COMMENTARY

INVITED SUBMISSION

Same Brush, Different Strokes: A Commentary on "Improving Long-Term Psychiatric Care: Bring Back the Asylum" by Sisti, Segal, and Emanuel.

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Situating the discussion

Sisti, Segal, and Emanuel (2015) have critiqued the idea of the de-institutionalisation practices that have swept the psychiatric world, followed by the move to embrace more community-based, integrated models of care and rehabilitation for psychiatric patients. The authors trace the history of the movement, albeit without discernible reference to the ground-breaking Basaglia (1989) work in Italy. The authors noted how "formerly institutionalized patients who self-identified as "psychiatric survivors" had developed alternative models of peer-facilitated community treatment such as Fountain House in New York City" (Basaglia, 1989).

Their paper expresses frustration and concerns about "mental health" issues in North America, and justifiably so, but the authors' proposed approach to psychiatric healthcare arises from the same framework of thinking which has spawned both "institutionalism" and "de-institutionalism". The paradigm is arguably misguided in that it presents a distorted understanding of ourselves and the world and serves to keep questions about psychiatric care endlessly circulating within an "either-or" orientation - as is evident in contemporary framing of psychiatric debate: "institutionalisation" *or* "de-institutionalisation".

This unhelpful paradigm arises from a metaphysical view of human-being that is deeply entrenched in Anglo-American thinking, and it is a view that underpins all neo-liberal practices. It has set up an alienating discourse of rugged individualism within which people are reduced to and treated as self-contained "entities", each with their own "internal economy". This discourse tends to translate the complex phenomena of being human into functional accounts of "the human subject" as hedonistic consumer. However, these accounts are only able to yield an instrumental and impoverished understanding of our situation here, as being-in-the-world–with-each-other (hyphenated to emphasise that we are fundamentally and inseparably discursively embedded creatures (Heidegger, 1927/1996). It has created a place where even "biology" ("*bios*" = *life*; "*logy*" = *an account of*) gets reduced to abstracted functionality and "life" itself becomes a metaphysical conundrum for us.

When an individual exhibits a mental health problem within this framework of thinking, it is seen as a manifestation of an "internal" or "underlying" dysfunction that is inherent within the person. On this basis, sets of individualistically-oriented mental health interventions become the "logical, rational response". These dominate the menu of possible responses, regardless of whether this is inside or outside a psychiatric institution, because within this paradigm, the underlying assumptions in both settings are the same. It therefore keeps us circulating within this "either-or" orientation. When we move in this way, we tend to hit up against the same problems again and again, with the only real difference each time seeming to be that "the parting on the left becomes a parting on the right" (Townshend, 1971), so to speak.

So this paradigm creates problems for all concerned in healthcare settings, whether in a hospital or a community. Its reductive orientation inclines us to try and separate human-being into different "components" - "biological", "psychological", "social", "spiritual" - that *appear* to constitute us when we take up and try to live this way of thinking. With such delineations "fixed" in place, we attempt to conduct medical assessments and interventions geared towards the accurate identification and correction of the "variable" that is deemed to be the "root cause" of the suffering that we witness. Foucault noticed how such an approach makes it easy to lose sight of ourselves. He remarked: "paradoxically, in

relation to that which he is suffering from, the patient is only an external fact; the medical reading must take him into account only to place him in parentheses.[1]" This creates a confusing and disorientating space for everyone, as individuals become bracketed from families, families become bracketed from communities, and communities become bracketed from the socio-political contexts within which they are embedded.

Amidst these fractures and fragments, it becomes very difficult to keep track of what is going on for all concerned, particularly for those who are suffering. In our efforts to seek, categorise and treat within this disorienting paradigm, patients can be inadvertently "lost" as we continually cycle from one intervention to the next – whichever side of the "parting" these interventions lie on.

Same brush, different strokes

The authors are concerned that:

> Deinstitutionalization has really been transinstitutionalization. As state hospitals were closed, patients with chronic psychiatric diseases were moved to nursing homes or to general hospitals where they received episodic psychiatric treatment at significantly higher costs. Others became homeless, utilizing hospital emergency departments for both care and housing. Indeed, the current crisis in Nevada—where the lack of psychiatric beds has resulted in overcrowded emergency departments filled to capacity with psychiatric patients—may be a harbinger of the future. Most disturbingly, US jails and prisons have become the nation's largest mental health care facilities. Half of all inmates have a mental illness or substance abuse disorder; 15% of state inmates are diagnosed with a psychotic disorder. Recent studies show that prisoners with a serious mental illness are 2 to 3 times more likely than prisoners without serious mental illness to be reincarcerated. (Sisti et al., 2015)

This observation very appropriately underscores a pertinent example of the individualistic way of thinking that frames and justifies all Anglo-American ways of knowing human beings, and the exclusionary ways of life that such a framework then constitutes. When people cannot fit into its regimes, they become excluded, either by falling somewhere into the margins of "mainstream" life or by being incarcerated in one institution or another.

This exclusionary paradigm is frustrating for the people who find themselves within it, as patients or clinicians. Clinicians find themselves in the challenging position of having to sustain patients, themselves and care teams across the "service divides" that this isolating and reductive way of thinking has inadvertently set up when it parcels "human (well) being" into apparently discrete (and seemingly endless) areas of "functioning" (Gillett, 2008). Thus, our healthcare system is divided up into, for example, psychiatry, neurology, endocrinology, cardiology, orthopaedics, gastroenterology, immunology, and so on. Experts in each "field" then attend to each of these "functions" in silos that are sometimes operationally and financially isolated from one another. These service divides are often more reflective of administrative boundaries rather than the reality of human wellbeing/health and, as such, they are not necessarily grounded in how things are for us as real people. Such bureaucratic landscapes lose sight of the fact that human reality is full of serendipitous happenings and messiness. It is impossible to hold this humanity well within an administrative system that is not really built for attending to human life.

These service divides collectively bring about and sustain a place that is not really inhabitable or bearable on a long term basis for anyone. The high levels of clinician "burnout" in healthcare may be explained by this paranoid (that is, "organised and rational", but nevertheless *insane*), parcelling of the world and human-beings along detached - even if "professional and caring" - functional lines. This approach is more framed by the delusion of efficiency, and the dehumanizing thought that every being has a *use* rather than an *existence* to be celebrated (Deleuze & Guattari, 1980/1987). However, the lines along which we organise ourselves are often "lines in the sand" laid out according to a set of distorting ideas (such as the ideal of the preference optimizing consumer underpinning the diverse delusions of certain political psychoses) that can be moved in favour of more helpful ways of framing things, even if they often evoke the "Remember the Alamo" spirit which sometimes digs in and will not budge.

Understanding humanity

To understand and attend appropriately to human existence we need to understand our human way of being, and how human life unfolds. When we do so, we notice that we are all discursively embedded (shaped by and enmeshed within the language and practices of our time), within a matrix of inter-related activity that connects us to one another and the world we inhabit, in a reciprocal way. For example, I can only be a mother in relation to a particular child in a particular family or community setting. How well I perform in this role depends upon the ways in which I have been cared for and brought into the world by others, as they inculcate me into and support me in sustainable practices of motherhood. My performance is therefore intimately related to how well the larger social structures regard the significance and value of motherhood. This is all conveyed to me through the language we use to articulate my life as a phenomenon, for me a lived subjectivity. These larger social structures in which we are embedded constitute the world that we inhabit: it is a place of significance in which things matter to us in a particular way. We are held in place – that is, *held in being* - by our relationships with others - relationships in which (if we are fortunate) we are continually nurtured and sustained.

Who we become is a matter of who we interact with in our shared world. As our identity is formed within and held within a community of others, it is important that our social structures are empowering and restorative. When we are valued by the families and communities that we find ourselves in, most of us are protected from psychiatric problems or "maladies of the soul" (Gillett, 2009). Our human condition of being-in-the-world-with-others is the background condition for making sense of ourselves and the things we do, enabling us to find a place in that world that is liveable and sustainable. Given that this is the kind of situation we need as human beings, it makes sense that it is also going to be the kind of

situation that needs to be cultivated if we are to get back on track when things go awry for some of us.

The authors have remarked that:

> A better option for a person with serious mental illness is assisted treatment in the community. For potentially dangerous patients, there is early indication that mandated outpatient treatment saves states money. In New York City, after 2 years of mandated outpatient treatment, service costs for individual patients were reduced by half. (Sisti et al., 2015, p. 244)

This is an instance of "holding in being" in a way that it is not linked to a regime of exclusion, discipline and punishment but rather grounded in a context of inclusion and responsive attention to the individual and what is going on - both for her and those around her. It is an example of how funding decisions *should* be evaluated, i.e. in terms of how well they contribute to fostering a social order that is committed to restoring people and situations to *wholeness*. This is so important when we realise that we are creatures whose existence here is a complex inter-relatedness, and that there are many ways in which we can come adrift. We can be assailed by adversities such as: divorce; the death of a loved one; the erosion of liveable communities (due to an emphasis on productive functionality by neo-liberal ideology); being brought up in unsustainable patterns of activity (for example, in a drug sub-culture or in situations of social deprivation); being assigned to the margins through prejudice and displacement (as indigenous peoples are in post-colonial societies). All of these can contribute to detrimental spaces in which to live and, given the framework of capitalism and schizophrenia, they manifest to us as "psychiatric illness".

Attending to such distress does not require institutional incarceration, in whatever form an institution might take. Nor does it necessitate living independently - where "independence" equates to being able to "function alone". Instead it requires the formation of community structures that can *hold* a person in a way that enables us to work with them in order to restore affirmative relationships, and forge a place in the world that can hold them well. This form of empowering care is able to accept the person where she is, whilst also working with her to find appropriate ways of being-in-the-world that enable her, and those significant others around her, to go on with the work of living in a sustainable relationship-based way. This takes time, and there is no way of skimping on it without huge losses.

It seems therefore that in contemporary society, Kierkegaard's "Either-Or" is relevant.[2] This work emphasizes the transition from a hedonistic focus, such as that of pleasure and consumption as a "functioning preference satisfying object" in a "developed society", to a *subjective truth* which is more ethical and more challenging. This move realises that subjectivity is situated in a matrix of relationships, and that it is an intrinsic and essentially shared aspect of human life. Kant (1798/1978) talked about this as *Geist* or spirit – that is a dynamic, responsive community of beings, and not a fixed metaphysical object. These insights therefore implicate all of us in the determination and development of mental disorder and suffering, rather than making it a matter of individual health or dysfunction, as it is frequently narrowly construed in contemporary healthcare.

This is the answer; what was the question?

Sisti et al. (2015) discuss the idea that:

> Asylums are a necessary but not sufficient component of a reformed spectrum of psychiatric services. A return to asylum based long-term psychiatric care will not remedy the complex problems of the US mental health system, especially for patients with milder forms of mental illness who can thrive with high quality outpatient care. Reforms that ignore the importance of expanding the role of such institutions will fail mental health patients who cannot live alone, cannot care for themselves, or are a danger to themselves and others.

However, we argue that if incarceration is the option that surfaces as something that "makes sense to do" within a certain framework of thinking, there must be an array of underlying questions that also need to be raised and answered. For example, why does incarceration seem like the best option? Why do we have aspects of our shared world that are uninhabitable for some? What makes these spaces unliveable or untenable? What is causing the suffering that we see? Why is this person unable to sustain a life amongst us? Why are we unable to sustain them? Why do we have a way of doing things that leads us to swing from one end of the spectrum (moving people into hospitals) to the other (moving them out of hospitals) into the urban jungle, and back again (moving them into hospitals)?

Asking and exploring such questions gives us the key: they reveal the telling idea that we are rapidly making for ourselves a world in which we have expelled humanity in favour of a bloodless, idealised model of consumption and functionality.[3] Those with mental health issues are, we could say, signalling to us constant messages about the un-inhabitability of that world for all of us. Like the miners who have no canaries to warn them, they have succumbed to the toxic aspects of living in this world (Gillett, 2004). Perhaps we should take heed and, for the sake of all humanity, respond with the care that is needed.

Endnotes

1. Michel Foucault (1963/1994, p. 8) coined this phrase in his work, The Birth of the Clinic: An Archaeology of Medical Perception.

2. "Reflection is directed subjectively to the nature of the individual's relationship; if only the mode of this relationship is in the truth, the individual is in the truth" (Kierkegaard, 1846/1968, p. 178)

3. See Gillett (2008), especially chapter 10.

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