SURVEILLANCE THROUGH CARE AND CONTROL:
The Case of the Mentally Ill in Madison and Britain.

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Abstract

Increasing moral panic in Britain, fuelled by newspaper reports of 'innocent' victims being murdered by persons with serious mental illness failed by the system of community care, has led the government to consider the introduction of greater powers of compulsory treatment and detention for such individuals. Government plans have encountered much opposition in Britain, in particular from mental health professionals and those concerned with civil liberties. The government insists that the community care of the most seriously and potentially dangerous mental health consumers has failed. Its draft powers of compulsion are one further example of a gradual drift in Britain towards mounting surveillance of difficult groups not on an inclusive and caring basis but on an approach dependent on exclusionary and compulsory means, many of which have implications for civil liberties. However, in contrast to the government's position, there is at least one place, Madison, Wisconsin, where a most successful system of community care for persons with mental illness can be found. There, even the most seriously ill individuals are frequently treated in the community so that they can exercise their civil rights to enjoy as normal and independent a life as possible.

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Introduction

Persons with mental illness, especially those with serious and persistent conditions, are often seen as a problematic group in terms of providing treatment and in terms of the potential threat they may pose to themselves and to others. One way to draw comparisons between different cultures in the manner in which they respond to problematic groups is to look at the relative importance they give to civil liberties, the levels of 'controlling' or 'caring' behaviour, and the extent to which such problematic groups are subject to processes of inclusion or exclusion. England and Wales and the city of Madison, Wisconsin, are in these respects significantly different cultures, at least in respect of the treatment of persons with serious mental illness. Of course, no culture, city, or country is completely respectful of civil liberties (especially at times of terrorist attack as we have seen in Britain). Levels of control and care will vary as will the extent of inclusion and exclusion. One can think of these concepts theoretically as being at either end of a continuum – little or no respect for civil liberties, a strongly controlling approach and high levels of exclusion occupy one end, while at the other extreme are found high levels of respect for civil liberties and a predominantly caring approach and high levels of inclusion. Thus, we can locate particular cultures at different points along this continuum. As a shorthand summary of the concepts located at each end of the continuum, let us call it the control/care continuum. Indeed, the treatment of mental health consumers in Madison and in England and Wales will reveal just where these two separate cultures are located along that continuum. Here, a brief explanation of how Madison fits into its own wider context is necessary.

Madison has been characterised as a socially progressive city for some time; it benefits in all kinds of ways from being the state capital of Wisconsin and the seat of a huge University of Wisconsin campus. But it is also a part of the USA, a country with a somewhat different culture to that of England and Wales. One obvious difference is that a Bill of Rights, existing from the very start of the USA, has imbued the political and legal cultures in particular with a healthy knowledge of, and respect for, human rights. In contrast, Britain (of which England and Wales is a part and which has its own mental health system distinct from that in Scotland and Northern Ireland) lacks a bill of rights and has relied on common law in the main to define rights; it was only in 1998 that Britain passed the Human Rights Act which incorporated for the first time into domestic law the provisions of the European Convention on Human Rights. A rights-based culture of law and of political debate is not as strong in Britain as in the USA. Respective levels of control and care are difficult to quantify, but what seems at least arguable is that Britain has traditionally had more of a caring approach to various different groups of citizens by virtue of the longstanding and extensive nature of the Welfare State. However, that position is changing, with a more 'punitive' and controlling aspect entering into the social, legal, welfare and political processes of Britain, especially in relation to groups seen as troublesome or threatening in some way. Control, especially in relation to criminal matters, has long been a feature of the USA.

Indeed, the USA has found a whole new way of controlling persons with mental illness – the prison. Panzer *et al* (2001: 41) noted that while USA prisons were intended as a method of incarceration and punishment for those who had broken the law, increasingly they were being used as an 'inadequate and inappropriate method to

contain mental illness'. Moreover, persons with mental illness were sent to jail at about 8 times the rate at which they were sent to public psychiatric hospitals (Panzer *et al*, 2001: 41). Due to the severe difficulties in securing long-term, involuntary committals to psychiatric hospitals in the USA and the fragmentation of mental health services in parts of the country, many persons with mental illness who commit even minor crimes are being directed into the criminal justice system and receiving prison terms that are longer than they might have received under a hospital committal process (Lamberti *et al*, 2001: 63). In part, such a development is the criminalisation of persons with mental illness; it is also a process through which many individuals who would have received 'care' in hospital are now receiving 'control' in prison.

While space does not permit me to go into greater detail about this criminalisation process, to some extent, as we shall see later, Madison tries to counter this trend in respect of persons with mental illness who come into contact with criminal and penal justice agencies. Similarly, exclusion and inclusion are topics that deserve papers in their own right. Suffice to say here that, in the treatment of mental health consumers at a country-wide level, both the USA and Britain have a history of poor treatment leading to exclusion and the denial of various human rights. Both countries adopted large scale de-institutionalisation programmes and decanted many thousands of seriously ill patients from their long-stay hospitals into communities often ill-equipped to deal with them, which in turn led to increased levels of neglect, homelessness, and suicide. Again, as we shall see later, Madison bucks this trend. It does so for one overriding reason – a belief that it is the right of a person even with a serious mental illness to live as independent and as normal a life as possible. So,

while the position of the USA as a whole on the control/care continuum is important, what is more important is the precise location on that continuum of Madison itself.

While Madison is clearly located towards the 'care' end of this continuum, it must also be stressed that it is not a typical American city. Madison is quite small by city standards; it does not have the feel of a large soulless space with significant areas of acute deprivation. It is Madison's history of respect for human rights, a highly educated and largely liberal population and a predominantly wealthy citizenry which make the city different from many others in the USA, and which also helped from the early 1970s onwards to set the foundations for a progressive system of community care for mental health consumers. The adult mental health budget for 2005 in Madison and the surrounding Dane County was almost $16 million - a considerable sum given the size of the general population and the number of actual mental health consumers. While budgets in the past two decades have been reasonably generous to provide a decent service, even the Madison authorities are very wary of increasing property taxes to pay for more mental health services. Accordingly, mental health services in general increasingly have to cope with annual financial settlements that barely keep pace with inflation. In short, Madison may be liberal and atypical in some respects, but its citizens will only go so far in funding such public services. That said, in Madison there is just about enough money each year to maintain a very good system of mental health care and, as importantly, there is now a long tradition (stretching back over four decades) of finding innovative and effective methods of helping even the most seriously ill people to live in the community with dignity. There is a large group of experienced professionals within the mental health care system who take such an approach as a 'given' and who know how to implement it.

Mental Illness – An Emerging 'Problem'

British society has seen increasing debate and concern about what to do with what are still called 'the mentally ill', which is in part an indicator of where that culture may be located along the control/care continuum. The concern focuses much less on the mildly neurotic (the so-called 'worried well'), but certainly targets the seriously mentally ill and especially those who might harm themselves or others. The British government has been intending to introduce new legislation in respect of the mentally ill and to reform the Mental Health Act 1983 for a number of years. Major indicators of the government's intentions in respect of reform have been found in the White Papers such as, *Modernising Social Services* (Dept of Health 1998) and *Reforming the Mental Health Act* (Dept of Health 2000)**,** and in draft Mental Health Bills. One of the major goals of these White Papers was to improve the quality and consistency of services for the many people who suffer from mental health problems. In this respect, the government was absolutely correct to focus on such an objective for there is a huge and growing need for effective mental health services. Let's look at the scale of the problem.

- Every year one in four British people consult their GP about a mental health problem
- In any given week, one in seven of the population will have a diagnosable mental health problem
- One in a hundred people will experience schizophrenia before they are 45 years old.

- Four of the ten leading causes of disability in industrialised countries are : depression; bipolar disorder; schizophrenia; and obsessive compulsive disorder.
- The World Health Organisation predicts that by 2020 the second leading cause of disability worldwide will be depression.

(Source: Mental Health Foundation 1999)

The government itself stated in 2000 that as many as one in six of the population face a mental illness at some point in their lives, and that 630,000 patients with *serious* mental health problems are being cared for by specialist mental health services in England and Wales. The political intention to improve services, in what has traditionally been the Cinderella area of health care, was also backed up by extra resources. Between 1999 and 2003 just over £700 million was provided to invest in better outreach services, 24 hour crisis teams, and better access to appropriate anti-psychotic drugs.

From 'Care' to 'Control'

When one examines such financial support for mental health, at first glance it looks very much like a caring and inclusive approach being implemented by a government with a desire to improve health care for the many thousands and thousands of people suffering from a range of mental illnesses. But the real imperative behind the White Papers, the draft Mental Health Bills and behind many of the new schemes that have already been introduced was to *control* the perceived threat from a relatively small number of mentally ill individuals who were seen as '*dangerous*'.

The White Paper *Reforming the Mental Health Act* (Dept of Health 2000) had another goal – more important than improving services for the majority – and that was the use of *compulsory* powers against dangerously mentally ill persons in order to preserve public safety. Accordingly, the White Paper spoke of the need to provide a new structure for the application of compulsory powers of detention and of treatment for those who posed a threat to the safety of others. These 'high risk patients' need not have committed any crime in order to be detained or treated against their will. The fact that they have been deemed to pose a significant risk of harming someone else will be sufficient to bring them within this new structure, which incidentally we are promised will be in full accordance with the provisions of the Human Rights Act 1998 – presumably in relation to the legality of being detained. Those deemed to be in need of treatment can be subject to compulsory treatment even if they are not detained in a secure hospital or in a jail.

What is going on here when concern for the many who have mental health problems through apparently liberal policies can so easily turn into an intention to impose compulsory detention and treatment of those deemed at risk by deploying policies that are anything but liberal? How do we make sense of this apparent inconsistency between caring for persons with mental illness and controlling them? Both the caring approach and the controlling approach are forms of surveillance, and persons with mental illness have always been under some form of surveillance in society, but the consequences of each approach are different. Let me explore these ideas in a little more detail in relation to the history and development of the treatment of the mentally ill in Britain. Later, I will contrast that with the experience of Madison in the USA.

Shifting Paradigms for the Treatment of Persons with Mental Illness

It was the Victorians who first started to incarcerate large numbers of people in asylums. For well over a century government policy and public opinion favoured the segregation of persons with mental illness in long-stay hospitals. Throughout the 19th and 20th centuries the number of people incarcerated in asylums grew until in England and Wales the resident population of mental hospitals peaked at 148,100 inmates. This was an institutional form of surveillance and control. I am not suggesting that asylums were lacking totally in care, only that the primary means of dealing with the mentally ill was through a system of *exclusion*, at the heart of which was control and surveillance. The locked wards, the setting of the Victorian asylums often in what were then remote places, and the high walls around most asylums spoke volumes about how we used to deal with such patients. They were set apart from society, excluded, and stigmatised (Goodwin 1997). The inmates of such places may have been patients, deserving of treatment, but they was little sense that such people actively had rights which they could exercise.

With the publication of Goffman's *Asylums* (1961) in the 1960s and the growing concerns about the ill-treatment of patients in long-stay hospitals, and the advent of newer and better drugs to control many of the more bizarre symptoms of mental illness, we see the rise of a more caring and humanitarian approach in the treatment of mental health issues – a movement that eventually becomes known as community care. Here, inmates of asylums become citizens who live in and are treated in the community – they should no longer be excluded; they should no longer be stigmatised. In fact, their lives should be normalised so that they can live as independent and as dignified a life as possible. They should have extensive contact

with mental health services and professionals. This is a powerful rhetoric and it is no surprise when, subsequently, the move away from incarceration to de-institutionalisation as part of the community care philosophy sees a steady decline in the number of patients held in long-stay hospitals. From a peak of just over 148,000 in 1954, the population falls to just under 30,000 in England and Wales by 2003 (Goodwin 1997; Jack 1998).

Of course, someone like Scull (1984) would not agree with this cosy process of change from a controlling ethos to one based more strongly on caring. Scull argued that the move to close many long-stay hospitals was driven not so much by humanitarian motives but by cost considerations – that community care would be cheaper or thought to be cheaper than institutional care. Thus, community care seems a benign way of treatment while also saving the state a lot of money (Scull 1984:135). The word 'seems' is important here, for while there were many medical, social, and ethical arguments in favour of community care and its supposed advantages, the reality turned out to be very different.

As wards closed and patients were decanted from hospitals to be treated in the community, many of them often found themselves in ill-prepared communities in terms of actual mental health services and appropriate accommodation. Indeed, in some areas, the community was actively hostile to the idea of former patients being 'dumped' on them as they saw it. Controlling, exclusionary and institutional forms of surveillance were supposed to be switched to forms of surveillance that were caring, inclusive, and community based. In fact, while this was true for some discharged patients in Britain, many were almost as worse off outside the hospital for they found

themselves isolated, with little or no effective medical treatment, and often living in appalling accommodation with no sheltered workshops or drop-in centres (Bean and Mounser 1993). This was the beginning of the revolving door syndrome. Such a state of affairs was, if anything, benign neglect. Improvements over the years to the system of community care have lessened this neglect and improved the decent, caring aspects of this approach, even though the system is still seriously flawed (Trieman and Leff 1998) . The 'natural' tendency in the past 30 years of community care, if I can put it that way, has been to steadily provide better and more inclusive forms of services – to improve the surveillance *and* the treatment of such individuals through an essentially caring approach. Government plans, if implemented, would re-introduce a significant element of surveillance via exclusionary and controlling (i.e. compulsory) means.

The treatment of and responses to persons with mental illness are frequently cyclical (Allderidge 1979). The main focus in the most recent cycle has been the government's insistence to concentrate on public protection, fuelled by media stories of 'madmen' running amok. In some ways, the British tabloid press is hostile to the notion of treating persons with serious mental illness in the community. Even though the actions of a very small number of persons with mental illness who might turn to violence are a legitimate concern, sensible legislation and policies to address this issue are by no means helped by ill-judged political reactions to moral panics caused by the tabloid media (Soothill and Walby 2001). Using the law and compulsion to control such individuals is not always effective (Prins 1996). According to Fitzgibbon (2004: 19) 'society has lost sight of the importance of justice and … vengeance and risk management have subsumed such principles [and] are gaining momentum'. This momentum may well be based on the mistaken but widespread public belief that the

number of murders committed by persons with mental illness has significantly increased in the years since the introduction of community care. Taylor and Gunn (1999) have shown that this is not so, as far as Britain is concerned, and therefore the idea that decarceration has led to greater violence by those released from mental hospital is not proven (Simpson et al. 2004). However, given persistent public concern (even if mistaken) and the government's political desires to be seen to be acting on these matters, Britain has recently witnessed the introduction of a new 'disorder' - dangerous severe personality disorder (DSPD) – a disorder named by politicians and not by mental health professionals.

In July 1999 the government began its consultations regarding the management of people with DSPD, and in 2002 produced its first draft Mental Health Bill. This was greeted with a storm of critical comment. Eldergill summarized the Bill thus:

The draft legislation seems designed to sweep from the streets, or to supervise and control, anyone whose behaviour causes the public significant concern, but whose behaviour does not allow the police or the courts to place them in custody in the absence of any proof of serious offending. In many respects, it does not comply with the European Convention on Human Rights, or with the minimum international standards agreed by nations as being the baseline for countries that wish to be considered civilized in this respect (Eldergill 2002: 359).

It may be that such strong criticism was responsible both for the draft bill not being placed before Parliament and for a second draft bill to be produced by the

government in 2004, which is still being examined by a joint Parliamentary Committee of MPs and Peers (Department of Health 2004).

The government's plans to treat and to detain compulsorily those deemed to be dangerous by virtue of their mental disorder is not an example of control via a community based system – it is an attempt to have control over a whole community of people**.** It is an expansion of surveillance using existing caring systems and a newer, tougher system of compulsion. It is intended to be a bifurcated system of soft control (care) and hard control (compulsion). Some persons with mental illness are to continue to be included under the existing system of community are, but others will be just as effectively excluded through systems of compulsion as they were when they were locked away in asylums. This tough stance, in the name of public protection and safety – words which are very common throughout the government's own reports and publications in this field – may have electoral appeal. The government may also think it is an appropriate response to public concern, even moral panic, about attacks on innocent bystanders by persons with mental illness. To cater, if that is the right word, for a small number of people labelled as 'dangerous' is certainly easier and cheaper than providing a modern, effective and caring system for all those persons with mental illness.

Drifting towards Surveillance and Control

However, leaving aside government motives, we can at least say that plans of this kind, involving tougher surveillance, are not limited to the handling of persons with mental illness. Arguably, we live in what Foucault (1997) called the 'disciplinary society' – a society based increasingly on more and more surveillance and regulation

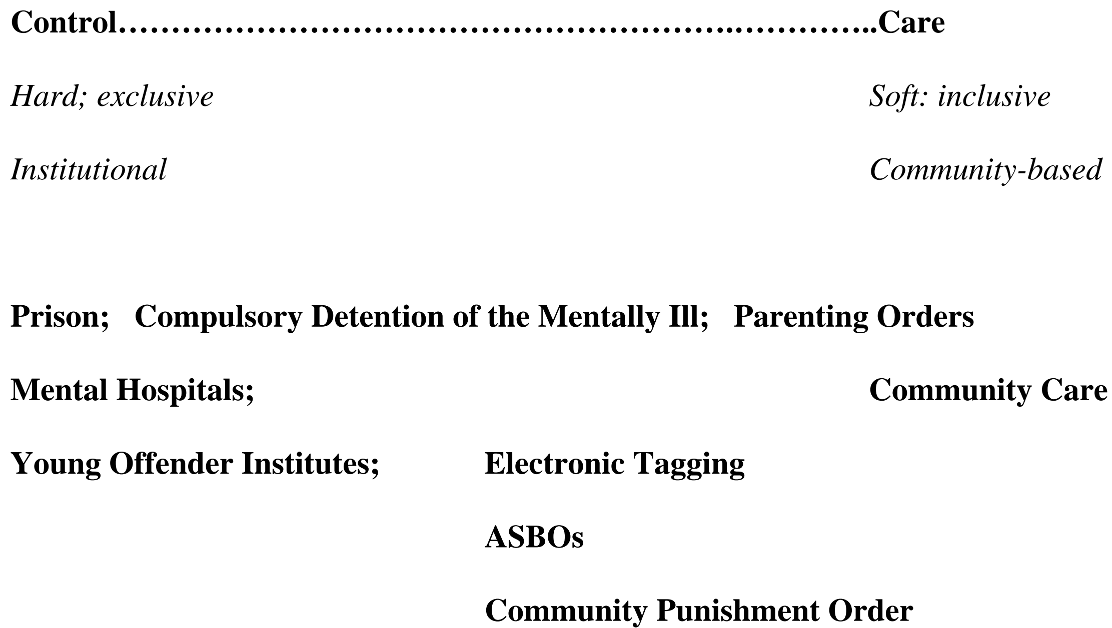
of ever more personal areas of life. A selection of what I have called the 'traditional' forms of surveillance are pretty well-known to us in Britain, and are set out below.

'Traditional' Forms of Surveillance

- Targeted (undercover) policing
- CCTV
- The work of Special Branch, MI5 and MI6 – intelligence services
- Probation
- Social Work
- Sectioning under the Mental Health Act 1983

We have in recent years moved beyond these 'traditional' forms of surveillance and have either introduced new ones or have revamped existing forms. A selection of these forms of surveillance can be set out along a continuum of care and control as shown in Figure 1. It is not intended to be an exhaustive selection, and there is certainly scope to argue about the relative location along the continuum of the selections. The contents of Figure 1 might well amount to what Foucault (1997) called the 'carceral archipelago' or 'continuum' – a modern version of the widening of discipline, control and surveillance in our society. It is a widening not only because of new controlling developments, such as anti-social behaviour orders (ASBOs) with their lesser order of proof before they can be imposed, but also because they include so-called caring initiatives such as Parenting Orders designed to engineer greater parent-child accord.

Figure 1: A Continuum of Control and Care as Forms of Surveillance



Some of the above matters require a little further attention in order to reinforce the argument that Britain is becoming a more controlling society. The advent of Mrs Thatcher's 1979 Conservative government saw large changes to Britain's systems of policing, criminal justice, prisons and sentencing. Police numbers and powers grew; there was much greater emphasis on the courts processing criminals more efficiently; the prison population reached new heights; and sentencing became more punitive. After almost two decades out of power, the Labour Party felt it could not be seen to be 'soft' on crime. Indeed, its leader, Mr Blair coined the phrase 'tough on crime and tough on the causes of crime'. On coming to power in 1997, Labour in fact began a kind of old-fashioned 'arms race' on issues to do with crime and deviance in all forms, vying to be tougher than Thatcher ever was and tougher than the current Conservative opposition. Community Service Orders had some years before 1997 been renamed Community Punishment Orders, reflecting the view among politicians

that the public needed to be convinced that a community-based sentence was no light let-off but an appropriately tough and controlling alternative to imprisonment. Blair's Labour government soon introduced its own, new tough measures in the Crime and Disorder Act 1998. Among these were Parenting Orders, civil orders imposed in family proceedings courts or in magistrates' courts acting under civil jurisdiction. Parents were compulsorily required to attend counselling or guidance sessions for up to 3 months to receive help and advice about managing their child's problematic behaviour. An order might also include a discretionary element, such as requiring a parent to ensure the child attended school regularly for up to 12 months – both compulsory course attendance and any discretionary duty being supervised by a member of a youth offending team. Despite the fact that such orders are normally imposed via a civil procedure where a child is deemed to be in need of some form of care and control, a breach of a parenting order can lead to a criminal prosecution in an adult magistrates' court and be punished by a fine, community rehabilitation order or other community sentence among others. Many critics have argued that this a backdoor and unacceptable way of involving the criminal law in family matters that are best dealt with by psycho-social and other caring means. What the law does do, according to the politicians who passed it, is to deal with 'troublesome children' in an effective manner, stressing to them and their parents that anti-social behaviour will not be tolerated.

Indeed, a further aspect of the Crime and Disorder Act was anti-social behaviour orders (ASBOs), another civil order with criminal consequences if breached. ASBOs are imposed on those likely to cause harassment or alarm to others and contain certain prohibitions, such as a ban on entering a certain area. Breach of such an order may

result in 5 years' imprisonment for an adult and 2 years on a detention and training order for a juvenile. While criminal standards of proof are required to find someone guilty of a breach, a magistrate may impose an ASBO after listening to hearsay evidence, which is admissible in civil proceedings. Other ways to control problem groups include the Curfew Order, under which an offender may have to stay at a designated place (usually the offender's home) for between 2 and 12 hours per day for between 3 and 6 months, depending on the age of the offender. The order is normally used with an electronic tag attached to the person to ensure compliance. Local Child Curfew Orders allow local authorities to tackle anti-social behaviour by groups of people by stipulating that *all* children under 16 years of age in a designated area must be at home by a certain time in the evening. This local ban on the evening movements of teenagers may last for 90 days. This area ban has been attacked as a gross slur on the characters of the many decent children living in areas where such orders have been sought and who have legitimate and harmless reasons to be on the streets at night. There are other examples that could be cited, but these (and the ones in Figure 1) provide ample evidence that in recent years there has been an increasingly controlling and sometimes exclusionary response by British governments to handling problem groups – a response that frequently puts being 'tough' (or being seen to be tough) before the rights of those targeted for controlling action, or indeed favours the tough approach (which is usually quicker) than a longer, more patient approach involving better education, community-based action, and other inclusive measures.

If we now return specifically to the issue of persons with mental illness (especially the seriously ill), we must remember that they will always be under some form of

surveillance, if only because many of them are vulnerable and often lack coping skills if left to their own devices. However, as we have seen with some of the above examples, government responses to problem groups can be controlling, 'tough', and exclusionary. The question is how can we ensure that we have a caring, inclusive system of surveillance, which is designed to deliver effective treatment? One answer to that question may lie with what I have described elsewhere as the Madison model (Stephens 1999).

The Madison Model

Madison is the state capital of Wisconsin. The population of the city is just over 215,000 and that of Dane County, in which the city is located, is 398,000. The area itself is well-known historically for adopting a tolerant approach to social and welfare issues, notwithstanding the introduction of 'workfare' in the 1990s. In Madison, there exists the Mental Health Center of Dane County (MHCDC), which is a private, non-profit, multi-faceted and multi-functional organisation which is at the very heart of mental health services in Dane County. The centre directly provides or coordinates services for a large range of needs, including: clinical services and assessment; alcohol and drug treatment; child, adolescent and family services; case management; community support programmes; emergency and medical services; and psychiatric rehabilitation programmes for persons with severe and long-term mental illness. Thus, the centre is a crucially important element in what is an integrated *network* of services in Dane County, which caters to the differing needs of a variety of mental illnesses. Most of the centre's consumers have complex mental health or drug and alcohol problems (many are dually diagnosed).

In 1990, five new community support programmes (CSPs) were created to cater for persons with serious and persistent mental illness, operating at separate community based sites. These CSPs are the forerunners of what are referred to in the UK White Paper as 'outreach teams' (Dept of Health 2000). Today, each of the Madison support programmes has a clientele of between 55 and 75 service users who are all known individually to the staff of the respective CSPs. Each CSP provides a comprehensive outreach programme offering a full range of treatment, rehabilitation and support services, which allow clients to remain in the community with as independent and dignified a lifestyle as possible. Furthermore, the programmes reduce significantly the amount of time that individuals spend in more restrictive environments, such as the mental hospital, nursing homes or prison. Indeed, the legal basis of the publicly funded services in Madison is founded on the prescription that patients have rights and are entitled to receive their treatment in the least 'restrictive environment'.

The essence of the outreach approach is to provide an integrated and comprehensive set of services *in vivo,* so that clients receive the intensive support they need to continue to live in the community. The programmes are assertive in two ways. First, over 80 per cent of contact with clients is in the community – in the client's home, local launderette or supermarket and such like. Professionals do not simply wait for clients to approach them at the CSP site. Secondly, professionals do not 'give up' on clients who may, at times, say that they want the caseworker to go away; mental health professionals in CSPs find ways of continuing to work with individuals during such 'rough' periods. As a result, the drop-out rate among the five programmes is virtually nil. By adopting such an approach, most patients remain *voluntary* users of these services.

For the most part, Madison has avoided the worst excesses of moral panics in which it is the apparent dangerousness of persons with mental illness that is emphasized. Indeed, the city has one relatively small unit, the Mendota Mental Health Institute, devoted to dealing with those individuals who are receiving involuntary acute treatment.

During the early 1970s, many long-stay mental hospital patients were discharged into a Madison community then ill-equipped to handle their needs. Poor community care often led to re-hospitalisation. However, in 1975, a Crisis Intervention Service was set up by the MHCDC to reduce both the incidence of the 'revolving door syndrome' and simultaneously the high costs of institutional care. The crisis unit exists to this day as a part of the centre's Emergency Services Program. The goals of this programme are: to enhance the well-being of people in emotional crisis and to help them cope with and overcome that crisis; to prevent suicides; and to minimise hospitalisation. To this end, the programme provides a 24-hour emergency telephone service that undertakes initial assessment of callers and can provide appropriate information or referral to other mental health services. This service has a clear suicide prevention focus. In addition, the Crisis Intervention Service has a mobile capability, allowing it to respond quickly to mental health emergencies, especially those involving threats to anyone's safety. The crisis staff support a client through a crisis, provide frequent contacts as necessary, diagnose an individual's condition and dispense appropriate medication. They also organize short-term intensive case management until the crisis is resolved (or the individual is stabilised) and the client can be referred to another programme in the network of services provided by the

MHCDC. Crisis workers also routinely provide information and support for police officers who may be called in the first instance to deal with mental health emergencies (Stephens 1994).

The most important aspect of the programme is its gate keeping role in respect of hospitalisation. All involuntary admissions to hospital must be authorised by crisis unit workers. Indeed, 70 per cent of cases involving potential involuntary admissions end not in a hospital stay, but in other forms of community-based treatment. Hospitalisation is used sparingly, and normally only for cases with a high suicide risk. Emergency services staff are committed wherever possible to voluntary treatment and they have a range of services and experienced professional staff who can be deployed to best suit the needs of the individual.

Mental health services in Madison interrelate on three levels. The first level constitutes the core programmes providing assertive outreach and continuing treatment for those clients at highest risk of hospitalisation. Such programmes are staff-intensive and most, if not all, services exist within a single treatment team or unit. Provision at the second level is composed of single-service programmes for clients less likely to regress and who are capable of maintaining contact with a number of other service providers. Level three provides for those unconnected to services, such as the homeless. The goals here are to meet clients' needs for food, clothing and accommodation and then to prepare them for subsequent mental health treatment. Most users within all three levels are treated voluntarily. These service or programme levels reflect the varying needs of different clients, which is essential if the system is to be integrated and comprehensive and if all clients are to be properly

supported. Such support is crucial not only in allowing service users to lead as normal a life as possible, but also to minimise any regressive and potentially violent and dangerous behaviour.

Madison, however, is not without its problems. One of the services provided by MHCDC is a dedicated jail crisis team based in Madison's main jail where the team see over 1300 male and female prisoners per annum in a facility that suffers from long term overcrowding problems. The team of social workers, drug and alcohol counsellors and psychiatrists act as an assessment and on site crisis intervention service, which daily reviews all new arrivals. It works especially closely with those who may be suicidal or actively psychotic. There is also a diversion element to their work whenever possible. The team provides a valuable service in helping prisoners with mental health problems to maintain their medicines, facilitating access for MHCDC staff on other programmes to which prisoners may already belong so that their long term care is not completely disrupted, and in helping to remove prisoners from jail to psychiatric care when possible. In fact, without the work of the CIS in the city itself, the jail team would receive even more mentally distressed prisoners. CIS can often persuade Madison police officers to release into their custody individuals with a mental illness who would otherwise have been arrested, charged and held in custody. Many jail diversion programmes 'lack effective linkages with clinical and social services', which severely hampers their own effectiveness (Lamberti *et al*, 2001: 66). This lack of linkage is not the case with the Madison jail team which has very clear and longstanding connections with a range of programmes supplied by MHCDC and other welfare agencies. However, the jail team is fighting against a strong trend for such jails to become in effect a low cost hospital facility with no

waiting list and with little or no ability to turn away mentally disturbed prisoners sent to them by the courts. Moreover, when the jail team does successfully divert someone from the prison, they are faced often with the problem of finding that person a position within an appropriate mental health programme. The same problem frequently occurs when prisoners with a mental illness complete their sentence and are released back into the community.

There are two issues to consider here, both of which further highlight some of the problems the Madison model is encountering - rationing and finance. To an extent, all the CSPs are the victims of their own success. They are so successful with their outreach capability and in delivering such effective support that there is little turnover of CSP clients. At the same time the population of persons suffering from serious and persistent mental illness is increasing; this leads to rationing, bottlenecks, waiting lists to join certain programmes, and some programmes desperately trying to pass on selected clients to other services so that a more pressing case can be taken on. Moreover, while the population of people requiring help with all kinds of mental health issues has been increasing, annual budgets have been lagging behind which has led to greater restrictions on some of the services that can be offered.

Finally, services in Madison are based on a strongly professionalised organisation - the MHCDC. In the past this has meant that consumer involvement in the decisions, direction and policies of MHCDC programmes has been severely limited. This is now changing with former and present clients being employed on some programmes in various capacities, and with widespread consumer involvement in planning services and in hiring professional staff.

Conclusion

There are several important lessons we can take from the Madison experience. First, there must be a *network* of *integrated* services reflecting the variety of mental health problems, but in particular focusing on the needs of those with serious and persistent mental illness. Second, it is beneficial to have one's core community-based programmes, such as CSPs and Emergency Services, provided through a highly experienced and professional mental health centre. Finally, there should be a professional commitment to using institutional options only as a last resort and for the minimum required period. The British government has encouraged the creation of what it calls 24-hour crisis and outreach teams, of which there are now over 200. But, as welcome as these programmes are, they are still not fully nationwide, which means some forms of treatment and help will remain a geographical lottery**.** Moreover, the British equivalents of Madison's CSP and Emergency Services do not as yet appear to have either the same commitment, nor the same capacity to keeping people out of institutions and to avoiding compulsory treatment. It is this network or spectrum of services in Madison that provides the kind of surveillance that is primarily caring and inclusive. It may be that too much of the work of the British crisis and outreach teams will be targeted on the 'dangerous' and their surveillance will be too exclusionary and controlling.

In Madison, there is a different attitude towards the idea of protecting the public. The public are normally best protected not by assuming that compulsory treatment and some form of institutionalisation are required, but rather through the provision of an effective, co-ordinated network of community-based services. The British

government has proclaimed that community care has failed, when some would argue that it hasn't yet been properly tried. It has been tried in Madison, and it works, and it does not depend on compulsion. The British government should think long and hard before it goes too far down the road of compulsion. Compulsion runs the risk of undermining the relationship and trust between mental health professional and patient; it frequently depends far too much on the use of medication to the detriment of employment, housing and other issues; it destroys the notion of personal autonomy. The extension of compulsory treatment will serve only to deepen the stigma associated with mental illness; and it may well end up being a process that is open to abuse and discrimination. In short, the government should think more seriously not about denying the civil rights of some persons with mental illness, but rather how it can safeguard those rights through investing in a system of community care similar to that operating in Madison.

However, the expectations of civil society (as they apply to the mentally ill) are somewhat different in Britain to those in Madison. Britain is too far along the controlling axis of the control/care continuum, which means that the civil rights of persons with mental illness can be undermined much more easily than those of other groups, for example pregnant women who also make demands on the British health system. It means also that the surveillance of persons with mental illness can more easily revert to exclusionary methods where the paramount concern is not the rights of the individual but the level of effective control being exercised. Within British civil society the emerging rights based approach is not yet strong enough to influence government policy in any significant fashion in respect of the treatment of such people – we have more radicalism and sometimes violent action devoted to stamping

out animal experiments or banning fox hunting than we do directed at creating a system of community care that is both effective and mindful that persons with mental illness also have rights. It seems that persons with serious mental illness are too big a 'risk', and that being a risk to other citizens is somehow enough to introduce new means of compulsion. Madison has people whom leaving in the community is also a 'risk', but that risk is effectively managed. No system is perfect, not all risk can be fully eradicated, but some systems are much better than others. The Madison system *balances* risk and rights; it does not do so in a cavalier fashion. Indeed, cases of violence against citizens by those being treated within the MHCDC are rare. What Madison recognizes is that the best way to look after both the rights of citizens not to be attacked and the rights of those persons with mental illness to live a dignified life within the community is to provide inclusive, respectful and effective care.

Madison places a priority on helping those with serious and persistent mental illness. The system not only provides an element of 'control', but also one of wide-ranging care. Indeed, caring in the way that it does for its mentally ill citizens ensures, as far as is possible, that those same citizens do not need to be locked away to protect the public. With support, effective treatment and a caring ethos, these individuals are able to live in the community with their fellow citizens.

Government, mental health practitioners and the public should recognize that the Madison model can be transplanted to Britain. We have many professionals with appropriate experience and we are already borrowing ideas from Madison such as assertive outreach programmes. Both Madison and Britain face similar difficulties such as the growing incidence of the criminalisation of individuals with mental illness

so that they add considerably to the problems in our jails. Of course, Madison and Britain are not the same, but neither are they so different and nor are the respective problems so divergent. What Madison has is a coordinated network of services and a decent financial base albeit an increasingly stretched one. A mark of the achievement of Madison and its citizens is that the MHCDC employs more people than the city's police force. Indeed, the police recognize the worth of the services it supplies. Britain could simply copy a great deal of what happens in Madison, but first it needs the political will. It does not need more laws based on controlling a new so-called 'dangerous' class.

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