

Mark Burton (1983) Understanding mental health services: theory and practice. **Critical Social Policy** , 3, (7), 54 – 74.

The following pages are a scanned version of the original paper, so the print quality is not great. The title is a little misleading – the article is relevant to all disadvantaged, marginalised, stigmatised, unvalued people.

The article, despite being 20 years old has interest for two reasons:

1) It was the first to mention Prefigurative Action Research, later developed by Carolyn Kagan and myself: Burton, M. and Kagan, C. (2000)

Prefigurative Action Research: An alternative basis for critical psychology? Annual Review of Critical Psychology 2. *available at*

<http://publications.compsy.org.uk>

2) It sets Wolfensberger's work within a wider societal context, a task that has been attempted at times, but perhaps less sympathetically than here. It also was one of the first to make a link between at least his earlier work and labelling theory (one that he denies).

Understanding mental health services: theory and practice

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Abstract

Two approaches (Wolffensberger and Scull) to understanding services for people with mental disabilities are compared and seen to make complementary errors based upon the reduction of phenomena to ideology or economics respectively. Approaches combining both areas of analysis are seen as necessary in order to state what good services would look like and to understand the contexts in which services form and develop. It is argued that Wolffensberger's principle of normalisation allows a plausible statement of ideal criteria for service evaluation and design. A discussion follows of some possible constraints on its implementation under the present social order. A notion of 'prefigurative action research' is discussed as one way of pioneering more ideal services, while documenting the limits imposed on them at the present time.

Something is wrong with the institutions in which mentally disordered and mentally handicapped people are cared for. Academic studies, government inquiries and policy documents, and numerous press and television reports make such a conclusion inescapable. However, understanding why services have developed in the way they have, and imagining what good services might look like, is less easy than recognising that a problem exists. Yet if we are to develop good services for people who are mentally disabled, avoiding the mistakes enshrined in existing services, it is essential. In recent years, two approaches have appeared that help answer both these questions: 'Why do we have the services we have?', and 'What would good services be like?'.

The two approaches can be identified closely with two writers, Wolf Wolffensberger and Andrew Scull, but each may be regarded as representative of a distinctive type of approach to the sociology of deviancy.^{1,2} Wolffensberger's articulation of the principle of normalisation draws heavily upon societal-reaction or labelling theory, pioneered by Lemert (eg 1951), which is a microsociological, or social psychological approach to deviancy. Scull's account rests on an analysis of the management of deviancy in the context of both classical free-market and modern welfare capitalism, and may thus be described as macrosociological.

On a casual inspection, the two approaches appear to be doubly incompatible: in addition to seeking explanations at different levels of analysis, they at first appear to take diametrically opposed positions on the community care of mentally disabled people. This article will argue that the two approaches are by no means incompatible, but that each represents a lacuna in the other, and indeed, an adequate approach to service provision must recognise the insights of both approaches as well as their limitations.

WOLFFENBERGER'S APPROACH

Wolffensberger's contribution comprises three linked parts: (a) the articulation of the principle of normalisation and its major implications, (b) the development of criteria, informed by the normalisation principle, for designing and evaluating services, (c) the historical analysis of service provision, in relation to ideologies other than normalisation.

normalisation

The concept of normalisation did not originate with Wolffensberger, but he is responsible for its restatement and elaboration. The concept stems initially from work carried out in Scandinavia. An early Danish definition was provided by Bank-Mikkelsen in 1957, 'Letting the mentally retarded obtain an existence as close to the normal as possible'. This statement was written into the 1959 Danish Law governing services for mentally handicapped people (Bank-Mikkelsen, 1969). The definition stressed its application to *mental handicap*, its *outcome* (ie an existence as close to the normal as possible), and it was framed in terms of the *individual*. This limited definition of normalisation is echoed by that in the widely used standards of the US Accreditation Council on Mental Retardation and Developmental Disabilities.

Wolffensberger's definition (first published in 1972), is more sophisticated. In fact he provides three definitions, roughly synonymous, but aimed at different audiences, and it is worth quoting them all,

- '1. The use of culturally valued means, in order to enable people to live culturally valued lives.
- '2. Use of culturally normative means to offer persons life conditions at least as good as that of average citizens, and to as much as possible enhance or support their behaviour, appearances, experiences, status and reputation.
- '3. Utilisation of means which are as culturally normative as possible, in order to establish, enable or support behaviours, appearances, experiences and interpretations which are as culturally normative as possible.' (Wolffensberger, 1980a, p. 8)

Wolffensberger's definition therefore focusses on service recipients in general, rather than on mentally handicapped people alone. It is also concerned with both the process and the outcome of normalisation, which now emphasises the interpretation and valuation of service recipients, rather than simply attempting to get them to approximate cultural norms.

This last point is important, since 'normalisation' sounds like, and has been interpreted as, a process of making normal, and of uncritical subservience to existing statistical norms. To explain the relationship between cultural norms and Wolffensberger's own normalisation theory requires a little background.

While Wolffensberger does not draw heavily upon the work of Lemert and other societal reaction theorists, his approach is sufficiently close that it might be regarded as an augmented application of societal reaction theory. Lemert (1951) distinguished between primary deviance and secondary deviance. In the case of mentally handicapped people, for example, the primary deviance is the mental handicap itself, often coupled with physical stigmata eg those associated with Down's syndrome, or other physical disabilities. These primary problems are exacerbated and added to by the effects of societal reactions to the behaviour, appearance, or public image of these people. A vicious circle is thereby set up so that their 'behaviours, appearances, experiences and interpretations' (Wolffensberger, 1980) determine their management by societal agencies, both directly and via the mediation of public support for policies of segregation, which in turn contributes to their deviancy. In Wolffensberger's approach (especially, see Wolffensberger and Glenn, 1975), this circle of segregation is to be broken by providing both interactions and the (prerequisite) interpretations of a type

that enhance the valuation of clients by the wider culture. The criterion for the desirability of interactions and interpretations, then, is the extent to which they are culturally valued rather than whether they are actually statistically normative.

Nevertheless, this still implies a degree of cultural relativism: by trying to enhance the way that people are seen by their culture, as a way of combating discrimination against them, some acceptance of the values of the host culture is implied. This will often be reasonable – most men for example, don't wear lounge suits with half-mast trousers, and only children carry teddy bears around with them – but problems can arise, say, when male clients do domestic work or when female clients have unshaved legs, within a sexist culture. It is probably unreasonable to expect culturally devalued clients to be at the forefront of progressive cultural change, but it should be remembered that the culture changes rapidly, so that, for example, mentally handicapped people often look deviant by virtue of their conservative dress, hairstyles, etc. In addition, since people are socially evaluated on a range of different dimensions, it would not be necessary to try to ensure cultural conformity in every area of personal self-presentation. As Britton (1979) has made clear, the process has its ultimate justification in 'enhanced self-experience and quality of life'. Without this consideration and an emphasis on self-determination, there is always a danger that the social reaction strand could drag normalisation down to being little more than an endorsement of conformity. Wolfensberger's concerns with rights, advocacy, etc (see O'Brien and Wolfensberger, 1979), as well as the content of The Program Analysis of Service Systems (PASS) – see next section – make it clear that his perspective has a greater sophistication than that.

Wolfensberger has spelled out the implications of the normalisation principle in relation to establishing *interpretations of and interactions for*, people who receive services. This would occur on several levels, from societal systems down to the individual client (see Wolfensberger, 1972, pp. 31-41). These implications may perhaps be understood best in relation to the PASS system of service evaluation (Wolfensberger and Glenn, 1975).

evaluation of services

The Program Analysis of Service Systems (Wolfensberger and Glenn, 1975) is a comprehensive tool for evaluating human services. It is heavily, but not exclusively, based on the normalisation principle. While initially developed to evaluate community-based services for mentally handicapped people in Nebraska, (see Thomas et al. 1978; Menolascino, 1977), the current (third) edition is phrased in terms relevant to all service recipients. A secondary function of PASS is a teaching tool, since through being trained in its use, the normalisation principle can be comprehended in detail, in relation to the evaluation of concrete services.⁽³⁾

The core of PASS is the Field Manual, which contains guidelines for making ratings. For most of the individual ratings that make up PASS, the format of the Field Manual provides explanatory text together with examples, and criteria for the different levels at which the rating may be made. Ratings are grouped as follows:

- | | |
|--|-----------|
| (1) Physical integration | 6 ratings |
| (2) Socially integrative interpretations | 5 ratings |
| (3) Socially integrative programme structures | 3 ratings |
| (4) Age-appropriate interpretations and structures | 7 ratings |
| (5) Culture-appropriate interpretations and structures | 5 ratings |
| (6) Model coherency | 1 rating |
| (7) Developmental growth orientation | 3 ratings |
| (8) Quality of setting | 4 ratings |
| (9) Ideology-related administration | 5 ratings |

- | | |
|--------------------------------------|-----------|
| (10) Human science orientation | 2 ratings |
| (11) Regional priorities | 2 ratings |
| (12) Manpower considerations | 2 ratings |
| (13) Internal administration | 3 ratings |
| (14) Finance | 2 ratings |

Headings (1)-(9) are related to normalisation. Some of these categories are self-explanatory, but others need explaining:

Sections 1-3 are to do with the extent to which the service maximises opportunities for clients to participate in the mainstream of the culture ie that culture which surrounds the service. Individual ratings assess the extent to which this is facilitated by the physical nature of the setting, the explicit and implicit representation (interpretation, image) of clients to others, and the day-to-day practices of the service.

Sections 4 and 5 concern the extent to which the service minimises the extent to which clients are likely to be perceived as deviant by the community. For example, a setting where middle-aged women carry dolls, or where many of the people have rotten or missing teeth, would do badly on some of these ratings.

Section 6, *Model Coherency*, is a rating of the service as a whole in terms of the way in which its elements 'combine harmoniously so as to meet the specific needs of each client at that particular time of his life'. The rating is difficult to make, and allows more variability than the other ratings, since it is bound to reflect the raters' own values – and this is made explicit. Nevertheless, it is a particularly interesting exercise to perform, allowing one to look at a service by starting from the position of the clients rather than from the existing service structures.

Section 7, *Developmental Growth Orientation*, is about the extent to which the service maximises clients' development: 'Overprotection' and 'intensity of relevant programming' account for the three ratings.

Section 8, *Quality of Setting*, includes 'physical comfort', 'environmental beauty', 'individualisation', and 'interactions'.

Section 9, *Ideology-Related Administration*, concerns the extent to which the service could be said to 'evolve according to a good plan; be part of a large schema, which aims at the meeting of all major human service needs, be well administered, structured and functioning in coordination with other services and agencies; and incorporate mechanisms for evaluation, chance and innovation'.

The remaining headings have to do with the administration of the setting, irrespective of the normalisation principle, and will not be discussed here, since while important, they are not essential to the principles underlying PASS.⁽⁴⁾

Full details of the evaluation process are given in the other PASS document: the PASS Handbook. Evaluations are carried out by a team, of perhaps seven or eight members. Composition is heterogeneous, thus allowing a wide range of observations and perspectives. The setting is visited over several days and information pertaining to the ratings gathered in a variety of ways. Staff and clients are interviewed formally and a formal interview takes place with the head of the service. Observations are made, as unobtrusively as possible, of for example, staff/staff, staff/client, and client/client interactions, of notices, signs and equipment, of routines, and other practices of the setting. In addition the neighbourhood and exterior of the setting are inspected. Notes are taken during this process, but generally teams are expected to behave as unobtrusively as possible. Many of the ratings are difficult for the service to fake, and since clients, visitors, ancillary staff and others can be talked to, and the team is present for at least the whole of one clients' day, the team can probably get as good a view of the service as outsiders could hope to obtain.

After the site visit, the team meets and the evidence in relation to each rating is pooled, and the team works towards consensus on the relative importance of its various observations for each rating. The process can be quite arduous. A score may be computed from the ratings, although the basis for this is fairly arbitrary.

Finally, the team provides verbal and written feedback to the service, in a form comprehensible to those unfamiliar with the jargon of the PASS manual. What the foregoing description omits, however, is that despite its concretisation in the PASS manuals, PASS may be used flexibly (provided that the basic principles are not lost), and the central rating of model coherency in particular is continually evolving and being redefined. This is particularly so in that variant of PASS practice, developed by O'Brien and others that has been disseminated in the UK.

PASS then, is a way of evaluating services in terms of the normalisation principle as elaborated in the various ratings. It can therefore be regarded as a means of defining the characteristics of a good service, since it is possibly unique in its use of *ideal* criteria. In this it is radically different from other 'quality assurance' tools since it forces its users to reflect on what services ought to be like, rather than taking the piecemeal reform of current provision as their primary point of departure. PASS then, is concerned with promoting non-incremental change in services (although this does not rule out the use of gradual reformist politics within a wider perspective of the radical alteration of the service systems). In this it is radically different from other 'quality assurance' tools. We will return to the question of how adequate normalisation is as the source of ideal criteria for this purpose.

History and ideology

Wolffensberger (1969) has written a history of institutions for people with mental handicaps, largely concerning the USA. This text is a fascinating source of often horrific information on the development of the mental handicap institution, yet its level of analysis contrasts with the analysis of Scull (see next section), and illustrates the inadequacy of microsociology to apprehend the determinants of the human services.

Wolffensberger sees ideology as the most important determinant of services.

There is probably little disagreement that aside from considerations of cost, or of the nature of the prospective residents, the design of residential facilities is affected by attitudes and philosophies held by the designers and those who guide and direct them. These attitudes and philosophies may be held without the holder being conscious of their presence. Indeed the holder may verbally and vehemently deny holding an attitude or philosophy which is strongly expressed in a building. (1969, p.2)

He looks at the ideology of services in terms of the 'language of architecture', and the expressed aims of providers of American mental handicap services since 1850.

The language of architecture is examined in terms of the roles imposed upon the residents by the building, and Wolffensberger (1969, 1972) identifies seven major roles that mentally handicapped people have occupied in history. He also asks what meanings, or messages about the residents, are embodied in, or conveyed by, the buildings, and finally considers for whose convenience the building was designed – the architect, the staff, the community or the resident?

Wolffensberger goes on to discuss the expressed aims of the service providers in terms of major phases in the evolution of services since 1850, namely making deviant persons undeviant, protecting deviant individuals from nondeviant people, and ultimately, protecting nondeviant individuals from deviant people. This last is the largest section of the text, and in many ways the most interesting, documenting the various measures (sterilisation, segregation) taken against mentally handicapped people and other minorities during the 'eugenic scare period' between 1885 and 1920. By the end of this

episode Wolffensberger suggests that the large institutions could no longer draw on the rationales that were previously put forward to justify their construction. He attributes the failure of community services to develop in their place at this time to: a) the introduction of the public (by the professions) as to the menace and poor prognosis of these clients, b) The change of areas of interest on the part of the professionals to social problems other than mental handicap around this time, c) The economic depression meant that social services did not develop, d) World War II further diverted attention and concern from mentally handicapped people. Apart from (c) above, then, the building blocks of Wolffensberger's analysis are all from the ideological level. It is attitudes, beliefs, or philosophies that determine practices, both societal (social policy for the mentally disabled) and interpersonal (the actual management practices within the institutions).

It is not within the scope of this paper to examine Wolffensberger's history in detail, the less so since the text is full of useful detail including quotation from contemporary sources. Instead the task here is to comment on the type of explanation, the meta-theory, of his account. It is in halting the analysis at the level of ideology that problems arise in the account, and this is not merely an academic problem over the interpretation of history, but has implications for the way we understand current social policy, and for the strategies that should be used in changing it to better serve the interests of people with mental disabilities. To illustrate where Wolffensberger's analysis ends, consider the following paragraph, where he hints at wider social determinants,

'Belief in the genetic causation of retardation had some convenient aspects. By proposing that most social problems would be solved if the poorer members of society would stop having children, one could be freed from a sense of responsibility for bad social conditions. Furthermore, one was relieved from the worry of the effects of slum conditions upon children. If one could believe that many such children were genetically inferior to begin with, it is probably no coincidence that the indigent period overlapped with periods during which Social Darwinism and laissez-faire socio-economic policies were prominent.' (1969, p.39)

The analysis stops there, with the hint that economics and societal ideology ie ideology not concerned solely with mental disorder/handicap, might be linked to each other, and to the administration of mental handicap. To find an analysis of the political economy of mental deviancy we can turn to the work of Scull.

SCULL'S APPROACH: THE POLITICAL ECONOMY OF DEVIANCY UNDER CAPITALISM

Scull has provided a detailed analysis of the origins of the asylum system in England, and also analysed the 'decarceration' or 'de-institutionalisation' of deviants (legal as well as mental) since World War II, largely focusing on the USA. Together, these two pieces of work attempt to relate the incarceration and decarceration movements to the developing capitalist system, in its free-market and welfare phases.

Scull's major focus, unlike that of Wolffensberger, is not mental handicap, but what is usually termed mental illness, and it is the evolution and devolution of the psychiatric hospital that forms the substrate for his analysis. The difference in client group is of little consequence for the present discussion, since again, it is the general characteristics, the meta-theory, of the account that is of interest.⁽³⁾

the incarceration phase

Central to Scull's analysis is the idea that mental disabilities only began to be treated differently from other deviancy during the nineteenth century, except perhaps for some of the more obvious cases (see: Foucault, 1965). Until the late eighteenth century, social deviancy was dealt with in informal noninstitutional ways. There were

some institutions (with roots in early institutions such as the Bridewells, or houses of correction), but their inmates were a heterogeneous group, small in number.

The system of outdoor relief, stemming from the Elizabethan Poor Law, continued to provide the most common response to destitution, and it was within this system that mentally disabled people were also dealt with. While allowing a wide scope for local discretion, it is striking that most parishes continued to provide for paupers in essentially similar ways. The majority of funds available for these people were spent on 'household relief' – that is support at the subsistence level of paupers within their home parish.

'Lunatics were simply one group among many who received such support. Those who remained permanently insane did not pose a unique problem, but formed part of the large class of the really poor and impotent: the senile, the incurably ill, the blind, the crippled, and the maimed. Efforts were made to keep these people in the community, if necessary by providing their relatives or others who were prepared to care for them with permanent pensions for their support.' (Scully, 1979, p.22)

The system in America was not substantially different, and while institutional solutions had been more widespread in continental Europe, the general situation was again similar to that in England.

However, around the end of the eighteenth century, the first steps were taken towards the institutional system that in the UK reached its peak (in terms of the number of people resident in psychiatric hospitals) in the middle of the twentieth century. So in England, justices of the peace were given powers to build asylums, workhouses and prisons (1808 for asylums), and later (1828 for asylums) they were compelled to do so. As the move towards institutional solutions to deviancy gathered strength, the splitting of functions into separate institutions for different kinds of deviancy took place.

Scully argues that economic transformations were responsible for the trend towards institutionalisation, these changes being the growth and consolidation of the capitalist system with its impact on social and economic relationships.

'In the first place, prior to the emergence of a capitalist system, economic relationships did not manifest themselves as purely market relationships – economic domination or subordination was overlaid and fused with personal ties between individuals. But the market destroyed the traditional ties between rich and poor and the reciprocal notions of paternalism, deference, and dependence which characterized the old order, producing profound shifts in the relationships between superordinate and subordinate classes, and of upper class perceptions of their responsibilities towards the less fortunate. Indeed, one of the earliest casualties of the developing capitalist system was the old sense of social obligation towards the poor.' (Scully, 1977, p. 24)

He goes on to point out that,

'At the same time, the "proletarianization" of labour and the detachment of the lower orders from the means of their own subsistence, together with the tendency of the primitive capitalist economy to oscillate unpredictably between conditions of boom and slump, greatly increased the strains on a family-based system of relief.' (p.25)

These processes intensified as free-market capitalism reached its industrial and urbanized climax.

These structural changes in turn increased the numbers of destitute people subsisting on the poor law relief system. They also provided a source of dissatisfaction with the old decentralised response to poverty and deviancy on the part of the powerful new bourgeoisie. An institutional system would, in theory, both enable a *close oversight* of those who received relief, and establish a *harsh regime* to deter all but the 'truly deserving poor' from applying. The distinction implied in the latter motive was crucial

to the system now that, with capitalism, people had 'become' free, autonomous individuals, who must be able to enter into those 'free contractual relations' dictated by the labour market. It was necessary to distinguish between the able-bodied and non-able-bodied poor. *Providing aid to the able-bodied poor would undermine the whole basis for the labour market.* This point will be returned to in discussing the decarceration phase, but for the moment two implications will be noted.

Firstly, it was not feasible to provide relief outside of an institutional context, since this might lead to abuse by those who did not need it, thus removing their need to hire themselves on the labour market.

Secondly, the distinction between those who could and those who could not work, necessarily required some sort of classification of deviancy, so that the chronic sick, the old and feeble, the insane, and the mentally handicapped, had to be distinguished from other paupers, as well as from one another. Thus older notions of insanity, for example, became transformed through the imperatives of free-market capitalism, bringing these groups into public awareness as never before (see Scully, 1979, Chapter 2). Again, in relation to mental disorder, Scully summarises why institutional solutions had to be chosen,

'Consider, for a moment, what an alternative policy of managing the insane in the community would have involved. Keeping lunatics "on the outside" would have entailed making provision for relatively generous pension or welfare payments to allow for their support. But at the least this would have raised the possibility that the living standards of families with an insane member would have been raised above those of the working class generally. Moreover, under this system, the insane alone would have been beneficiaries of something approximating a modern welfare system, while their sane brethren were being subjected to the rigors of a Poor Law based on the principle of less eligibility. Such an approach would clearly have been administratively unworkable, especially given the labile nature of lunacy itself, and the consequent ever present possibility that given sufficient incentive (or rather desperation), the poorer classes would resort to feigning insanity. These obstacles presented an absolute barrier to the development of a plausible alternative, community-based response to the problem of insanity – in fact none of the critics of the asylum was ever able to suggest even the basis of such a program.' (Scully, 1977, p. 130)

The above précis of Scully's account of the political economy of incarceration is necessarily schematic. Of particular importance, it omits the richness of his analysis of political economy, ideology and theory, the emergence of professional groups (in this case psychiatry), and the rise of the asylum system. In other words, economic determinants are shown to be mediated via these other developments. As Figlio and Jordanova (1979) put it, 'The economy and the rhetoric were in consort' (p.102).

the decarceration phase

Scully's (1977) intent in examining the decarceration phase is polemical, to question the humanitarian rationalisations for decarceration, and to again locate the policy within the relevant context of political economy. He sees decarceration in wholly negative terms – hence the seeming incompatibility with Wolfensberger. His negative view actually does seem to extend to his valuation of mentally disabled people

'What has the new approach meant in practice? For thousands of the old, already suffering in varying degrees from mental confusion and deterioration, it has meant premature death. For others, it has meant that they have been left to rot and decay, physically and otherwise, in broken down welfare hotels or in what are termed with Orwellian euphemism, "personal care" nursing homes. For thousands of younger psychotics discharged into the streets, it has meant a nightmare existence in the blighted centers of our cities, amidst neighbourhoods crowded with prostitutes, ex-felons, addicts, alcoholics, and other human rejects now

repressively tolerated by our society. Here they eke out a precarious existence, supported by welfare checks they may not even know how to cash. They spend their days locked in or alternately the prey of street criminals (who may themselves have been 'decarcerated'), and as a source of nuisance and alarm to those "normal" residents of the neighbourhood too poverty-stricken to leave... Excluded from the more desirable neighbourhoods by zoning practices and organized community opposition, the decarcerated deviants are in any case impelled by economics – the need for cheap housing and to be close to a welfare office – to cluster in the ghettos and the decaying core of the inner city... Decarceration thus forms yet one more burden heaped on the backs of those who are most obviously the victims of our society's inequities. And it places the deviant in those communities least able to care for or cope with him.' (Scully, 1977: pp. 1-2)

Conventional explanations for the shift to decarceration have invoked either the 'pharmacological revolution' of the 1950s, that allows the maintenance of those suffering from major mental disorders (schizophrenia and severe affective disorder) outside hospital, and/or the effects of the criticisms of mental hospitals by the societal reaction theorists, especially Goffman (1961), as well as by liberal psychiatrists such as Barton (1959). Neither explanation stands up, however.

Without necessarily wishing to deny their clinical value, it must be noted that the new drugs have often been exaggerated in their impact (see Paul, Tobias and Holly, 1972). They would not be expected to have had any influence on groups other than those with severe mental disorder, yet mentally handicapped and other groups of people have also been decarcerated, especially in the USA. Furthermore, the trend of decarceration antedates the introduction of chlorpromazine, the original wonder drug for schizophrenia. (See Scully, 1977, for a discussion of other shortcomings of the pharmacological theory of decarceration.)

Criticism by social scientists is perhaps unlikely to have led to changes in social policy, unless there were other compelling reasons, such as economic ones, for the state to make reforms. To believe that social scientific research really leads to changes in social policy on its own implies a rather naive empiricism wherein the scientist produces neutral facts to which policy makers respond with an 'Oh how interesting, fancy that, let's change the whole basis of our welfare system to better serve the interests of its recipients!' (see Taylor-Gooby, 1981). Again, Scully provides other reasons for the inadequacy of this explanation and its subsidiary assumptions. Instead, he again turns to economic relationships for the fundamental explanation. Scully summarises his thesis as follows,

'with the coming of the welfare state, segregative modes of social control became, in relative terms, far more costly and difficult to justify. This is particularly clear in the case of the group we have given most attention to, the mentally disturbed, who were formerly confined in "monasteries of the mad"'. As we have just seen, until well into the twentieth century, there had been little or no alternative to keeping the chronically disabled cases of insanity in the asylum; for although the overwhelming majority were harmless, they could not provide for their own subsistence, and no alternative sources of support were available to sustain them in the outside world. However, with the advent of a wide range of welfare programs providing just such support, the opportunity cost of neglecting community care in favor of asylum treatment – inevitably far more costly than the most generous scheme of welfare payments – rose sharply. Simultaneously, the increasing socialization of production costs by the state, something which has been taking place at an increasing pace during and since the Second World War, and of which modern welfare measures are merely one very important example, produced a growing fiscal crisis, as state expenditures continuously threatened to outrun available revenue. In combination, a focus on the interplay of these factors enables us to resolve what at first sight is a paradox – namely the emergence and persistence of efforts to curtail expenditures for control of "problem populations" at a time when general expenditures

on welfare items were expanding rapidly. For it is precisely the expansion of the one which made both possible and desirable the contraction of the other.' (Scully, 1977, p. 135)

So, with the advent of welfare capitalism, the possibility arose of maintaining mentally disabled people in the community on welfare payments. Meanwhile, the increase in state spending made the seeking of cuts imperative, and mental hospitals were an obvious target, particularly given costs arising from inflation, the decay of nineteenth century buildings, and the increased wages bill consequent upon the growing unionisation of the employees. Welfare capitalism became the social system in the core capitalist countries in general, and a certain similarity of experiences of decarceration in each lends some weight to Scully's attribution of causality to the contradictions of this system. So too does the wealth of evidence assembled into the short chapter (Scully, 1977, pp. 134-160) in which the thesis is advanced.

Scully's account of the societal determinants of decarceration, unlike his much more detailed account of the incarceration phase (Scully, 1979, and 1977, pp. 3-40) contains little analysis of the ways in which the economic imperatives were translated into social policy, and of the processes by which ideologies became transformed from custodial to noncustodial forms. In their review Figlio and Jordanova (1979) put it this way,

'Talking about the need for a disciplined workforce for early industrialization, Scully implicitly suggests a coherence between the economic need to mobilize a labour force on a national scale, the establishment of institutions to rehabilitate and maintain that work force, theories of human nature which converted social relations into medical necessity, and the emergence of professionals who specialized in rehabilitation. The economy and the rhetoric were in consort. But for welfare capitalism, the period of decarceration, Scully loses all sense of mediation. There is no coherence between the rhetoric (the humanitarian potential of drugs), the economy (relentless slashing of social services expenditure), and theories of human nature (no longer mentioned at all). Scully's argument deteriorates into the issue of saving money on social services. From a treatment of complex mediations which blends the history of ideas, the history of science and medicine, and the sociology of knowledge and the professions with a politically organized critique, he passes on to detecting a fiscal crisis on which he hangs other charges with no organic connections'. (Figlio and Jordanova, 1979, p. 102)

They go on to suggest that the 'ideology of community' is the most important of these mediations between proposals and arguments for reform, their implementation, and the economics of state expenditure. Unfortunately, Figlio and Jordanova do not define the 'ideology of community'. However, they imply that by attempting to argue that mentally disabled people are not better off in the community, Scully appears to accept that it is possible to talk meaningfully of 'the community'. In spite of all the talk of community politics, community work, community nursing, community centres etc, there is a mismatch between the implied camaraderie of the word 'community', and the alienation, privatisation, or individualism, of a society fractured into nuclear units ('the family' being, of course, another part of the ideology of welfare capitalism) with few real links between one another, particularly in the inner cities to which decarcerated mentally disabled people often gravitate. As Raymond Williams notes, 'unlike all other terms of social organisation (*state, nation, society*, etc.) [the term "community"] seems never to be used unfavourably, and never to be given any opposing or distinguishing term.' (1976, p. 66)

Furthermore, Scully pays little attention to the expansion of the 'legitimate' terrain of those professions concerned with the management of mental disability and distress; the process that he caricatures as simply 'decarceration' was actually rather more complex. Miller (1981), reviewing a French book (Castel, Castel and Lovell, 1979) on American mental health services over the last century, suggests that what has happened is not a simple 'decarceration' of those resident in hospitals, but,

'a renegotiation of a domain . . . which entails a triple process of alteration of institutional form, of criteria for the recognition of professional competence, and of the technologies which operate across such a field.'

Despite the reduction in the number of psychiatric hospital beds, the number of annual admissions has increased. What has happened is that the psychiatric hospital has been modernised. We can perhaps see this best in its form as the psychiatric unit in the general hospital, where, formally integrated with medicine, and at least in theory unencumbered by chronic cases and inappropriate admissions, the multidisciplinary team (under medical hegemony) assumes a treatment role in liaison with specialist units (psychogeriatric units, alcoholism treatment units, etc.) and community-based services (cf. the volume of psychotropic drug prescription by general practitioners, and the role of community psychiatric nursing, of which a proportion is concerned with little more than the administration of neuroleptic depot injections).

A great part of these developments may be seen in terms of the struggle of the psychiatric profession for recognition on equal terms with other medical specialities. From the restrictions placed on British asylum doctors in the last century (in residence requirements and licence to practice privately) to the current situation with a Royal College, psychiatrist media personalities and a hugely expanded terrain of practice, we can see that this professional group has indeed been successful in this struggle (See Scull, 1979, Treacher and Baruch, 1981). That history, however, needs to be seen as one of the mediations between structural changes in capitalism, and the actual form of services that developed. Busfield (1980) has argued that decarceration in the post World War II period may be seen as the logical outcome of an extended history, commencing at the end of the nineteenth century, of policy developments that gradually broke down the actual and perceived isolation of the asylum. These developments, such as open doors, voluntary admissions, and more active treatment programmes, had been advocated by the psychiatric establishment since Maudsley's day (1868). It was only as the welfare state gradually developed, however, that this liberalization of the asylum could occur. In other words the development of psychiatry was a major mediator between the economy and changes in the form of service provision.

The position of mental handicap might have been understood more easily in terms of decarceration had decarceration actually been the major change in this area, yet in the UK, the targets set for hospital discharges in the 1971 White Paper (DHSS, 1971) have not merely been met (See Wertheimer, 1981). No mental handicap hospitals have closed, and as Tyne (in press) argues, the decrease in the number of mental handicap hospital residents is attributable chiefly to very high admission rates in the 1930s (anyone who has spent time talking to, or looking at the case records of, residents admitted during this period will attest to both a high admission rate and very lax criteria for incarceration). These people are now ageing and dying, hence the drop in numbers documented by Scull. The wider picture than Scull's is relevant to this client group in two main ways.

Firstly, the simultaneous expansion of the terrain and the alleged technical precision of psychiatry has led it to focus on client groups for whom medical treatment can be more plausibly offered than for those with mental handicaps. The expansion of terrain, together with an unpopularity of psychiatry as a career option for doctors, has led to a staffing crisis in psychiatry, to which the development of ancillary professions such as clinical psychology has been linked. With regard to mental handicap services, the result has been the virtual abandoning of the field by psychiatry. With minimal psychiatric cover, or medical cover by general practitioners, the mental handicap hospital has become a less than plausible basis for a service. Indeed, in the UK, their hospital status only stems from 1948 and the National Health Service.

Secondly, the 'ideology of community' has had its effect on theory and practice in

mental handicap. Normalization, which originated with this client group, must be evaluated within this societal context, and this will be attempted in the next section.

This section begins by describing Scull's analysis. While helpful, it is incomplete, lacking a detailed analysis of how theory and ideology have come in line with the economic imperatives and caricaturing a complex process of service reorganisation as simply one of decarceration.

SCULL, WOLFENBERGER, AND THE DEFINITION OF APPROPRIATE SERVICES

Thus far the work of Wolfenberger and of Scull has been summarised and some criticisms made. It has not been appropriate to make a detailed evaluation of their work since the intention is to illustrate how, as general forms of approach to the problem, each has a value, if a circumscribed one.

Wolfenberger has criticised custodial services, using the normalization principle as a heuristic device in this task. He (with Glenn and others) has developed the PASS system as an 'accounting tool' for evaluating existing or planned services, thereby stating the criteria for good services, again on the basis of the normalization principle. Wolfenberger has no empiricist illusions – the values on which his system is based are stated, and in using PASS the same thing is done by the raters. Of course, empirical data have a role, but not as a value-neutral arbiter for judging the adequacy of the normalization principle (Wolfenberger, 1980). It is consistent with a sophisticated position on empirical data that Wolfenberger (1969) looks to history in order to try and understand why human services have their current form. However, as we have seen, his account is inadequate since it only considers the ideology of the services themselves and ideologies in society more widely, without any attempt at explaining the origins of these ideologies. Wolfenberger's history thereby lapses into moralism, situating the problem in the minds and hearts of people, rather than in the relations among them. Scull's analysis (1977, 1979) of the history of incarceration provides a plausible account of how economics, ideology, theory and the form of human services interacted, and it is here that his work provides a necessary complement to that of Wolfenberger.

Turning to decarceration, it is more difficult to evaluate the work of the two writers because of the proximity of this phase. Wolfenberger (e.g. 1972, 1980a) does not appear to ask where the ideology of normalization comes from, but presents it as the rational approach to the design of services. Scull (1977) describes the economic imperatives behind decarceration, but fails to consider either the complexity of shifts in the terrain and methods of social administration (which go beyond a simple process of 'decarceration'), or the mediations of ideology, theory, and professional interests, something that he did discuss in relation to the incarceration phase (Scull, 1979). So, while Wolfenberger restricts explanation to ideological factors, Scull makes the converse error by restricting its scope to the economics of 'decarceration'.

It is important to distinguish between *decarceration*, as a policy concurrent with welfare capitalism, and the *principle of normalization*, developed, in its most sophisticated form, by Wolfenberger as well as by others, within the context of welfare capitalism and the possibility of decarceration. Workers using the Wolfenberger perspective have been careful to distinguish normalized services from the dumping of clients in 'the community' with inadequate support (see Ferleger and Boyd, 1980), a practice that can take the form in Scull's description above, or rely on the unpaid domestic labour of women (see Walker, 1981). Yet, it seems likely that had decarceration not emerged, then the normalization principle would not have been formulated. Just as in the period of incarceration, 'the economy and the rhetoric were in consort', normalization may be seen as one consequence of 'decarceration'. However, this need not invalidate it. In Mackenzie's (1981) terms 'sociological

relativism' does not imply 'philosophical relativism'. Ideas must come from somewhere, and while it helps to understand their lineage, it is the consequences of their use that matter. In the case of normalization, the point is that, if it does provide an adequate definition of appropriate services, the guidance of this principle can act as a critique and check on those forms of decarceration, disguised as 'Care in the Community' (DHSS, 1981), that are either merely cost-cutting dumping or administrative redefinition of clients as the responsibility of local government social services departments instead of central government – the NHS. So does the *normalization principle adequately define appropriate services*? It would be hopelessly pompous to attempt to provide a definitive answer to this question, but some issues will be raised. As above, the discussion will treat mentally disabled people as a group, although it is recognised that the needs of mentally handicapped and mentally disordered people are likely to differ and a disservice may be done by mixing them, either conceptually, or in actuality.

It will be useful to recall the definition of normalization given above, and the discussion on the social valuation of clients. The central ideas are that the interpretations that services present of clients should enhance their image, and that interventions should take place that integrate them into the mainstream of the community. These two processes are mutually supporting. In terms of service provision this implies non-segregative facilities such as residence in ordinary houses and use of generic community resources wherever possible, but with provision of any specially required supports as necessary, e.g. assistance with eating, physiotherapy, etc. So rather than placing clients in hospitals, or even in 24 or 12-bedded hostels, ordinary houses, scattered through a neighbourhood might form the residential base of the service, and educational, vocational, and leisure activities will occur within or alongside those for the rest of the public. (Those 'alongside' might include those where direct competition with non-handicapped people would lead to negative valuation, such as sharing classrooms: wherever possible, however, integration would be complete.) Only a brief sketch of normalized services can be given here, but more detail may be found in Wolfensberger (1972), Wolfensberger and Glenn (1975), Flynn and Nitsch (1980), Thomas et al. (1978), or Development Group (1980).

In one sense, it is unnecessary to argue in detail for such services. To do so would be to accept the terms of debate imposed by segregative services and their apologists. It would therefore entail argument with respect to an historically arbitrary criterion. Similarly, it would be absurd to have to produce empirical evidence for the effectiveness of such a service system, since this would again imply that the competing, segregative system had some kind of scientific sanction. As it is, there have been a number of attempts to empirically examine the effect of variables such as size of residence in isolation from the rest of service provision e.g. Landesman-Dwyer et al. (1980), a scientifically meaningless enterprise (see Wolfensberger, 1980b). There has, however, been recent research which avoids the pitfalls of atomising discrete factors of quality of environment, yet indicates the utility of normalized environments on several criteria e.g. Hull and Thompson, (1980, 1981a, 1981b, 1981c), Kiesler, (1982), Willer and Intagliata, (1981). It should be noted, however, that such research still has to choose its criteria for evaluating service effectiveness. Instead of reviewing the research, I will discuss three problems that attempts to implement normalization might encounter within the present social formation.

the nature of the community

The first concerns the notion of community again. The interpretation-interaction perspective outlined above is plausible as a means of enhancing clients' experiences only if there is a natural context for interactions with the public to occur in. But what is life actually like for the ordinary subjects of welfare capitalism? It is difficult to have

an overall picture, but very many people who are not stigmatized by any major mental disability might be regarded as less than integrated with the community. In evaluating the degree to which a service facilitates the social integration of its clients, PASS raises relevant questions about access, use of community resources, coordination with other parts of the service system, competition from other client groups, etc but no mention is made of the viability of the neighbourhood as a community.

Neighbourhoods inevitably vary in the degree to which it makes sense to talk of them as communities, but overriding all this variability, a condition of social fragmentation, alienation, or privatisation, is chronic under welfare capitalism, and can be attributed in the first instance to employment, housing, transport, incomes, and other aspects of social policy required of that system. Even in relatively intact and well established neighbourhoods it is, for example, extremely difficult to find a sufficient range of potentially integrative leisure resources that handicapped persons could be helped to use, e.g. by volunteer citizen advocates/befrienders, and this reflects the way in which, with some important exceptions, leisure is structured for all of us through factors such as the pressures towards living in nuclear units and by the replacement or takeover of popular forms of leisure by commercial interests.

Of course none of this should be seen as an excuse for failing to take all possible steps to encourage the real integration of mentally disabled people with the rest of us, but it has to be recognised that the community itself has become a less than welcoming place. This is the case for the inner city ghettos described by Scull and for owner occupied neighbourhoods, where in addition to a lack of potentially integrative resources, campaigns against plans for residences for mentally disabled persons are common. Rather than accepting this position as wholly immutable, however, it might be worth working out, via actual attempts, what it takes to synthesize a community for given handicapped individuals, and what support would be necessary to sustain it. The notion of prefigurative action research, which is implicit here, will be returned to, but the idea is to simultaneously create images of what could be possible while exploring and documenting the actual limits imposed by the current system.

positive valuation

The second problem concerns the limits on the positive valuation of people who are seen as mentally deviant, and here the inadequacy of an approach based only upon ideology or attitudes (Wolfensberger) arises again. Scull has shown us how the management and perception of deviancy have historically been related to the labour market. Braginsky (1981) has similarly discussed the experience of being surplus to the functioning of society as central to the esteem that others as well as ourselves have for us. Capitalism, whether free-market or welfare, encourages us to view people in this sort of way, as a commodity for sale in a labour market. Notions of the superfluity of some of us, of the burden we put upon society, are never far from the surface, and while the Nazi solution to mental disability shocks us (Wolfensberger, 1981) it may be seen as the extreme form of this reification of human beings (see Guse and Schmacke, 1980, for an interpretation of the extermination of mental patients that stresses its ideological continuity with Social Darwinist notions and its implementation by members of the 'caring professions'). This reification or objectification of people is not restricted to labour relations, but, as the feminist movement has demonstrated, it extends to interpersonal relations too, again affecting the most powerless people most strongly.

This then is the context within which we must consider the social valuation of mentally disabled people. It is not just attitudes that have to be changed, but the structural relations that define the very way we think about concrete human individuals (see Seve, 1975, or Sedgewick, 1982, pp. 53-54, where he notes Goffman's omission of any discussion of the origins of social comparisons in the 'sex race', the

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race, the money race and the class race [imposed by] a neurotically competitive and mercenary society'). While a person's value is defined by the structures of the capitalist labour market and by patriarchal relations, the hope that we can learn to positively value mentally disabled people may seem hopelessly utopian. Again, this is not an argument against trying, particularly in attempting to expel negative valuations wherever we find them (cf. the experience of the women's movement in a strikingly analogous task), but we must recognize the origins of negative valuations or else we may do a disservice to clients by default.

A very practical concern that relates to this issue is the role of wealth in defining a person's social valuation. Mentally disabled people are almost universally condemned to live in poverty; even where their living environments are excellent they are likely to subsist on welfare cheques or low wages. This will be a limit to social valuation, and it is a limit that clearly derives from the existing social formation. It is possible that hitherto a strong focus of reformers on residential services – aimed at replacing hospital provision with ordinary housing – has had the unfortunate effect of diverting attention from day and vocational services, and hence from the (direct) relations between mentally disabled people and the labour market. Within the current employment situation it is difficult to imagine what might be appropriate ways for mentally disabled people to spend the day. Clearly psychiatric day facilities and adult training centres are inappropriate, functioning largely for the purpose of containment from 9–5, despite the commitment of many staff, but again it is likely that only by promoting and evaluating a range of integrative alternatives can the necessary conceptual jump be made.

mentally disabling conditions

The final point concerns the actual definition of mentally disabling conditions. This is related to the above considerations, but goes beyond them. It is also difficult to spell it out clearly.

Scull (1979), like writers such as Foucault (1965), has illustrated how conceptions of mental disorder have evolved in tandem with the evolution of the social system and with the forms of administration that have dealt with the people in question. The evolving conception of disabling conditions is not unique to mental disorder, but also applies to physical illness. Figlio (1978) has discussed the way in which somatic illness is 'socially constituted'.

'There are two aspects of this socioclinical phenomenon: the social relations of disease and the embodiment of social relations in the concepts of disease. They may be isolated for analysis, but they must be reunited to understand the disease in the concrete historical case.

This is another way of saying that medicine mediates social relations, and is itself constructed in the process.' (Figlio, 1978, p. 589)

Similarly, Taussig (1980) talks of the 'phantom-objectivity of disease',

'because by denying the human relations embodied in symptoms, signs, and therapy, we not only mystify them but we also reproduce a political ideology in the guise of a science of (apparently) "real things" – biological and physical thinghood. In this way our objectivity as presented in medicine represents basic cultural axioms and modulates the contradictions inherent to our culture and view of objectivity.' (p. 3)

The very definition of a disabling condition, then, can be seen as caught up in the very system of social relations that helped to determine the occurrence of those features that we use to identify it. An analogous approach might be applied to mental disability. Sedgewick (1982) for example, argues that the 'antipsychiatrists' by failing to criticise physical medicine as societally bound in its concepts and practice thereby limited their critique of psychiatry so that, predicated on the Cartesian distinction

between mind and body, it asserted that mental disorder lies outside the realm of medicine. This led to a critique of the medical assault on the mind that appears to have done little to improve life for the majority of mental patients (Brown, 1981), no doubt because its programme was limited to an individualistic civil rights approach. (Interestingly, the major British mental health pressure group, MIND, is currently changing its emphasis from civil rights agitation to the promotion of community-based services – see annual report, 1982.)

Mental disability has quite definite social relations, both aetiological and consequent, and many of the concepts we have for it themselves embody social relations. Following the arguments of Figlio and Taussig, then, mental disability, while actually socially constituted, is obscured by a socially mystifying definitional framework, such that the disabilities appear to be no more than a part of nature. The analogy is with Marx' analysis of the reification of commodities, that are in reality one point in a system of social production.

The issue is not one of social versus organic aetiology – to claim, for example, that senile dementia or Down's syndrome did not have a biological base would be absurd. However, these conditions are linked into a system of social relations in such a way that social aetiology and social consequence become linked. So for Down's syndrome, the provision of amniocentesis and abortion services would lead to a reduction in the prevalence, yet the prioritisation of such a service is linked with assumptions about the uselessness of people with Down's syndrome, with the provision and achievements of early educational intervention, and with the rights of potential parents. (See also Silverman, 1981, on how sick children with Down's syndrome become redefined in non-medical terms such that cardiac surgery is denied them at a paediatric cardiology clinic.) As Scull has shown, our more general concepts of mental disorder and mental handicap are relatively transparent with regard to social relations. They attained modern forms as ways of classifying and hence administering some of those people surplus to the requirements of free-market capitalism. More recently, such concepts have been overlaid with themes from more modern social relations, for example, the stress on modifiability and therapy (with its positive and negative aspects) which relates, through the evolution of psychiatry, education and related practices, to the fundamental requirements of the labour processes of evolving capitalism for trained operatives, whether trained to perform skills or trained for the monotones of deskilled work or of no work. In this process, first the neuroses (around the turn of the century) and then a range of other 'maladaptions', were added to the 19th century diagnostic groupings (see Miller, 1981). Lest the analysis should seem overly economic, it is worth noting that at least in the area of mental disorder, the whole process of socially constituted syndrome emergence has been suffused with sexual as well as class divisions (see, for example, de Swaan, 1981, on agoraphobia).

The point of all this for normalized services, or rather any attempt at rational reform of the mental health services, is simply that the concepts that we are likely to use in characterising our clients, are concepts that – based upon social relations – are likely to obscure the real problems faced by those people, as well as the origins of those problems.

One tendency of work within normalization and PASS has been to translate much of the sociological jargon about deviancy, etc. into ordinary accounts of what has happened, and what is happening to the service recipients. An interesting development has been the use of such detailed accounts of what life is and has been like for a person or persons, to form the basis of service design, either for a concrete individual or for a group of such people (see Brost and Johnson, 1982). While not without its dangers e.g. the bourgeois nature of much 'common sense' and ordinary language, this pragmatic and 'innocent' approach – 'what does this person spend the day doing? oh, she looks at a wall or plays bingo for 4½ hours and spends 3 hours travelling to and from the day centre; why? oh, as part of her rehabilitation programme' – undermines much dubious

professional categorization and pat formulas such as 'reality orientation' for the confused elderly, soft furnishings for the profoundly handicapped, group therapy ... etc, focussing on the actual experiences and social relations of the real disabled people. As such the approach can provide both a powerful critique of apparently good services, and lead into a linked statement of what ought to be provided for a given person in the light of their current deprivation. As a way of understanding people in terms of their links with a wider system of social relations, the approach has a similar orientation to that of the theoretical approach to the study of human personality outlined by Séve (1975) as an alternative to the essentialist accounts of both empirical and Freudian psychology. Séve's starting point was the sixth thesis on Feuerbach where Marx rejects an idealist definition of the 'human essence' in favour of one that defines it in terms of 'the ensemble of social relations'. The point is rather poignant for those human beings whom the present system of social relations has systematically excluded.

Implications for activity

Three problems have been identified as limiting the adequacy of normalized services. They were the myth of community, the societal definition of a person's value, and the social relations of disability and of professional concepts of it. A fourth problem, of course, is the ever present lack of resources, which while not sufficiently explaining the inadequacy of present services, will contribute another limit to the development of good services.

I'll try to briefly sketch out the implications of the first two points for the activity of radicals. The third point has been partly answered above, while discussion of cuts in welfare spending is well discussed in left circles.

Neither the limits of community nor valuelessness are absolute barriers to progress, but rather limits whose boundary can only be charted through its exploration. This brings us back to the notion of 'prefigurative action research' which was mentioned before in relation to attempts at providing real community integration for actual mentally disabled people. It is here that the normalization approach seems particularly useful as a best guess about what to aim at, both in relation to describing the needs of the clients, and for the purpose of defining the likely dimensions of an integrative service.

Prefigurative action research can be done at various levels – in relation to a client, a group of clients, part of a service system, or maybe a whole local authority area and health district. However, getting agreement and support for qualitative changes in services is a 'bootstrapping' type of operation, heavily dependent on extant models of practice. The availability of successful models of normalised service provision will be helpful, but change cannot rely on this. Ramon (undated) lists four lessons from a study of a reformed Italian psychiatric service that has strong affinities with normalisation:

1. The potency of untraditional alliances in bringing on reforms.
2. The need to have a well-thought program prior to campaigning for a major change.
3. The value of a small group of professionals with a high degree of commitment and readiness to take on risks involved in any far reaching reform.
4. The centrality of *demonstrating* to the community and the clients that clients are respectable people and that professionals can be effective without exhibiting the traditional professional distance.

Points 1 and 3 were also present in the setting up of ENCOR, the Nebraskan pioneering residential mental handicap service, based upon ordinary housing dispersed through the community (Thomas et al. 1978), while 2 and 4 are intrinsic to the normalization approach. Point 4 really implies that locally based integrative services

need setting up as the best way of breaking the cycle of segregation-devaluation-segregation. It is worth stressing the importance of a clear programme, or of an image of a possible alternative way of providing services – this has been all but lacking in the writings of recent socialist commentators on mental health policy. Thus Scull says nothing about what services should be like, Brown (1979) devotes less than half a page of his 15 page article to some vague proposals, and Sedgewick (1982) naively seizes on an amalgam of the Mental After Care Association, Kropotkin's anarchist critique of the state, and the Belgian village of Geel where 5.8 per cent of Belgium's mentally ill people board with families, accounting for 5 per cent of Geel's population, and (according to Shearer, 1982) suffer some exploitation and widespread discrimination. Without advocating a utopian approach, it seems clear that there is a great need for some idea of what we might struggle towards, and while imperfect, the work of Wolfensberger and others on normalization seems like a good candidate.

CONCLUSION

Macrosociological and microsociological approaches to services to people with mental disabilities may be seen as complementary. Scull's account is useful in detailing why we have institutionally orientated services but begins to break down in explaining the development of community-based services. However, a macrosociological account that included consideration of mediation between economy and services could provide an adequate analysis. Wolfensberger's more microsociological work is useful in establishing images of what adequate services might be like, but its ideological basis does not allow it to explain why services develop as they do, and a perspective on this is important for understanding possible failures of normalized services under the current social order. Nevertheless, in some areas, exponents of normalization, by engaging in alliances, have brought about certain qualitative, non-incremental changes in service structures. The active development of examples of normalized services enables models to be available for (flexible) adoption elsewhere, and also allows for the exploration of the limits imposed by modern capitalist social relations on the social integration of hitherto devalued persons. The process of developing these services and documenting their success and failure in relation to their context was termed 'prefigurative action research', and it was suggested that it could be a major but insufficient contributor to the struggle of and for mentally disabled people.⁶

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References

- 1 The legacy of medical and institutional definitions of mental disabilities has meant that there is not really an adequate set of terms for referring to these client groups or to the services provided for them. In particular it is misleading to regard *mental handicap* as a *mental health* problem. However, it is difficult to find a more suitable generic term that describes both services for mentally handicapped people and those for mentally ill/disordered people. Without taking a particular stance on the nature of mental 'illness', the more neutral term 'mental disorder' will be used here, while 'mental disability' is generic for the very different groups of mentally disordered and mentally handicapped people.
- 2 Other sources include Brown (1979), Busfield (1980), Foucault (1965), Goffman (1961), Miller (1981), Ramon (1982), Rothman (1971), Sedgewick (1982), Treacher and Baruch (1981).
- 3 PASS training workshops are organized by CMHERA, 16 Fitzroy Square, London, W1P 5HQ in the UK; by the Training Institute for Human Service Planning, Division of Special Education and Rehabilitation, at Syracuse University, NY 13210, in the USA; and by the NIMR, York University, Downsview (Toronto), Ontario, M3J 1P3, in Canada.
- 4 See also the 'Walk through PASS' appended to Thomas et al. (1978).

- 5 Scull's account may be found in two texts (1977 and 1979 – the 1979 is derived from a 1974 doctoral thesis, but the 1977 book, *Decarceration*, provides the broader analysis).
- 6 I am grateful to the following individuals for encouragement, support, and helpful criticism of an earlier draft: Christine Adcock, Chris Cullen, Ian Fleming, Chris Gathercole, Carolyn Kagan, Maria Thomas, Alan Tyne and two anonymous CSP reviewers, but failings in the final product should not be attributed to them.

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