *western industrialised countries*", the sentiment would have been unexceptionable, but no sociologist worth his salt would have listened to him.

Perhaps we can now turn from how Scull writes—and his style may strike readers as mildly distressing, not only on grounds of literary taste but because while it guarantees him one audience, it loses him another—and pay some attention to what he says.

The first jolt is that, though he is clearly aware of the existence of labelling theory (in fact he spends several pages of *Decarceration* outlining it for the benefit of his readers) (Scull, 1973d) he uses labels himself without apology. Thus, he writes of "younger psychotics" leading "a nightmare existence in the blighted centres of our cities crowded with prostitutes, ex-felons, addicts, alcoholics, and other human rejects now *repressively tolerated* by our society" (Scull, 1973e).

If toleration is repressive, what is repression—tolerable? And how can anyone taught in the social sciences in the past twenty years use these stigmatising terms? The answer is, of course, that pure labelling theory—the belief that one must never affix labels to human conditions—had a relatively short life, because if there are no labels it is almost impossible to have a discussion at all. Other writers, such as Geoffrey Pearson in *The Deviant Imagination* (Pearson, 1975) have pointed to the inherent sentimentality of a view which assumes that all the deviant's problems are caused by "society", and none by his own actions; and some of the new wave, like Scull, react into the use of labels which are unacceptable to the liberals of social policy, who are really rather careful in what they say about people.

The second jolt is that, despite all the abuse which is heaped on the heads of those responsible for the existing services, Scull is capable of a thoroughly nineteenth century defence of the institution:—"It may well turn out that the protection an institution offers the community from the deviant and the protection it offers the deviant from the community are of equal importance" (Scull, 1973f).

So we are back to the traditional functions of the mental hospital—custody and sanctuary. It is sometimes appropriate to treat people in an institutional setting if their actions make them a danger to themselves or to others—which is not very different from what the Mental Health Act says. We can only conclude that Scull is the radical's radical, or the revisionist's revisionist. He is so far in front of the field that he has ended back in the liberal camp. Let us make him welcome, because he has something useful to tell us.

What Scull does—what any sociologist does—is to search for social explanations and his particular search area leads him to look for the answers to two questions: why did the asylum system develop in the nineteenth century? And why have we tried to knock it down in the twentieth?

On the first of these questions, he is admittedly rather muddled. He spends a good deal of time in opposing "a naïve, Whiggish view of history" in which the story of the growth of the asylum is seen as one of social progress, and thinks that the view that this was a matter of humanitarian concern is "grossly distorted and misleading" (Scull, 1979d). He spends too much time on the "urbanization" argument—that is, the argument that asylums grew up because the cities could not support or contain lunatics in the way in which villages once did, and it is not quite clear whose argument he is attacking, because there is no reference to any historian who said that the growth of asylums could be neatly correlated with population statistics on city size: and having demolished this Aunt Sally to his satisfaction he then falls for the equally generalized view that ". . . just as surely as urbanization, the market when given its head destroyed the traditional link between rich and poor which had characterised the old order . . . (and) sharply reduced the capacity of the lower orders to cope with economic reverses" (Scull, 1979e).

If the old order was breaking down it had been in the process of doing so for at least four or five centuries, as some of the "naïve Whig historians" (Tawney, for example) could have told him.

But by page 256 of *Museums of Madness*, he has developed a shrewd enough picture of how the asylum doctors built up a new profession, and its rather difficult relationship with general medicine because of the lack of a specific knowledge-base in psychiatry: and he is prepared to entertain "The revival, albeit in a more sophisticated and seductive modern guise, of the traditional meliorist interpretation . . . if the *results* can hardly be applauded, the benevolent *intentions* remain" (Scull, 1979f).

The asylum doctors, it appears, were not such bad chaps, after all.

On the process of knocking down the mental hospital, however, he takes the argument further: he describes how the new pharmacotherapy of the 1950s provided psychiatry with a specific knowledge-base, quoting Sir Keith Joseph's confident statement that "people go into hospital with mental disorders and they are cured" and looks for explanations of why the impact of pharmacotherapy may have been overestimated.

These are not far to seek: a policy which was open to thorough-going commercial exploitation by the drug companies, offered an escape from some of the most intractable problems of psychiatry, brought the

practice of psychiatry closer to that of general medicine, seemed to work like magic, appealed to patients (many of whom preferred taking tablets to the more tedious and self-revealing kinds of treatment) *and* reassured Sir Keith Joseph was bound to be popular. But whatever the merits of the psychotropic drugs, they cannot be held solely responsible for the run-down in mental hospital beds, because this is part of a much wider picture of de-institutionalization: in both Britain and the United States, the retreat from institutional provision has extended into fields unaffected by the drug revolution: non-institutional forms of provision have been equally sought after for the inmates of geriatric wards, prisons and hospitals for the disabled. Only a fraction of these populations will go into the miniature institutions which are called community Homes because local authority and voluntary places for residential care are relatively few in number.

The strategy for reducing institutions has some disquieting features, as Scull points out. Services have been fragmented and decentralized to the point where it is impossible for them to be properly monitored or evaluated and we can no longer have confidence in what is termed "territorial justice"—that is, that the services available in one part of the country will be available in another. Changes seem to be deliberately left vague and open-ended—this deprives the opponents of change of a focus, because they cannot define what it is they are opposing. The old system is destroyed before the new one is created, and without any sort of guarantee that the new system will provide an equivalent service. Small model schemes are much publicised and praised, without any consideration of whether they can be extrapolated to other settings. Scull's study of the complete shutting down of all state facilities for juvenile offenders in the state of Massachusetts between 1969 and 1973 is a classic account of how this process works, and worth studying by anyone interested in the present state of psychiatric practice in Britain (Scull, 1973g).

And of course, much of this is admitted in the introduction to that Government White Paper oddly entitled *Better Services for the Mentally Ill* (DHSS, 1975). Mental illness is described as "a major health problem—perhaps the major health problem of our time". Mental hospitals are on their way out, but "some will continue in use for many years" though staffing is often "less than adequate" and "basic facilities and amenities are often lacking". Social services facilities—hostels, day centres, group homes—"have to be built up from their present minimal levels", but the demands which the mentally ill make on the community "must not be more than the community can accept". The effects of pharmacotherapy are imperfectly understood, and there is much debate as to whether they are purely palliative, suppressing severe psychological and social problems. There are acute problems with violent patients, and not enough secure units. "What, then", asks the Secretary of State, "are we to do?" Scull's Dilemma could scarcely be better put.

It is important to note that the dilemma is not just confined to monetarist administrations—though the run-down of institutions is obviously popular to the present governments in both Britain and the United States, it started long before that, and has been enthusiastically supported by the radical Left. Nor is it just confined to periods of extreme economic stringency—the determination to reduce institutional populations took effect in the early 1960s, in a period when steady economic growth was taken as axiomatic, and no-one foresaw the oil crisis. In Britain at least, the key to the story of the failure to provide seems to lie in an event now nearly thirty years behind us: the House of Commons debate on the Mental Health Services of February 19th 1954, initiated on a Private Member's motion by Kenneth Robinson. On that occasion, the Government spokesman, replying to charges of outdated mental hospital buildings, outdated practices and minimal provision, described the situation as "an appalling legacy" and said that replacement was "not a question of a few million pounds . . . (but) a question of thousands of millions over many years" (Parliamentary Debates, 1954).

The thousands of millions were not available then, and are scarcely likely to be available now. What happened instead was that the policy-makers began casting round for less costly solutions; and they soon had additional reasons for doing so. Labour costs increased with unionization, which meant higher wages and shorter hours for staff. The patients' rights movement led to higher demands, and to the withdrawal of patient labour, on which mental hospitals depended to keep their costs down; and, in an age of media scandals and media pressure, mental hospitals were all too visible to the outside world, a constant reminder of poor quality provision, a constant drain on the social conscience.

The whole situation became unmanageable, and a new solution had to be found. In America, Community Mental Health Centers were founded as a specialist answer to comparable problems. In Britain, we had a developing network of general medical services and generic social services, and, as Scull points out, the opportunity-cost of *not* using this network to carry mental health provision increased sharply (Scull, 1973h). The result was the 1975 White Paper's "ideal scheme"—not to be in full operation until well into

the twenty-first century, but based on the concept of the "primary care team" composed of general practitioner, district nurse, health visitor and social worker, who would carry responsibility not only for the physical well-being of their patients but also for their mental well-being. The snag is, of course, that the members of the primary care team are trained in physical health care, but not in psychiatric care.

Dr Anthony Clare and I disagreed some years ago (Jones, 1979; Clare, 1980; Jones, 1980) on the subject of whether it was appropriate to use a service delivery method based on general medicine to carry psychiatric care, and in the course of the argument I wrote that it was like asking the coalman to deliver milk. This caused great confusion in the United States, where there are no coalmen and one buys milk (preferably skimmed) in the supermarket; but it was interesting to know that Americans were following our debate, and that they too are very conscious of Scull's Dilemma, and seeking a way out of it.

In the present state of research and statistical evidence, it is unlikely that the argument with Dr Clare can be resolved. Each of us can give anecdotal evidence. Each of us can quote examples of practice which support our contentions. The fact that we differ may have something to do with the fact that he is a psychiatrist and I am a social scientist; perhaps he sees the successes, and I see the failures. Or it may have something to do with the fact that he lives in the south, and I live in the north; but mere assertion, based on personal experience, is not going to resolve the issue. The problem is that mental health statistics are now in total disarray. The last detailed *Mental Health Enquiry for England and Wales* was published in 1976, with 1975 figures. The Royal Commission on the National Health Service (1979) does not consider the psychiatric services as a separate entity. *Health and Personal Social Services Statistics* is still published, but the most recent figures for mental illness are those for 1978; and none of these statistics gives us any picture of how patients move through the fragmented services, what kinds of help they seek, how useful services are, or what the outcome is. Equally, none of these statistics has any reference at all to the services of the primary care team.

Research based on individual administrative units—hospitals, clinics, day centres and so on—is no longer definitive (if it ever was) because we do not know what the other variables in the patient's life-situation are. What happens in the family, in the work-place, in contacts with neighbours and friends may be as important, or more important, than what happens in mental health agencies. Until we mount major studies to find out what patients experience, we cannot resolve Scull's Dilemma in realistic terms.

An American policy analyst from Berkeley, Dr Aaron Wildavsky, puts the issue in a wider framework. He writes of "the Five De's" which have characterized social policy in the past twenty years: Deinstitutionalization, Decriminalization, De-education, Demedicalization and Decentralization (Wildavsky, 1980a). All these have their counterparts in England. Decriminalization is the process of trying to reduce the prison population in the face of evidence that our rehabilitative techniques for preventing recidivism do not work: it varies from crime avoidance techniques like better burglar alarms to the most punitive policies for proving that crime does not pay. De-education is a response to the discovery that "no known technology or productive function will turn teaching inputs into cognitive skills"—that is, that the tremendous expectations placed on education as a means of social engineering have not been fulfilled. Schools and universities in Britain are feeling the impact of "de-education" now, as the financial cuts take effect and teachers and dons are sent into exile. Demedicalization is the retreat from the view that good health is largely a matter of adequate medical care, and that "delivery of health services" can ensure it: "Except for the classic public health measures of sanitation and inoculation, and a few major medical procedures, only people themselves can maintain and help improve their own health. In a word, Mother was right. You should eat a good breakfast every day; you shouldn't smoke and you shouldn't drink; you should sleep seven or eight hours a day, and not four or fourteen; and you shouldn't worry, because worry is bad for you" (Wildavsky, 1980b).

This may sound like basic medical advice; but one has to add to it the sharp attacks on the medical profession, and on psychiatry in particular, which were a feature of Ian Kennedy's Reith Lectures, now published as *The Unmasking of Medicine* (Kennedy, 1980) and Anthony Flew's *Crime or Disease?* (Flew, 1973). Decentralization is the key to the other four De's. By allowing local differences to occur, it is possible to abandon national standards and national responsibility.

Wildavsky may be right in his contention that all this occurred in a "strategic retreat on objectives". The objectives of the humanitarian and idealistic fifties—maximum care, maximum understanding, maximum opportunity, maximum health—were set so high that they simply could not be reached, and they have been an embarrassment to governments ever since. Public expectations grew too fast, and had to be checked; but, he adds, "the retreat from objectives may become a rout" (Wildavsky, 1980c).

That is why we must not forget Scull's Dilemma. Of course there are good mental hospitals and good

community care services, new experiments and original ideas; but the spirit of the times is against them. If they are to be more than islands of hope in a sea of public apathy, we need to reassert the objectives, perhaps in a more limited and attainable form, and to provide systems of monitoring and evaluation which will tell us whether we are achieving what we intend. The mental health services are too easily sent to the bottom of the waiting list, too susceptible to rhetoric and wishful thinking, to the "word-magic" of public pronouncements. A clear recognition of what is happening, and why, may be the first step to recovery.

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Kathleen Jones, *Professor of Social Administration and Social Work, University of York, Heslington, York YO1 5DD*