THE STATE AND SOCIAL POLICY OUTCOMES

by

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THE STATE AND SOCIAL POLICY OUTCOMES

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ABSTRACT

This study is concerned with analysing the effect of the state in influencing policy outcomes within the field of mental health care. An historical-hermeneutic approach is adopted and this requires a theoretical investigation of the state and its apparatuses in capitalism; an historical review of mental health care; the formulation of propositions to be tested; and the empirical investigation of the propositions. Trends within mental health care are examined over the period 1960-1979 using the Hamilton Psychiatric Hospital as a sample of the trends in Ontario. A Cochrane-Orcutt least squares regression model is used to link these trends to indicators of the propositions. Supplementary descriptive data are also examined to incorporate trends outside the hospital. The results reveal the importance of the current fiscal crisis of the state in influencing mental health care policy outcomes. An increasing number of state apparatuses, including the mental health professionals and their ideologies, are required to legitimate the deinstitutionalization policy, which aims more to avert the fiscal crisis of the state than to benefit the health of mentally ill patients.

ACKNOWLEDGEMENTS

Rothman (1971) notes that in 1845, one physician in New York listed 43 causes for mental illness among 551 patients. They ranged from ill health (104), religious anxiety (77), disappointed ambition (41), and loss of property (28), to excessive study (25), blows on the head (8), political excitement (5), and going into cold water (1). Having experienced most of these, in 1980 I am not labelled as mentally ill. Definitional changes aside, the primary reason for this has been the unending support given to me by my supervisor, Michael Dear. I am indebted to his guidance and patience.

I would also like to thank Marcel Lemieux for encouraging and facilitating the study; Edith Hoare for providing a wealth of data from the Hamilton Psychiatric Hospital; Barrie Humphrey for providing preliminary data; Gordon Clark for his suggestions regarding analysis; John MacGregor for help with stochastic time series procedures; and Dianne Laskowski for typing a mess into a manuscript (single spacing long may you live!).

Last but not least, thanks to Debbie Reid, Bob Hughes, John Boeckh, Cecil Beamish, Paul Mills, Joe Manion and Rob Thorpe for gatoring entertainment at 1014; to the admirers and supporters of Rex both here and abroad; Monty Python; and Foucault's (1977) grisly first three pages which constantly reminded me that things could be worse.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION AND OBJECTIVES

1.1 Introduction: The State and Mental Health Care

The provision of social services is usually understood to fall within the general realm of a public authority which makes policies concerning the configuration and organization of those services. Geographers have traditionally been interested in the locational outcomes of such policy decisions, and have pursued questions regarding the equity and efficiency of service provision. In this research, however, the decision making body -- usually some level of government -- has usually been treated as a 'black box', and the principles guiding its behaviour have traditionally been regarded as exogenous to the research. This treatment has resulted in an over-emphasis on empirical work at the expense of a closer examination of the underlying structural causes which are fundamental to the observed reality.

Based on this assertion, this study focusses upon the decision-making body and its relation to the various exogenous and endogenous forces that influence its policy-making capacity. In particular, the study will examine the relationship of government to the provision of care for the mentally ill in Ontario. This encompasses much more than

an isolated case study with respect to mental health because any study of the government's relation to medicine or any other social service is necessarily a study of the inner functionings of *the state*. In this, the state is defined as that composite of government and supporting institutions, of which mental health is only one sector.

Hence this is a study of *intra-state* relations, using mental health care provision as a focus. Of particular interest are the changes in mental health care provision which arose as a response to a government policy to 'deinstitutionalize' the mentally ill. This policy places an emphasis upon improving the accessibility pattern and treatment setting for mentally ill patients. It encourages the release of patients from inpatient, hospital-based facilities to utilize the rising number of outpatient, community-based facilities (eg. psychiatric units of public hospitals). In terms of patient numbers, the result has been an almost immediate decline in the numbers of patients on the books of provincial asylums, a trend which prior to this time had been slowing rising for over a century (Table 1.1). The number of hospitals have declined slightly (Table 1.2); however, the rise in admissions and discharges in outpatient care (Table 1.3) has been accompanied by a substantial increase in the total number of facilities (see Table 1.2).

While the facility locational accessibility has improved, and treatment is claimed to have improved, the fate of released patients remains questionable. Recent studies (Dear 1977b; Wolch, 1978;

Table 1.1 Admissions, Discharges and Patients on Books, Ontario Provincial Asylums for selected years, 1880-1976.

YEAR	ADMISSIONS	DISCHARGES	ON BOOKS*
1880	574	204	2899
1890	697	262	3955
1900	793	335	5877
1910	1140	555	6670
1920	2379	858	7689
1930	2469	1265	10,390
1940	3224	2257	15,283
1950	4334	2636	18,923
1960	7320	6184	19,507
1971	15,712	15,868	8,838
1976	14,112	14,163	5,030

SOURCE: Annual Reports, Ontario Mental Hospitals.

*Before 1901, 'On Books' is taken as the annual number of patients under treatment. After this date 'On Books' is the number of patients under treatment at the year's end.

Table 1.2 The Numbers of Mental Institutions in Ontario and Canada 1969-1977

	PUBLIC PSYCHIATRIC HOSPITALS		PUBLIC PSYCHIATRIC UNITS OF PUBLIC HOSPITALS		ALL INSTITUTIONS	
	ONTARIO	CANADA	ONTARIO	CANADA	ONTARIO	CANADA
1969	5	10	38	84	98	253
1970	4	11	41	86	103	263
1971	4	11	43	91	106	275
1972	4	11	43	91	106	389
1973	4	10	43	99	111	310
1974	4	11	48	116	122	333
1975	3	10	50	129	135	365
1976	3	10	54	137	143	377
1977	3	10	60	148	148	382

SOURCE: Ontario Statistics, 1978

Table 1.3 Province of Ontario, Trends in Patient Population of Psychiatric Units of General Hospitals and Community Mental Health Agencies, selected years, 1965-1976.

	PSYCHIATRIC UNITS			COMMUNITY MENTAL HEALTH		
YEAR	ADMISSIONS	DISCHARGES	ACTIVE*	ADMISSIONS	DISCHARGES	ACTIVE*
1965	8,515	8,458	617	17,319	16,421	10,042
1970	18,914	18,820	1,118	37,536	33,729	28,156
1972	23,005	22,985	1,226	46,651	36,257	44,237
1974	26,795	26,702	1,355	49,417	43,440	53,637
1976	28,441	27,643	1,343	50,332+	43,115+	70,661+

Sources: Ontario Ministry of Health Hospital Statistics, 1972, 1974, 1976, Table 41, 49.

*Active Cases at Year End

+This figure is approximately 90% of the total figure as figures for Community sponsored clinics only are included (provincially sponsored Figures are deleted).

Wolpert and Wolpert, 1976) suggest that the released mentally ill patients are among the community of service-dependents who are "ghettoized" in the inner city. These important spatial changes in facility and patient location represent the geographical outcomes of a social policy. It is the forces behind these outcomes that this thesis aims to explain.

The two research themes in this thesis (the state and mental health care) have only recently begun to gain prominence in the geographic literature. The slow emergence of studies in mental health care appears to be partly related to the nature of the service, which clearly differs in demand and locational criteria from other services that have traditionally received geographic attention. In fact, with past forms of care (asylums only), a location 'problem' did not really exist. Most facilities were located on the outskirts of urban areas to ensure the safety of citizens and, it was claimed, to provide a more peaceful treatment setting for the patient. However, the change of treatment format, from hospital-based to non hospital-based modalities, has generated a new research interest in questions of the accessibility and utilization of services; the location of releasedpatients; and neighbourhood opposition to facility location (cf. Dear, 1977a).

The issue of the state has also received relatively little attention in the geographic literature. Only recently has there been increasing theoretical concern over the role of the state, following the realization of its crucial nature in influencing urban and regional spatial processes. Prior to this, it was either largely

ignored or treated as an ensemble of institutions which acted to constrain market forces. Clearly, however, many vital questions remain to be examined with respect to the state. In fact, the literature is still debating fundamental questions of the form and function of the state (cf., for example, Clark and Dear, 1978). As will be argued, further attempts to elucidate the nature of the state and its impact on spatial outcomes is highly desirable in geographical research.

1.2 Epistemological Principles

In keeping with the change of focus of this study away from spatial outcomes and toward the major forces underlying those outcomes, progress must be made with an analytical framework which is best suited for interpreting the underlying structural causes of spatial outcomes. According to Habermas (1974), this involves a movement away from the 'empirical-analytic' tradition of positivist science, which has tended to isolate researchers from society making "...social science an activity performed *on* rather than *in* society" (Gregory, 1978, 51), towards the 'historical-hermeneutic' focus of what Gregory calls a critical science.

The historical-hermeneutic approach seeks to delve below the "level of appearances" to the underlying structural causes of spatial patterns. It stresses that it is necessary to investigate the

historical conditions[1] leading to present day appearances and to elucidate upon the link between underlying structural causes and levels of appearances.

In developing an appropriate mode of analysis for this study, the choice between the empirical analytic and historical-hermeneutic approaches is crucial. The former offers a well defined analytical methodology which has to date succeeded only in describing the superficial level of appearance of locational processes. The inadequacy with which the relationships between social process and spatial form have been treated seems to reflect not the inability of the empirical approach to consider these factors simultaneously, but is rather an outcome of an excessively restrictive practice of the scientific method.

The historical-hermeneutic approach, however, offers a complex but powerful heuristic for interrogating the relationship between empirical observation (ie. observed spatial form), and the underlying structural causes (ie. social processes). In it, the relationship between spatial form and social process (ie. the relationship between observation and theory) is seen as "reflexive" -- one mediates the other. Interpretation thus moves in a circular fashion; any new

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[1] Historical investigation implies an investigation into "the dynamics of social change, not simply an investigation into the past... to analyse a problem historically is to study contradicitons and changes, not simply to uncover 'origins'." (Wright, 1978, 13, footnote 5).

interpretation changing that which is interpreted (Gregory, 1978, 145). Reality cannot be reduced to a set of categorical constructs; rather, it must be viewed as a dialectical *totality*.

Historical-hermeneutics thus invites an interrogation of the totality of the social relations (called the social formation[2]) underlying observed spatial patterns. This interrogation, by the very definition of hermeneutics (to interpret), ultimately aims for an *understanding* of the social formation and its levels of appearances. However,

> "If we remain entirely at the level of appearances we might be able to describe social phenomena, and even predict those phenomena, but we cannot *explain*[3] them".

The explanation/prediction distinction marks a fundamental difference between positivist and critical science. Wright (1978) notes that "one of the hallmarks of positivist social science is the collapsing of the distinction between explanation and prediction"; however, a critical science "insists on the radical distinction

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[2]Gregory (1978) argues that the social formation is the touchstone for future analysis. It replaces the structuralist concept of the mode or production (with its conception of separable economic, political, and ideological levels) by viewing all levels as dialectically related to each other, rather than viewing the political and ideological as being subservient to the economic.

[3]Gregory (1978, 145) notes that there is no clearly defined distinction between "explanation" and "understanding", hence the terms are used interchangeably in the text.

between the two" (Wright, 1978, 12). One can easily predict by simply describing the level of appearances but in order to explain, the underlying dynamics of these appearances must be discussed. The explanation thus sought in a critical science is based on *dynamic* social processes; the explanation sought in a positive science does not differ from prediction based on *appearances*. The precise focus of *explanation* thus differs between approaches; however, it is evident that explanation of critical science has the potential to subsume positivist explanation whereas the reverse is *not* true.

This study uses the historical hermeneutic approach. It is important to note the following crucial issues that this choice implies:

Firstly, the choice does *not* imply that the empirical analytic mode is intrinsically wrong. The choice of analytical mode depends entirely upon the purpose of the investigator. Hence, traditional geographical concerns of accessibility may generally be approached via the empirical-analytic mode. However, explanation of location decisions in the context of the wider social formation usually require the historical hermeneutic mode (cf. Dear, 1978b).

Secondly, the empirical-analytic approach in contemporary geography has undoubtedly weakened the social "relatedness" of much geographical analysis. The choice of the historical hermeneutic approach opens up a rich source of *historical* information which

grounds the analysis in the dynamics of social change. An historical investigation highlights the existence and interaction of many important causal factors; thus separate, historically-based *scenarios* can be identified and studied, but each must ultimately be related to each other as a totality.

Thirdly, the choice implies that an important distinction must be made between the level of appearances (practice) and the underlying structural causes (theory). However, the approach also strives to link theory to practice (empirically observable phenomena). This requirement, though simply stated, is one of the most difficult methodological hurdles in social science. It is made even more troublesome because critical science has a Marxist theoretical base , and many Marxists reject the use of positivist analytical techniques and empirical data. Despite this, Wright (1978) argues that "Marxist theory should generate propositions about the real world which can be empirically studied" (p. 10). Thus, the historical-hermeneutic approach should not rule out the analytical methods of empiricism. It is merely that they are used in a critical science which is a dialectical relation between the empirical and the analytic (see Gregory, 1978, 70).

In summary therefore, the historical-hermeneutic approach adopted in this study *implies:*

(1) historical investigation of a problem;

(2) theoretical investigation of the problem so that testable propositions concerning the theory can be formulated; and

(3) empirical investigation of the propositions.

Not only does the historical-hermeneutic approach imply the above three modes of investigation, but it also gives direction to the total investigation by

(1) emphasizing the *historical* and evolutionary nature of the processes underlying spatial outcomes;

(2) insisting that the totality of social relations be considered when examining any level of appearance which is necessarily *embedded* in the wider social formation; and

(3) emphasizing the *dialectical* relationship between theory and empiricism.

1.3 Research Goals and Objectives

There are two major research goals in this thesis. The first is to take an historical view of processes influencing mental health care, situating community mental health care in the wider social context so that the current level of appearances can be understood. The second goal is to arrive at a general understanding of the underlying forces influencing these levels of appearances, and in particular to elucidate the nature of the state as a force in determining spatial outcomes.

Translating this into a design for studying the particular problem of the changing nature of mental health care is done as follows.

First, it is crucial to recognize the wider social relations that contain mental health practice and to *embed mental health practice*

within this context of relations. Thus, since mental health care is a subfield of medical care, these wider medical practices must be considered. Health care, however, is but one social service provided through state intervention and the primary apparatus of the state for this provision is the government. As already noted, the government is part of the state, and hence a full understanding of the state is required if we are to understand how the government acts towards mental health care. The state, in turn, is an actor in the wider capitalist society, and hence the contextual framework for this problem is as follows:

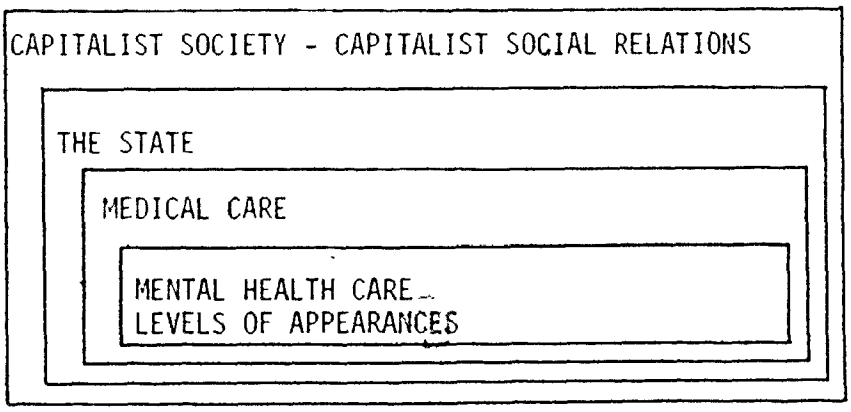

Figure 1.1 Conceptualization of the embedded nature of mental health care levels of appearances.

Secondly, the theoretical relationships of the state to capitalism, and medical care to the state (and capitalism) is investigated in an evolutionary manner. In addition, the historical evolution of the current level of appearances in mental health care is examined. From this investigation, several historical scenarios are identified, and forwarded as propositions concerning the underlying causes of community mental health. These propositions stand to be empirically tested. The results are then related to the theory.

The goals and the conceptual framework suggest four specific objectives in this study:

1) to review the relevant literature concerning the state to arrive at a preliminary understanding of its form and functions;
2) to review the historical course of mental health care in order to develop interpretative historical scenarios;
3) to test the scenarios by first reviewing methodological literature and then using appropriate analytical techniques on the empirical data; and
4) to evaluate the findings from the theory, the history and the empirical tests.

The remainder of the thesis is organized into five chapters. Chapter Two deals with theories of the state in capitalist society and examines the historical course of the state in civil society.

The government and medicine, as institutions partially comprising the total state apparatus, are then examined and related to the state. The embedded nature of mental health care is thus established. The historical social influences on mental health care delivery are the focus of Chapter Three, and three plausible structural causes for the changes in mental health care are posited as scenarios to be tested. The theoretical and historical preconditions for empirical research are thus set. Chapter Four is primarily methodological; it describes the appropriate models and lists data sources needed to operationalize the scenarios of Chapter Three. The analysis of each scenario occurs in Chapter Five and a summary of the findings is made. Finally, Chapter Six attempts to synthesize and evaluate the historical facts, the available theory and the results of the analysis. This then suggests possible further research fields.

CHAPTER 2

THE CAPITALIST STATE

2.1 Introduction

Following closely the epistemological principles of Section 1.2, this chapter is devoted to an analysis of the state. Initially, an introduction to some fundamental questions concerning the state is given; this necessitates a brief examination of capitalist social relations. The state, as an integral part of these relationships, is then given closer scrutiny via examination of the literature concerning the capitalist state. In particular, those theories arising out of the "State Derivation Debate" are reviewed because of their emphasis on deriving the form and functions of the state from wider capitalist social relations. The current theories are then supplemented by a brief historical review of the changing nature of the state with respect to civil society.

In the latter part of the chapter the focus changes from a theoretical concern for the entire state to government and medicine as institutions comprising the state. In particular, historical investigation of the state leads to a translation of state functions into specific government action. The necessity of capitalist

accumulation also points towards the functions that medicine performs in capitalism, and hence specific propositions concerning the intra-state relation between the branches of government and the medical profession are made. The "embedded" nature of mental health care is thus established.

2.2 What is the State?

It is evident that the state is becoming increasingly involved in every aspect of daily life, whether it be in production, consumption, recreation, education, health etc. The state no longer stands in some way divorced from the operation of the free market; it has become inextricably part of nearly every operation and transaction. Consequently, the role of the state should not be regarded as some given constant, to be dismissed as just another factor in the market. The state must be afforded a central role in analysis if social and spatial outcomes are to be understood.

> "Henceforth, observed problems in specific categories of state intervention, such as urban and regional planning, should no longer be regarded as failures of particular mechanisms. Instead, they should be traced to systematic, structural contradictions in the form and function of the state, and their relationship to the capitalist mode of production." (Clark and Dear, 1978, 22-23).

Two important questions are raised in this discussion. First, what is meant by the term the *state*? And secondly, what is meant by *form* and *function* of the state?

The latter question is of central importance both to the entire chapter and to the answering of the first question. Essentially its answer requires recalling the central epistemological principle outlined in Section 1.2: that it is necessary to distinguish between "levels of appearances" and the underlying "social reality". Studies which are concerned only with state *functions* (ie. what the state does) tend to remain at the level of appearance of state actions. However, those studies which consider the underlying structural causes of particular state configurations and ask why the state acts as it does, concern themselves with state *form*.

State functions can therefore be viewed as relating to levels of appearances, whereas state form relates to the forces underlying any social reality (eg. capitalist or socialist). The former studies can only guess at probable state form whereas the latter studies can (and do) derive state functions from state form. Clark and Dear (1978) characterize those modes of investigation which focus on state function as theories of the *state in capitalism*, whereas those modes which focus on form and function are designated as theories of the *capitalist state* (1978, 4).

Since theories of the capitalist state tend to derive levels of appearance of state action (state functions) in a dialectical fashion

from the underlying structural causes (state form), the explanation offered by these theories tends to subsume explanation offered by theories of the state in capitalism. It is thus epistemologically sound to begin with a discussion of state form and lead into state functions. However, some preliminary understanding of the state, its functions, and its relation to capitalism is initially required: that is, what is the state?

A useful beginning with this question can be made using Marxist concepts of capitalist society and its social relations, which are viewed as being closely related to the capitalist mode of production. Within society there are basically two 'classes': the capitalists (usually the owners of the means of production), and the labourers (usually the users of the means of production). The social relations of capitalist production are essentially the social relations between capitalists and labourers. Of course in contemporary society, the capitalist/labourer division is no longer clear. However, much structuralist analysis centres around this division and the class antagonism which results from the struggle of the labourers and capitalists to appropriate the surplus value of production. More specifically, capitalism requires that the surplus value or profits of production be reinvested (to some extent) in the form of capital to ensure the continuation of production. However, labourers demand

that the profits made by the owners of the means of production be returned to them as higher wages. Thus, there is a conflict over the needs of capital and the needs of labour. The conflict is inherently contradictory, since outcomes favouring capital may lead to societal revolt and the downfall of capitalism, and outcomes favouring labour mean diminished profits, less reinvestment and lost production, and ultimately, a loss to labour through a decline in the market system.

It is the inability of capitalism to be self regulating and its ability to generate harmful conflicts that has led to the rise of, and the necessity for, the state. But what is the state? Robson (1977), notes that,

> "In capitalist society there is no single entity which *is* the state. Rather, it is the sum of those institutions, agencies and groupings which sanctions the activity of those who own and control the means of production. This grouping, this class, is the dominant class... that exercises state power." (Robson, 1977, 9, 10).

The power that the state exercises is directed towards fulfilling two basic and often contradictory functions, namely accumulation and legitimation (see O'Connor, 1973). This means that the state must maintain or create the conditions necessary for profitable

capital accumulation whilst simultaneously maintaining or creating the conditions for social harmony. If the state favours one class in the accumulation of capital at the expense of another, it may lose its legitimacy and undermine its basis of loyalty and support. Habermas (1976) labels this as a crisis of legitimacy. If on the other hand, however, the state ignores the necessity of assisting the process of capital accumulation, it risks drying up the source of its own power -- the economy's surplus production and the taxes on that surplus. Habermas (1976) labels this a rationality crisis.

Capitalist society is thus inherently crisis-ridden, and the state must exercise its power to avoid such crises. The exercise of state power, however, requires a translation through some forms of state apparatus. The usual conception of such apparatuses are that they combine the apparatus of government and the private apparatus of civil society. More specifically, there are the 'public' institutions such as the military, the police, the statutes of the judiciary, prisons, the coercive (rule making) tools of the government, etc., which perform the *formal* exercise of power (Althusser (1971) calls these repressive apparatuses). In addition, there are the 'private' institutions of civil society such as religious, educational health and other[1] institutions which carry on the *informal* (primarily by ideologal means, according to Althusser (1971)) exercise of state power. (See also Robson, 1977, 10).

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[1]Any institution which is spatially dispersed throughout society and which exhibits an ideology reflective of that of the ruling class will be in this category.

In summary, the state thus has a multi-dimensional character, with several apparently contradictory functions. It is inevitably bound up in the wider system of capitalist social relations which tend to be inherently crisis-producing.

2.3 Theories of the Capitalist State

2.3.1 Classical Theories and Contemporary Variations

Although the theories of the capitalist state derive from Marxist work, Jessop (1977) notes that

> "Nowhere in the Marxist classics do we find a well formulated, coherent and sustained theoretical analysis of the state"
> (Jessop, 1977, 357).

He classifies the classical Marxist theories into six approaches. These are:

(1) The state as a *parasitic institution* with no essential role in economic production;

(2) The state and state power as *epiphenomena,* i.e., simple surface reflections of the economic base;

(3) The state as a *factor of cohesion* with the function to regulate class struggles and moderate class conflict without undermining the continued domination of the ruling class;

(4) The state as an *instrument of class rule* where the state is neutral and can be used with equal effectiveness by any class;

(5) The state as a *set of institutions* with no general assumptions about its class character; and

(6) The state as a *system of political domination* with specific effects on the class struggle

(Jessop, 1977, 354-357)

Each approach adds to an understanding of the state, but each tends to take a restricted view of the state either as it relates to economic relations or political relations in capitalism. Only the sixth approach directly considers the wider context of social relations in capitalism.

Contemporary Marxist research has attempted to extend our understanding of the function of the state in capitalism (Gold *et al.*, 1975; Harvey, 1976). Three approaches have evolved: the "instrumentalist", in which the ties between the ruling class and the state are examined; the "structuralist", which elaborates how state policy is determined by the contradictions and constraints of the capitalist system; and finally, the "Hegelian-Marxist" or "ideological" perspective, which places an emphasis on the consciousness and ideology through which the state pursues class exploitation and control (see Gold *et al.*, 1975).

These treatments of the state begin with the fundamental observation that the state in capitalist society broadly serves the interests of the capitalist, or ruling class. The instrumentalists (see Miliband, 1973) explore the "conspiracy" between the ruling class and the state's elite; the structuralist view (see Poulantzas, 1969) is that the functions of the state are broadly determined by the structure of society rather than the people who occupy positions of power; and the ideological approach portrays the state as an "illusory community" serving the interests of the ruling class under the guise of the "national interest" (Gold *et al.*, 1975, 36). Most of these studies tend to emphasize the way in which the "economic base" determines the "political superstructure". However, more recent research has begun to ask why social relations appear as separate economic and political forms; why is the state not a private mechanism of the dominant class?; and why is the state divorced from the dominant class, taking the form of an impersonal mechanism?

The answers to these questions lie in analysing the *totality* of capitalist social relations since these necessarily impose limits on the form of the state, which in turn limits state action. Thus, if we are to understand state functions we must understand state form, and this implies its form must be *derived* historically and logically from the wider context of capitalist social relations (Holloway and Picciotto, 1978, 17).

2.3.2 The State Deviation Debate

Holloway and Picciotto (1978) claim that the starting point of contemporary debate on the state begins with the critique of those theorists "who divorce the study of politics from the analysis of capital accumulation" (1978, 14). Thus they claim that:

> "Instead of simply reiterating the connection between capital and the state... the contributions to the debate have accepted the separation of the economic and the political, and have tried to establish, logically and historically, the foundation of that separation in the nature of capitalist production".
> (Holloway and Picciotto, 1978, 14)

As a result of the recent debate in the German literature (summarized in English by Holloway and Picciotto, 1978), two approaches have become evident, (1) the "capital logic" school, and (2) the materialist approach.

The *capital logic school* insists that the state must be separate from civil society. This is both (a) possible, because of the form surplus labour takes (surplus value); and (b) necessary, because no individual or competing capital is able to ensure the reproduction of the social formation. The separation of the state is thus vital to the accumulation of capital, but the state is not itself capitalist;

rather, it "is a distinct, political institution corresponding to the common needs of capital, [ie.] the state is an ideal collective capitalist" (Jessop, 1977, 362).

The state also cannot be neutral because it must deal with the class struggles which arise in the process of capital accumulation. Thus, although the state can be, and needs to be, divorced from the actual process of accumulation, it is heavily *dependent* on that process. In fact, it is "trapped within... its contradictions and crises" (Jessop, 1977, 363). Two aspects of state form, exclusion and dependence, have thus been recognized, and the concomitant state functions "are concerned primarily with correcting the deficiencies of private capital, and with organizing individual capitals into a viable aggregate" (Clark and Dear, 1978, 18-19). These concerns translate into four specific functions:

(1) the provision of the material conditions of production;

(2) the establishing and guaranteeing of general legal relations;

(3) the regulation of the conflicts between labour and capital; and

(4) the safeguarding of total national capital on the world market (see Altvater, 1978, 42).

Despite the emphasis on the state's relation to capital, the state is not viewed as merely an instrument of capital. In fact, it is "... a political force that complements the economic force of competition between individual capitals" (Jessop, 1977, 363); this may mean intervening *against* capital when individual capitals threaten the

interest of capital in general. This fine theoretical distinction, however, does not detract from the fact that political class relations are seen simply as epiphenomena of the economic base, and this is certainly not the totality of social relations. The approach is also fundamentally ahistorical, in a manner which is rejected in this thesis. It is

> "... only able to indicate probable forms of the state, and to specify broad limits...within which the process of capital accumulation will not be threatened" (Clark and Dear, 1978, 19).

In reaction to the weaknesses evident in the capital logic approach, the *materialist approach* attempts to introduce "a greater degree of historical specificity and a sharper awareness of the role of class struggle" (Jessop, 1977, 364). The state is regarded as

> "a specific and historically conditioned form of the social relations of exploitation, a discrete form which cannot simply be identified with economic form" (Holloway and Picciotto, 1978, 24).

This approach takes an embedded and historical view of the state, and derives the state as a specific form from the wider social relations of capitalism. The crucial focus is on the antagonistic

relation between capital and labour in the process of accumulation, emphasizing the coercive class nature of the state due to the inherently crisis-provoking nature of the process of capital accumulation. This implies, contrary to the capital logicians' approach, that the state *cannot* direct all its efforts towards the needs of capital. In fact, Jessop (1977, 365) notes that state intervention is rarely directed towards the needs of capital, usually it reflects a *response to the political repercussion of accumulation.* State intervention is thus primarily conditioned by the emergent crises of capitalism and the state is essentially restricted to reacting to these crises (cf. Offe, 1975; Habermas, 1976; Roweis, 1975). The state is thus a *crisis manager,* being constantly reshaped in form and redirected in its actions by the crises that evolve out of the necessary process of capital accumulation.

Four crucial elements characterize state operations:

(1) *Exclusion:* The state is an 'ideal' capitalist only, necessarily existing outside the process of accumulation.

(2) *Dependency:* Although it is excluded from the accumulation process, every interest the state has can only be pursued if it is in accordance with the imperative of maintaining accumulation.

(3) *Maintenance:* The state has a *mandate* to create and sustain conditions for accumulation because capitalism is neither self-regulating nor self-sufficient.

(4) *Legitimation:* Faced with this precarious combination of exclusion and dependence, the state can function on behalf of capital only if it can equate the needs of capital with the national interest, and secure popular support for measures that maintain conditions for accumulation, while respecting its private character.
(see Offe, 1975, 126-127; and Jessop, 1977, 366)

The first two categories refer to state form, and the latter two refer to state functions which stress the importance of the state in mediating in the process of accumulation. The state assists in accumulation by

(1) *Contributing to production:* This involves intervening directly to correct market malfunctions, through buying, selling, investing and speculating as an agent in the market in order to correct the malfunction.

(2) *Reproducing the productive forces:* This involves

a) reproducing the means of production, ie. the material conditions for production or the infrastructure of production (e.g. machinery, capital, technology etc); and

b) reproducing the users of the means of production ie., wage labourers, by giving labour the means (ie. wages) with which to reproduce itself. (Capitalism requires a diversely skilled labour force. Once produced, it must be reproduced with a similar range of skills plus any evolving new skills)

(3) *Reproducing the relations of production:* Reproduction of labour power according to skills is useless unless its submission to the rules of the established order are reproduced. This is achieved through the exercise of state power in the form of ideological and repressive state apparatuses. Reproduction of the relations of production ensures that the relation between labour and capital -- the contradictory, but nevertheless fundamental driving force of capitalism -- remains intact (see Althusser, 1971).

At the same time, the state must also ensure its own legitimation. Depending on the degree of crisis, the state will alter its contribution to production or reproduction.

The materialist theory of the state is adopted in this work as the theory most closely connected to the epistemological principles outlined in Section 1.2. This is because it allows for an historical interpretation of both the form and function of the state in the context of the totality of social relations (the social formation). The materialist theory isolates crises in capital accumulation as the catalyst for state intervention, and stresses the political nature of state activity.

However, to understand how the state responds to crises requires an investigation of the historical circumstances which have led to the crisis and the subsequent response. The following section thus expands upon the changing nature of civil society over time, and the rise of the state and its interventions.

2.4 The Changing Nature of Civil Society and State Intervention

Roweis (1975) notes that in early capitalism (mid seventeenth to late nineteenth centuries), civil society was characterized by the private ownership of capital, a free and well functioning labour market, a 'free' competitive market, and the derivation of income from the sale of individually owned factors of production. The state's fundamental roles were essentially minimal, such as assuring observance of the rule of the market game, securing internal and national stability, and administering a minimum of public works programs. However, early capitalist society contained the very irrationalities and contradictions that forced increased state intervention because of its reliance on the market mechanism as the principle whereby social needs could be satisfied. Under a market system, however, production is primarily for exchange, not for need satisfaction, and hence fundamental social tensions arose in early capitalist societies. These economic crises, "market failures", and the related social crises, necessarily increased the political role of the state, the exercise of state power, and the number of state apparatuses required to satisfy increasing social demands.

As already recognized, the driving force behind increasing state intervention was thus the naturally arising crises inherent in

capitalism. However, this was balanced by the desires of many to remain free of state control, hence

> "The nature of the late capitalist state can be understood as embodying those structural characteristics which result from the balance of... forces ... for and against state intervention... at any given time" (Roweis, 1975, 1a)

Due to the inherent crises in capitalism, the state took an increasingly central role in all social relations and clearly today "... one can no longer reasonably speak of spheres of social relations which are free of state intervention" (Roweis, 1975, 13). As a result, Roweis characterizes late capitalist society as follows. Private property (land and capital) is subject to *politically* decided limitations and constraints (eg. land: zoning, subdivisions, planning regulations; capital: fiscal, monetary, tariff and price regulations); the labour market is subject to *politically* decided provisos (legal rights, strike, minimum wages, social security, health and safety regulations); the market for goods and service is no longer 'free', it is subject to *political* regulations (anti trust, price control, foreign trade regulations, incentive policies, subsidies etc.); and income is no longer derived essentially by selling owned factors, rather they are subject to direct or indirect *political* decisions (welfare, unemployment benefits, minimum income

guarantees, etc.).

More and more aspects of society are thus becoming 'politicized', and hence controlled by the state. This is primarily an effort to *control* the inherent crises in capitalism. Roweis (1975) thus notes that

> "... state apparatuses have come to rely heavily on what can be called *pre politics 'processing' of political information*" (Roweis, 1975, 18).

Basically this is at the heart of the state's conflict avoidance strategy. It involves 'preparatory legwork' by state bureaus

> "in anticipation of, in response to, or in attempt to forestall political disputes or confrontations. The main purpose... is to set the stage... for maximally predictable and controllable politics" (Roweis, 1975, 18).

This control by the state can be seen in the state's role in increasingly socializing (itself paying for) the costs of production and in being increasingly actively involved in the socialization of reproduction.

The state has become increasingly involved in production due to the conflicts over the share of societal surplus value. Capitalism constantly requires more surplus value. This requires more (or more

efficient) production; hence the means of production vie for more of the surplus value to be devoted in the form of state-provided infrastructure. At the same time controllers of capital desire more profits to reinvest, whereas labour increasingly demands that the surplus should be returned to them in the form of increased wages. As labour movements grow increasingly organized, threatening the basic relations of production, their demands placed on the controllers of the surplus value increase. The conflict over the division of surplus value threatens a legitimation crisis if labour demands are not met, and threatens to strangle profits (rationality crisis) if they are met. The state has thus been increasingly forced to avoid these conflicts by removing the cost burden from the private sector by socializing the basic costs of production previously paid out of surplus value. The socializiation of production has also involved removing possible legitimation crises by compensating those members of society who suffer from the competitive nature of capitalism. The state therefore provides a number of welfare payments (cf. Piven and Cloward, 1971) as a method of avoiding future conflict from this class of people. The result of the state increasingly socializing production costs has been that profits have contined to be made by the private sector whilst costs have been borne by the public sector. This has resulted in a gap between state revenue and state

expenditures creating the current *fiscal crises* of the state (see O'Connor, 1973).

Attempting to avoid legitimacy and rationality crises has thus created another crisis, and this in turn has forced the state to take a more active role in production by becoming a producer of commodities itself so that it can appropriate its own surplus value. As can be expected, however, this conflicts with the production hegemony of the private sector suggesting a rationality crisis is evident. Because of this, the state is increasingly required to reproduce a 'frame of mind' (Althusser, 1971) consistent with the perpetuation of capitalism. Thus the state must continually imbue the ideology of "competitive and possessive individualism" (Harvey, 1975) into all individuals so that they will become more and more dependent on the state for their well being. This dependence erodes their capacity for self-help; the individualism ideology has the potential to disarm possible societal revolt over conflicts, by stressing *individual* rather than collective reaction.

The reproductive aspects of the state are thus aimed at dissolving the family structure which previously was the protector of societal values (Lasch, 1979). This action is needed because of the increasing demands capitalism is making on the workforce. The state therefore is increasingly taking on the role of a parent (Rothman, 1978); educating, providing health for, providing leisure for and supervising the rearing of children. Lasch (1979), thus argues

that

> "Whereas in earlier times the family passed along the dominant values but unavoidably provided the child with a glimpse of the world that transcended them, ... capitalism in its late stages has eliminated or at least softened this contradiction (Lasch, 1979, xxiii).

The state has played a crucial role in this change, Lasch (1979) thus summarizes the changing nature of state intervention as follows:

> "The history of modern society, from one point of view, is the assertion of social control over activities once left to individuals or their families. During the first stage of the industrial revolution, capitalists took production out of the household and collectivized it, under their own supervision, in the factory. Then they proceeded to appropriate the workers skills and technical knowledge, by means of "scientific management", and to bring these skills together under managerial direction. Finally, they extended their control over the

> worker's private life as well, as doctors, psychiatrists, teachers, child guidance experts, officers of juvenile courts, and other specialists began to supervise child rearing, formerly the business of the family".
> (1979, xx-xxi).

Lasch's analysis emphasizes what the state has been *forced* to do historically in order to ensure continued production and surplus value. In essence, it notices the *limits* imposed on state action by the changing nature of civil society, especially as it changes with respect to the process of capital accumulation.

2.5 State Institutions: Intra-State Relations Between Government and Medicine

Historical evidence points to the increasing socialization by the state of the production and reproduction spheres in capitalist society. These actions have been primarily stimulated by the emerging crises in capitalism, the latest major crisis being termed "the fiscal crisis of the state" (O'Connor, 1973). Not only does state intervention seek to control such crises, but as history reveals, intervention seems to create further and more complex crises. Intervention by the state is thus inherently part of an ongoing crisis-ridden situation which characterizes civil society, and calls for ever increasing rounds of state intervention and the creation of state apparatuses for this purpose.

The apparatuses that enact state intervention include the government and institutions such as medicine. The government and the state are thus *not* synonomous, rather, the government is formally invested with state power, but this does not mean it controls that power (see Robson, 1977). Government action is thus one translation of state power, and as such, it has guiding principles to follow in the interests of capitalism.

Roweis (1975) notes, that (1) since the state is a crisis avoider, political/administrative intervention will give high priority to those classes who can contribute most effectively to ease crises; (2) social demands and problems whose consequences do not have pervasive ramifications on the stability of the social order will receive little if any attention; (3) state intervention will tend to be characterized by a minimum level of regulation necessary for stability because 'overdoses' tend to create problems in other areas; and (4) the need for capital expansion diminishes the state's available resources and policy tools, and creates a widening gap between spheres of intervention (compare expenditure on advanced technology and military apparatus to expenditure on housing, health, education, etc.). The general rules influence the formal exercise of state power by government, which in turn influences other public and private institution intervention.

Medicine, as a quasi-public institution of the state apparatus, is related to the state through the government which is the formulator of its policies. The relationship of medicine to the

government is thus a relation within the state (i.e., an *intra-state* relation), and government policies towards medicine will therefore always reflect the wider concerns of state.

The genesis of state medicine could be attributed to the need for a social control mechanism, especially to maintain a healthy labour force, but it appears that (a) the need for care arising out of the unhealthy conditions of industrial capitalism and (b) the inability of the market to provide such a 'good' may have been the initial stimuli. Certainly, since this time, medicine and the state have become closely fused, a fact which is clearly evident from several observations.

First, the class composition of the medical care profession "... replicates the class hierarchy that characterizes capitalist societies [in general]" (Navarro, 1976, 206). More importantly, however, the professionals (physicians) who occupy the upper echelon of the medical elite, tend "... to be drawn from those sections of the population that have historically allied themselves with the ruling class" (Robson, 1977, 10). Thus in terms of membership at least, the medical profession contains part of the state elite.

Secondly, the ideology of medicine closely supports the state. It sees the 'fault' of the disease as lying with the individual and emphasizes an individual therapeutic response. Thus, at a time when much disease is *socially* determined by conditions of capitalism (eg. cancer, psychosomatic and occupational diseases) this ideology is useful to the state because (1) it absolves the economic

and political environment from responsibility for the disease; and (2) it reduces potential response and rebellion to an individual and hence less threatening level (see Navarro, 1976, 207-208). Medicine thus legitimizes state actions by ideological control.

Thirdly, over time, medicine's economic functions have become more closely tied to the interests of the state and capitalism. Health care, as a commodity, has become part of the process which creates surplus value and hence, profits. This has opened up investment opportunities and helped to create new markets (eg. markets for hospital supply industries, drug companies). Medicine also benefits capitalism by maintaining a healthylabour force and by absorbing surplus labour (cf. Rodberg and Stevenson, 1977).

The wider interests of the state thus guide the policies by the government towards medicine, and medicine in return helps legitimate state actions through ideological control. When state agenda, acted out by the government, coincide with the agenda of the medical professionals, the intra-state relationship between government and medicine is one of fused interests. Many authors (Scull, 1976; Illich, 1977; Illich *et al.*, 1977; Robson, 1977) prefer to interpret this as a conspiratorial relationship in order to achieve social control. However, this view is partial because it fails to fully consider the embedded nature of this relationship within the state.

The importance of the embedded nature becomes clear when state and medical agendas clash, because the motivations of the state

are no longer hidden behind the guise of the professionals' motivations. Professionals' desires to protect the medical institution and its ethics become obviously different to wider state concerns when the state requires the medical profession to act in the interests of capitalism, not necessarily in the interests of care. Thus, whether or not the conspiratorial view is accepted, the importance of the embedded nature of the government-medicine intra-state relation is indisputable.

In summary, the intra-state relation between government and medicine may be conflict ridden, and government policies may actually contradict the best interests of care and the medical professionals. This is because of the embedded nature of this relationship within the state, which directs government intervention into medicine.

2.6 Summary

This chapter has aimed to establish the embedded nature of mental health care. Initially, a brief exposé concerning capitalism and its social relations led to a consideration of the state. The materialist theory of the state revealed that the state is excluded from, but dependent upon the process of capital accumulation, and has a mandate to maintain the conditions necessary for successful capital accumulation whilst simultaneously legitimizing its actions to the populace. In the process of capital accumulation, the state contributes to production and reproduction.

The view of the state as a crisis-avoider, reacting to the inherent crises endemic to capitalism, is supported by the historical course taken by the state in civil society as the needs of capitalism changed. State intervention has thus necessitated the rise of state apparatuses such as the public institutions of government, and the quasi-public institutions of medicine. The government gains its directions for the formal exercise of state power from the wider interests of the state. This implies that the policies towards medicine, which informally exercises state power, tend to depend upon the particular crisis facing the state rather than upon the interests of the medical profession. The medical professionals' own private agenda and the aims of the state for control (where control is either viewed as maximally predictable politics, or social control which implies a conspiracy) may thus clash.

Mental health care is thus set within a wider context of

1) increasing state intervention
2) the private, self-interested motivations of health and mental health professionals, and
3) the need of the state for some form of policital or repressive control.

CHAPTER 3

COMMUNITY-BASED MENTAL HEALTH CARE: AN INTERPRETATIVE OVERVIEW

3.1 Introduction

Having examined the theoretical roles of the state and medicine in capitalism, the historical course of mental health care needs to be investigated. Wright (1978) notes that historical investigation requires an investigation into the dynamics of social change, not simply an investigation of the past. Thus, rather than simply uncovering "origins", the contradictions and changes must be studied in any historical investigation. A duality of historical investigation can thus be recognized -- first, a study of the levels of appearance of history, or the historical facts; second, a study of the underlying social reality, or the dynamics of historical change.

As a contextual setting, the historical facts of mental health care will be first presented; this is then followed by a study of the structural causes of these 'facts'.

3.2 A Brief History of Mental Health Care*

Mental illness has long been recognizable throughout many civilizations. Institutional care, however, is a relatively recent

*This section draws heavily on Dear and Taylor (1979, Chapter 3).

phenomena in the entire history of mental health, springing primarily from the shifts in social attitudes that occurred in the seventeenth and eighteenth centuries. Prior to this, there was very limited public responsibility for the mentally ill, and care was the responsibility of family or friends.

The asylum, as we know it today, has its origins in the "houses of confinement" (Foucault, 1973) that arose to restore order to society in the seventeenth and eighteenth centuries. The first example of such an institution was the Hôpital Général, established in Paris in 1646. Its purposes were *not* solely medical, rather, it had social, economic, religious, and moral functions as part of its mandate to improve society. However, this and similar institutions rapidly became overcrowded and the melange of inmates created its own new problems, forcing the separation of the ill, mentally ill, and criminal populations. This social movement represented the true birth of the insane asylum, a birth which Rothman (1971) notices occurred approximately simultaneously with the birth of penitentiaries and almshouses in the Jacksonian era of the United States (beginning approximately 1820).

The birth of the asylum seemed to fuse social attitudes and values, science, and morality into 'care'; a firm belief that mental illness was curable through "morale treatment" existed in the

early to mid-nineteenth century. However, the gap between the ideal model of a mental hospital and the social reality steadily widened. Curiously, however, little if anything was done either by governments (who had, by now, control over an extensive network of public hospitals) or the populace to rectify this situation, and 'care' slipped into custodianship as management and patient problems multiplied. As Rothman (1971, 240) points out: "The promise of reform had built up the asylums; the functionalism of custody perpetuated them". These conditions of rising admissions, discharges, and patients on books continued throughout the twentieth century until approximately 1960 (see Table 1.1 for these trends in Ontario).

From the mid 1960's the pace of change has accelerated so that it is no exaggeration to speak of the 'revolution' in mental health care. The history suggests that there are several factors which may have led to these developments. First, a 'revolution' in the treatment of the mentally ill was made possible by the introduction of new psychosomatic drugs which enabled a symptomatic management of many psychotic patients. This was combined with the adoption of new psychosocial methods of treatment which stressed the avoidance of seclusion or restraint and the development of group techniques, such as the therapeutic community and so on. Secondly, the government either formalized or stimulated the move towards community oriented treatment by altering legal and administrative systems,

> "... to enable cost sharing arrangements with the federal government to be made: the general hospital was encouraged to develop psychiatric service units; and provincial hospital patients could be transferred to community residential or nursing homes on a cost sharing basis"
> (Dear, Clark and Clark, 1979, 46).

Thirdly, a change in community awareness over the problems and sources of mental illness led to a new concern with the infringements of patients' civil rights through incarceration (Klerman, 1977; Williams and Luterbach, 1976).

The impact of these changes has been immense. In Ontario, asylum trends are well represented by the figures for the Hamilton Psychiatric Hospital for the era of change, 1960-1977 (see Table 3.1). Trends elsewhere in Ontario have already been documented in Tables 1.2 and 1.3. Admissions and discharges rose from 1960-1969 but fell from 1969-1977 and discharges consistently exceeded admissions *in the aggregate* in the former period. The reverse occurred in the latter period (see Figure 3.1). The number of available beds was subject to almost continuous reduction throughout the entire period and a parallel drop occurred in the number of patients on books. The relationship between these two indicators has been that the number of patients on books at the end of a month exceeded the number of available beds set up at

Table 3.1 Average Monthly Indicators of Hamilton Psychiatric Hospital, 1960-1977.

YEAR	ADMISSIONS	DISCHARGES	NUMBER OF AVAILABLE BEDS	NUMBER OF PATIENTS ON THE BOOKS
1960	91	90	1730	2173
1961	105	111	1851	2178
1962	129	135	1583	2030
1963	136	136	1608	2024
1964	140	146	1588	1843
1965	163	180	1586	1955
1966	157	187	1484	1498
1967	146	168	1317	1343
1968	162	183	1127	1080
1969	175	170	1148	1063
1970	152	168	1141	1065
1971	113	117	833	810
1972	197	109	812	789
1973	118	116	800	773
1974	87	98	747	698
1975	87	96	637	676
1976	68	75	547	502
1977	60	61	525	456

Source: Hamilton Psychiatric Hospital Admission Records

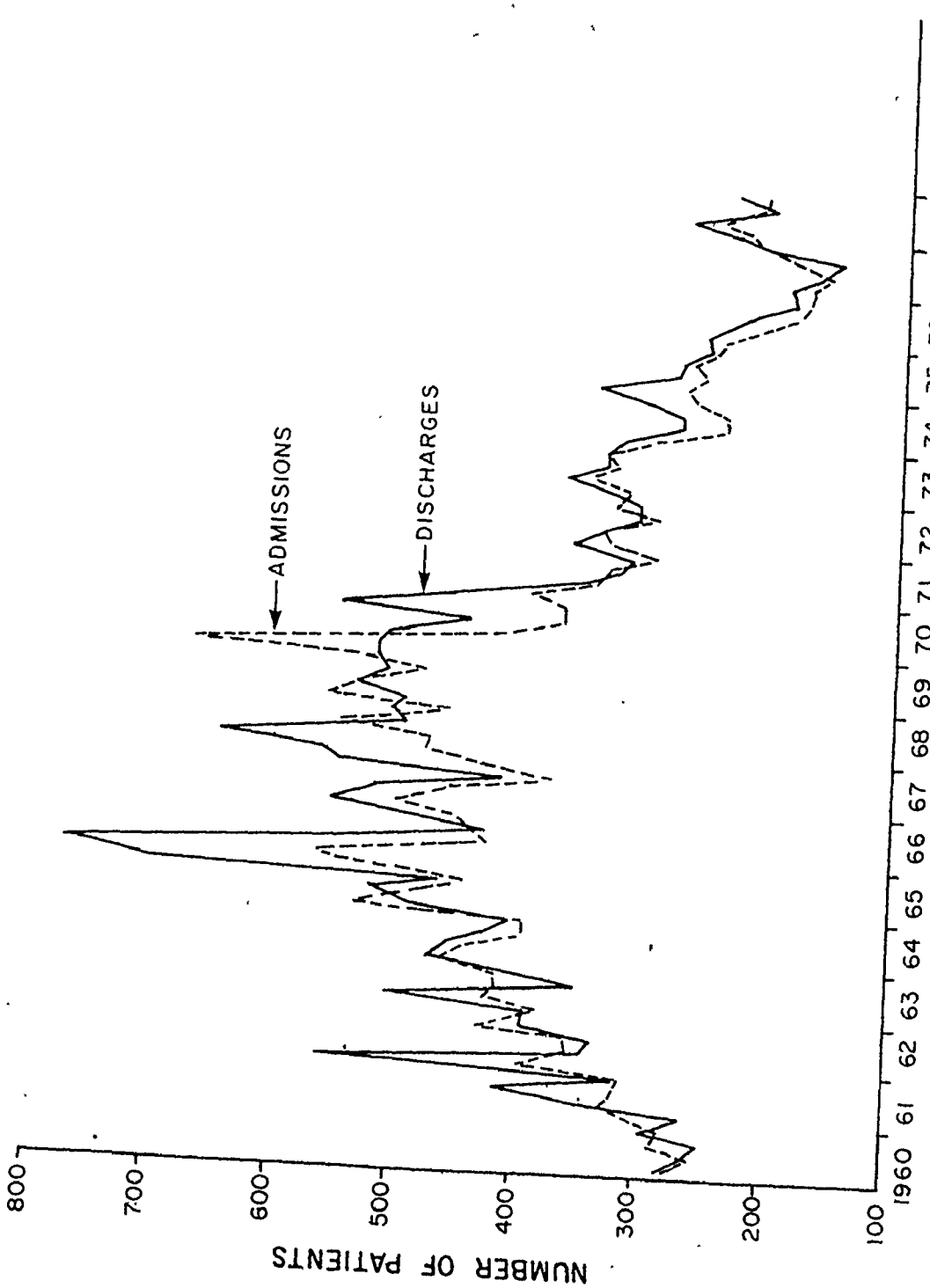

Figure 3.1 Admission and Discharge trends within the Hamilton Psychiatric Hospital, 1960-1978.

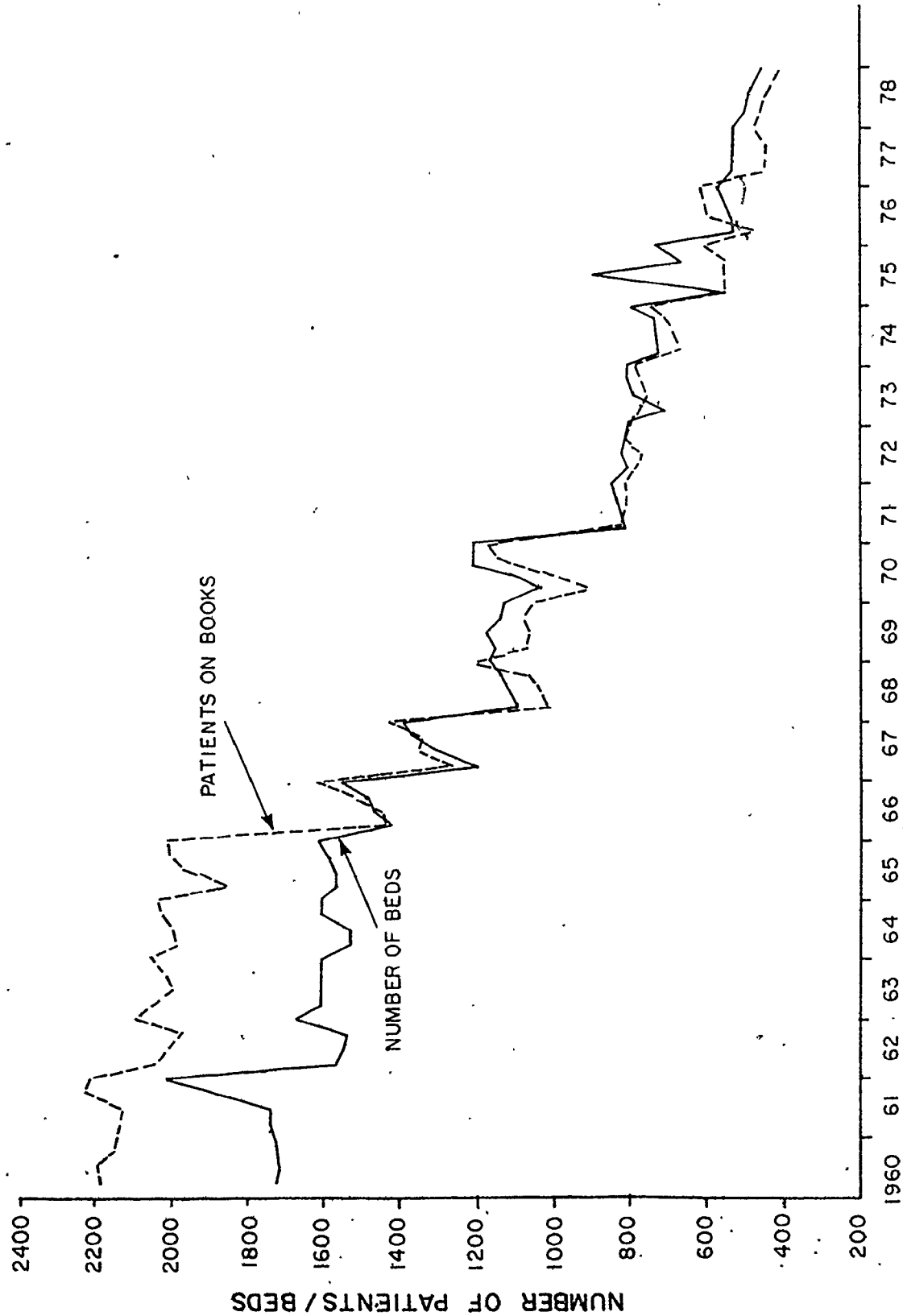

Figure 3.2 Patients on Books and Number of Available Beds within the Hamilton Psychiatric Hospital, 1960-1971.

the end of a month until 1968, when the situation reversed itself until 1975. This has since been restored in the post 1976 period (see Figure 3.2).

These descriptive trends indicate that substantial activity has been occurring within asylums over the period of deinstitutionalization. But how in fact do we interpret these changes in the hospital and outside the hospital? -- was humanitarian reform the motivation?; was it due to the treatment advances?; or due to societal attitude changes?; was it due to political motivations?

To answer these questions we must delve below the facts described in order to achieve an understanding of the dynamics of the state mental health care system.

3.3 Interpretative Scenarios of Community Mental Health

A study of the growth of community-based mental health care requires an historical overview in order to interpret the shift in treatment modality. At the level of appearances the facts of deinstitutionalization are clear, but the history of social change suggests that several different interpretations of the community mental health movement can be made. At least three plausible scenarios exist, each relating to, and consistent with, different levels of the wider socio-political context within which mental health care is embedded. The scenarios may be identified as follows:

1) Mental health care as *social control;*
2) Mental health care as a manifestation of increasing *state interventionism*; and

3) Mental health care as a consequence of increasing *professionalism*.

3.3.1 Social Control

The first scenario, primarily associated with Foucault (1973) and Scull (1977a), situates change in mental health care within the wider social content of capitalism. Scull and Foucault argue that policy is *pre-planned* by the responsible decision making body in order to achieve "social" control. Primarily, this involves (1) economic control to maintain a smoothly operating capitalist system; (2) maintenance of social order to retain proper capitalist social relations; and (3) ideological control to maintain allegiance to capitalist ethics.

Scull (1977b) reinterprets Rothman's (1971) analysis of the birth of the asylum in terms of social control. This incorporates Rothman's view that it was "moral reformers" in society who stressed the need for asylum based care because of their avid desire to maintain social stability at a time of societal flux. Certainly, the social order of the post-colonial era had become "startingly fluid" in comparison to the rigid fixity of the previous feudal society. Rothman, however, fails ".. to give us any understanding of why these [moral reformers] became anxious about these things at this time" (Scull, 1977b, 338).

Thus, contrary to viewing policy as a reflex to societal attitudes, as Rothman does, Scull claims that

> "many of the transformations underlying the move toward asylums can be more plausibly tied to the growth of the capitalist market system and to its impact on economic and social relationships" (Scull, 1977b, 339-340).

In particular, he claims that the asylum arose as the necessity for a mechanism of social control to ensure the perpetuation of capitalism became more pressing. Clearly, the capitalist market system at this time was beginning to make profound shifts within the social order causing some 'classes' to rise whilst others faltered. The stress created by the liberal ideology -- that every person should be free to seek their fortune and be responsible for the losses or gains incurred -- probably caused an increase in stress and mental illness (cf. Brenner, 1973). This, however clearly threatened capitalist production, which, as we have seen, requires adherence to a work ethic, not deviance from this ethic. The threat that any form of social deviance posed to the well-ordered capitalist system therefore was serious and required public intervention. The rise of the asylum was thus an integral part of social control, and was necessary for the smooth operation of the economy (Foucault, 1973). The labour force was being rationlized into able-bodied and non able-bodied, with the former being forced to sell their labour to benefit production, and the latter being housed in institutions to be "instilled with the

virtues of bourgeois rationality" (Scull, 1977b, 341). The asylum was also important for its symbolic value because it "... served as a constant reminder of the awful consequences of non conformity" (Scull, 1977b, 348).

Both Scull and Foucault recognize that the increasing network of asylums was both cause and effect of the increasing rise of psychiatric professionals and a central administrative authority. They highlight the important links among policy, the economy, and the above actors in the policy formation process. However, their view of the policy-making elite is conspiratorial (as Rothman (1971) notes). This view, however intuitively appealing, tends to imply there is little else to be explained. It closes the theoretical debate somewhat abruptly, and simultaneously creates a large gap between theory and observed practice.

It does however, suggest that there should be a demonstrable link between crises in capitalism and policies for the mentally ill, since social and economic control exists primarily to regulate capitalism and avoid crises. Interestingly enough, deinstitutionalization occurred during a time of increasing government fiscal crises, and also, according to Scull, represented merely a change in the format of social control from institutional to welfare state control (cf. Statman, 1971). He thus views the deinstitutionalization movement and its claimed benefits for treatment as a myth, "comparable only with the similar myth that attended the birth of the asylum" (Scull, 1976, 185).

3.3.2 State Interventionism

The second scenario attempts to clarify an important relationship implied by Scull (1977a), and hinted at by Rothman (1978): the relationship of the state to mental health policy making.

Both Roweis (1975) and Lasch (1979) note the increasing nature of state intervention over time, with control being extended into all aspects of life. This has required not only more state intervention, but also different types of state intervention. There has thus been the necessity for the involvement over time of more and more state apparatuses in social relations.

Lemieux (1977) notes that originally the provincial government had the care of the insane as its domain, with local or community involvement being negligible. Admissions into asylums were involuntary, and provincial laws provided strict control over admissions. The judiciary, as a formal state apparatus, had the power to commit patients to asylums, but Lemieux notes that admission laws changed over time with the delegation of authority being placed increasingly with medical professionals. This shift to an informal state apparatus as a method of control, marked a significant change in state intervention over time.

State intervention was also clearly evident in the periodic bursts of funding which occurred throughout the twentieth century in response to the need for more facilities. However, the responsibility for funding changed significantly with the introduction of federal government cost sharing programs, as part of the deinstitutionalization policy. The

introduction of the federal 'level' of government represented a significant change in the form of state intervention, (Klerman, 1977) and the introduction of another state apparatus.

Mental health care became integrated within the general health care system (eg. the creation of psychiatric units of public hospitals points to this). This change represents the introduction of medicine as a state apparatus within mental health care. The welfare apparatus of the state has become involved by providing the means by which released mental patients could live. State intervention has also changed the spatial configuration of service delivery within mental health, and this has implicated the community and 'local' government apparatuses. These changes in mental health care over time thus seem to point to the importance of state intervention and its changing forms within mental health care.

3.3.3 Professionalism

The third scenario examines the motivations and impact of the medical and psychiatric professions. This scenario relates mental health care delivery to the changing boundaries of medical practice. It implies that mental health service delivery has been strongly influenced by the self-interested motivations of various professional groups (cf. Szasz, 1970).

It is frequently claimed (Illich, 1977; and Illich *et al.*, 1977) that the private agenda of professionals is responsible for many forms of iatrogenesis which exist in medicine. One particular result is that

> "Medical practice sponsors sickness by reinforcing a morbid society that encourages people to become consumers of curative preventative industrial and environmental medicine" (Illich, 1977, 43)

This, and other forms of iatrogenesis, which destroy the potential of people to deal with their human weaknesses, together ensure the continuance of ill health in society. This continues to happen despite increases in the quality of care and the training of professionals.

In the earlier times of mental health care, the drive to control or care for people of sick mind, initially led to the need to differentiate between deviants, dependents, and people of sound or unsound minds, in order to know who should be institutionalized. This also led to "the establishment of a new, organized profession claiming to possess a specific expertise in the management of sanity" (Scull, 1977b, 344). The process then became self-reinforcing: Patients required "mad doctors" with a restorative ideal; which required a greater commitment to an institutional approach; which, in turn, necessitated a flow of more patients. The asylum thus enhanced professionalism by providing the specialized, professionally-supervised, environment that enabled closer examination of mental illness and the subsequent categorization of degrees of illness. This categorization then led to specialization within the psychiatric profession and hence to a larger group of professionals. (A parallel process in prison reform has been described by Foucault, 1977). However, it is curious

that the early successes could not be replicated in the long period of custodial care, despite increasing numbers of professionals (cf. Grob, 1973). These outcomes appear to emphasize the "negotiated" character of mental illness, hinting at the dangers inherent in a socially-determined definition of illness. Simply stated, in negotiating the definition of mental illness, some professionals may be tempted to exaggerate society's need for their services (D'Arcy, 1976; McKnight, 1977; Scheff, 1967).

The policy of deinstitutionalization could be interpreted as a result of the self-interested motivations of the medical and psychiatric professionals. One of the main claims commonly posited as a reason for the decarceration of the mentally ill was the 'revolution' in treatment. However, the movement to a new treatment setting could be regarded as equally beneficial for the professionals as for the patients. Certainly, the massive turnover current in psychiatric hospitals (Table 3.1), the rapid rise in patient episodes in community-based care centres (Table 1.3), the rise in the number of facilities (Table 1.2), the change in staff numbers, and staff salary changes (See Chapter 5) all suggest that this may be a plausible hypothesis.

3.4 Summary

This survey of historical facts suggests that (at least) three alternative interpretations of the changes in mental health policy exist. The history of previous trends allows for the effect of each factor to be deciphered. This is particularly important in the movement to community-

based care, since each factor tends to obscure the others due to their simultaneity. However, it is evident that each scenario may contain some element of truth. The trend towards deinstitutionalization can be interpreted in at least three different ways: as an extension of Social Control; as increasing State Interventionism; or as expanding Professionalism. All three scenarios hold some basis in fact, and may provide a method for structuring the complex social reality.

CHAPTER 4

RESEARCH DESIGN

4.1 Introduction: Theory into Practice

The wider theoretical context of state intervention in mental health care (Chapter 2) and the historical investigation of mental health care policy (Chapter 3) together suggests three possible underlying structural causes of the levels of appearances of deinstitutionalization. We require that these propositons (scenarios) be empirically testable. Thus it is the aim of this chapter to decide upon the appropriate data and methods required in order to operationalize each scenario.

Each scenario will be examined by analysing trends for the Hamilton Psychiatric Hospital. This 'sample' of Ontario mental health institutions is very representative of the trends within mental hospitals in Ontario. The changes outside the mental hospitals tend to be essentially opposite to those happening within. Thus the salient features of change are captured by this sample.

These hospital indicators will be linked in turn to indicators of each scenario -- see Table 4.1:

TABLE 4.1 LIST OF INDICATORS TO BE USED TO OPERATIONALIZE EACH SCENARIO

SCENARIO	HOSPITAL INDICATORS	INDICATORS SPECIFIC TO THE SCENARIO
1. SOCIAL CONTROL	NOB=Number of available beds ADM=Number of Admissions DIS=Number of Discharges POB=Number of Patients on the Books	UN=Unemployment rate CPI=Consumer Price Index HPH=Hamilton Psychiatric Hospital Total Operating Expense TOTOPEX=Total Institutional Operating Expense for all Institutions in Canada
2. PROFESSIONAL ACTIVITY	HINDEX=Hospital Activity Index, Net Admissions Plus Net Discarge	UN=Unemployment rate CPI=Consumer Price Index PD=Interest on the Public Debt TOT=Total Provincial Government Budgetary Expenditure
3. STATE INTERVENTION-ISM	NOB=Number of Available Beds ADM=Number of Admissions DIS=Number of Discharges POB=Number of Patients on the Books	UN=Unemployment Rate CPI=Consumer Price Index GG=Ontario Government Revenue and Grants for all Mental Institutions PT=Provincial Government Transfers to all Hospitals PGS=Provincial Government Expenditure on Goods and Services

1. The first scenario, *social control* links the statistics of activity at the Hamilton Psychiatric Hospital to indicators of the economy such as unemployment, consumer price index and government grants to the hospital.

2. The second scenario, concerning *professional activity*, links an indicator of the level of hospital activity (as a surrogate for social control within the hospital) to the wider societal crisis indicators such as the interest on the public debt, total provincial expenditure, unemployment and inflation.

3. The third scenario, concerning *state interventionism*, takes a closer look at state activities by examining expenditures of the government apparatus. This is thus a surrogate for state intervention. Indicators such as government grants to all mental institutions in Ontario, and total operating expenses for all institutions in Canada are surrogates for government monetary activity with respect to hospitals, and hence these are related to the hospital admission indicators for Hamilton Psychiatric Hospital.

The data thus required are hospital, economic, and government data for the years over which the change to deinstitutionalized care took place (1960 onwards) and since the data is essentially of time series nature, the analytical models considered are constrained by this fact. The choice of model is also constrained by the amount of data available. It is preferable to obtain as many data as possible to enable a better interpretation of trends and cycles; thus monthly or quarterly data are desired. Because of the socio economic nature of the data an econometric

model posited by Cochrane and Orcutt (1949) is preferred. While this is the preferred model, it will become evident that data limitations often prevent its full development.

4.2 Data and Sources

Each scenario requires a specific set of data for the application of the model, and in the case of the Professionalism and State Interventionism scenarios, supplementary data also exist. For the Social Control scenario two other indicators of activity in the Hamilton Psychiatric Hospital were also collected -- average monthly vacancy rate, and average daily population in the hospital -- but these were deemed to be either difficult to interpret or peripheral to the main trends. This is because the averaging procedures used in these indicators tend to disguise more information than they reveal. These indicators were consequently deleted from the analysis.

The data collected will therefore be listed for each scenario with the sample interval (year or month), the length of the series, and the data source. See Tables 4.2, 4.3 and 4.4.

In all cases, prior to analysis, the data were transformed as follows on the basis of preliminary identification procedures (see Section 4.3 for discussion on this):

(1) all variables were logged (to the base e) to enable interpretation of regression coefficients as beta elasticities, and to enforce stationarity in the variance of those series (eg. UN, HPH) with visual inconsistencies in the variance over time.

TABLE 4.2 DATA REQUIREMENTS FOR THE SOCIAL CONTROL SCENARIO

DATA	SAMPLE INTERVAL	LENGTH OF SERIES	SOURCE
Number of available beds at the end of the month Number of admissions at the end of the month Number of discharges at the end of the month Number of patients on books at the end of the month	Monthly	1960-1977	Hamilton Psychiatric Hospital Admission Records
Ontario unemployment rate National consumer price index	Monthly	1960-1979	Canadian Statistical Review
Hamilton Psychiatric Hospital total operating expenses*	Yearly Monthly	1960-1979 1969 (2nd Quarter)-1979	
Total institutional operating expenses for all institutions (excluding ambulatory care) in Canada	Yearly	1961-1976	Mental Health Statistics Volume III

*This indicator is an excellent surrogate for government grants to the Hamilton Psychiatric Hospital because the hospital has tended to spend right up to its budget in most years.

TABLE 4.3 DATA REQUIREMENTS FOR THE PROFESSIONALISM SCENARIO

DATA	SAMPLE INTERVAL	LENGTH OF SERIES	SOURCE
(a) Professional Social Control			
Number of admissions plus discharges at the end of the month	Monthly	1960-1977	Hamilton Psychiatric Hospital Admissions Records
Ontario Unemployment rate, National consumer price index	SEE TABLE 4.2		
Provincial government share of the interest on the public debt in Ontario	Yearly	1961-1976	Provincial Economic Accounts
Total provincial government budgetary	Yearly	1960-1977 (fiscal years)	Ontario Budget
(b) Professionalism			
Bed capacity, admissions, discharges, active cases at December 31, average daily population for psychiatric units of public hospitals	Yearly	1963-1976	Hospital Statistics 1976
Admissions, terminated cases, active cases at December 31 for outpatient community mental health centres	Yearly	1963-1976	Hospital Statistics 1976
Personnel in hospitals in Ontario	Yearly	1961-1975	Ontario Economic Council: Issues and Alternatives, Health 1976
Staff numbers in Hamilton Psychiatric Hospital (total, clinical, nursing, administration, other)	Yearly	1966-1979	Hamilton Psychiatric Hospital Accounts
Raw clinical and nursing wages: average wages per head	Yearly	1970-1979	Hamilton Psychiatric Hospital Accounts
Staff: Patient ratios	Yearly	1966-1977	Admissions and Accounts Records of Hamilton Psychiatric Hospital

TABLE 4.4 DATA REQUIREMENTS FOR THE STATE INTERVENTION SCENARIO

	DATA	SAMPLE INTERVAL	LENGTH OF SERIES	SOURCE
(a)	Data for model NOB, ADM, DIS, POB, UN, CPI	SEE TABLE 4.2		
	Ontario government revenue and grants for all mental institutions	Yearly	1961-1976	Mental Health Statistics Volume III
	Provincial transfers to all hospitals	Yearly	1961-1976	System of National Accounts: Provincial Expenditure
	Provincial government expenditure on goods and services			
(b)	Other interpretative data			
	Ontario budgetary expenditure on Health	Yearly	1970-1977 (fiscal years)	Ontario Budget
	Ontario budgetary expenditure on the Social Development Policy Field			
	Local, Provincial and federal government shares of the total interest on the public debt in Ontario	Yearly	1961-1976	Provincial Economic Accounts

(2) All monthly data except POB and CPI showed yearly seasonality. These variables (NOB, ADM, DIS, UN, HPH) were thus deseasoned using a monthly moving average, a method, according to Coen *et al.*, (1969) which will not "seriously distort the data" (1969, 145). No yearly series showed seasonality.

(3) All expenditure and wages series, no matter whether monthly or yearly, were converted to 1961 constant dollars using the CPI.

4.3 Analytical Procedures

The choice of method for analysing socio-economic time series data has been a source of controversy in the literature. Basically a dualism presents itself to the reader: first, statistically-oriented methods could be used, where model structure is primarily stochastic; or secondly, economically oriented methods, characterized by deterministic model structures, could be used.

4.3.1 Economic Time Series Approaches

This approach is characterized by correlation or ordinary least squares regression techniques. However, both correlating two time series X_t and Y_t (where X_t and Y_t are vectors of observations over time) to attain a measure of association between two variables, and regressing one series against another to test the significance of various parameters, share similar drawbacks. The major problem lies in the interpretation of the results gained. Correlations, as indicators of the strengths of relationships, are inherently misleading

since one could expect high correlations by chance simply because of the autocorrelated structure of most time series (Yule, 1923). Similarly, significant ordinary least squares (OLS) regression coefficients are equally meaningless unless one is sure that all important 'effects' have been accounted for, and that these other variables satisfy the assumptions of the regression model. In this regard, regression has the potential for more powerful results than simple correlation since the relationship of one variable to another can be examined with all other important variables being held constant. However, whether we obtain regression or correlation coefficients, the question of *causality* cannot be resolved unless one is working from a substantive theoretical foundation.

If the underlying theory is strong, regression or correlation results will have meaning; however, in this study, the theory is still in its formative stages. As an example, Brenner (1973), suggests that stress caused by economic conditions eventually causes mental illness in individuals whose "tolerance level" is surpassed. However, the theory of *when* mental illness becomes manifest as a result of high unemployment is not well established; i.e. the problem concerns the specification of the lag structure in the model. If admissions (Y_t) depend on unemployment (X_t) and inflation (Z_t) a model

$$Y_t = \alpha + \beta_o X_t + \gamma_o Z_t + \varepsilon_t \qquad (4.1)$$

where ε_t is an error term, simply examines the relationship of *present* unemployment and inflation with present admissions. We suspect, however, that unemployment and inflation of *previous* time periods have an effect. We may therefore specify the model to be:

$$Y_t = \alpha + \beta_o X_t + \beta_1 X_{t-1} + \ldots + \beta_k X_{t-k} + \gamma_o Z_{t-1} + \ldots$$

$$+ \gamma_j Z_{t-j} + \varepsilon_t \qquad (4.2)$$

where k and j are the time periods back to which the 'effect' is believed to exist. The lag structure, either theoretically or practically, is unknown; hence the results *may* test our understanding of the lag structure *only* if we believe the model is comprehensive and representative of reality. However, in this case the complex nature of the links between mental illness indicators in a hosptial and extraneous factors are not well astabished, and hence interpretation of regression results is hazardous. The best one can hope for is that the regression results will challenge our intuition and that this will lead to a clarification of the causal links of a more refined model.

Several other problems exist in regression analysis, particularly with respect to the time series that are examined in this work. One such problem, *autocorrelation,* is particularly important.

Chaterjee and Price (1977, 123) note that autocorrelation in a regression may be due to (i) the temporal correlation between successive

residuals in a series; (ii) spatial correlation; or (iii) mis-specification of the model (omitting or including a variable). The usual results are biased estimates of parameter values; a false impression of accuracy; and a failing of significance tests on the parameters.

Economic time series typically have high temporal auto-correlation if the sampling interval is small, such as a week or a month. Granger and Newbold (1974) note that in this case,

> "The usual recommendations are to either include a lagged dependent variable or take the first difference of the variables involved in the equation or to assume a simple first order autoregressive form for the residual of the equation" (Granger and Newbold, 1974, 117)

Multicollinearity between variables is the second major problem associated with regression analysis of economic data. When one variable is linearly related to another the method of least squares breaks down, making parameter values difficult to interpret due to the increase in the standard error (Merrill and Fox, 1970). Avoidance of such a situation involves either careful variable choice or the creation of representative indices based on *a priori* information.

4.3.2 Stochastic Box-Jenkins Time Series Approaches

An alternative to the heavily *a priori*-dependent regression approach is to take a purely stochastic approach following Box and Jenkins (1970). In this approach, a single series, Z_t, is assumed to be generated by passing independent, randomly drawn (from a normal distribution) shocks a_t, a_{t-1}, a_{t-2},... (called white noise) through a linear filter. This filter contains a function

$$\psi(B) = 1 + \psi_1 B + \psi_2 B^2 + \ldots \tag{4.2}$$

called the transfer function of the filter, where B is an operator such that $BZ_t = Z_{t-1}$; $B^2Z_t = Z_{t-2}$ etc., and ψ_1, ψ_2, ... are weights of the previous values of the process. Transfer functions can be purely autoregressive (denoted AR), where the current value of the process is expressed as a finite, linear aggregate of previous values of the process plus a random shock; (ii) purely moving average (MA) where Z_t is expressed as an infinite sum of random shocks; or (iii) a combination (ARMA) of these two.

Autoregressive operators are defined to be

$$\phi(B) = 1 - \phi_1 B - \phi_2 B^2 - \ldots - \phi_p B^p \tag{4.3}$$

and the autoregressive model may be written as

$$\phi(B)Z_t = a_t \tag{4.4}$$

$$\text{or } Z_t - \phi_1 Z_{t-1} - \phi_2 Z_{t-2} - \ldots - \phi_p Z_{t-p} = a_t \tag{4.5}$$

Moving average operators are defined to be

$$\theta(B) = 1 - \theta_1 B - \theta_2 B^2 - \ldots - \theta_q B^q \tag{4.6}$$

and the moving average model may be written as

$$Z_t = \theta(B)\, a_t \tag{4.7}$$

$$\text{or } Z_t = a_t - \theta_1 a_{t-1} - \theta_2 a_{t-2} - \ldots - \theta_q a_{t-q} \tag{4.8}$$

Thus an ARMA model has the following form:

$$\phi(B)\, Z_t = \theta(B)\, a_t \tag{4.9}$$

$$\text{or } Z_t = \phi_1 Z_{t-1} + \ldots + \phi_p Z_{t-p} + a_t - \theta_1 a_{t-1} - \ldots - \theta_q a_{t-q} \tag{4.10}$$

A model for a univariate series is derived by an iterative three stage process of *identification* of the form of the model (AR?, MA?, ARMA?); *estimation* of the parameters in the model (i.e. $\phi_1, \ldots, \phi_p$,

$\theta_1, \ldots, \theta_q$); and *diagnostic checking* of the residuals to ensure that they are white noise.

Similarly to the univariate case, these three steps are used in modelling the transfer function that connects an input X_t to an output Y_t. The stochastic time series approach also has the capability of modelling more than one input, and incorporating feeback into a model. However, multivariate time series modelling represents a far more difficult problem than that discussed previously. Problems in identification and uniqueness require that the structure of $\phi(B)$ and $\theta(B)$ be restricted to certain "canonical" forms, and it is at this stage that a highly complex system of economic variables with many feedback loops becomes exceedingly complicated to model. In addition, it is still not certain whether the model identified "... measures a process that actually exists or merely reflects the presumption of the individual researcher" (Dear *et al.*, 1979, 51). It could be that the model developed will mean very little, since it has been developed solely on the basis of the available data and on theoretically derived autocorrelation structures. In the case of economic inputs to a mental illness outcome, the transfer function formed by random shocks and unknown lags, may not be truly indicative of the underlying *process* which presumably exists.

The time series modelling approach, despite these drawbacks, is especially useful when its identification procedures are used in unison with regression approaches. By examining the autocorrelation and partial autocorrelation functions of each series, lags at which auto-

correlation persists can be identified. This implies the data transformations that are required in order to account for auto-correlation. First order autocorrelation due to small sampling intervals, and seasonal autocorrelation, can be removed prior to modelling. This, prior to a regression model, saves tedious regression runs and deciphering of residual plots.

4.3.3 The Model Chosen

The pure time series approach of Box and Jenkins (1970) was discarded due to the complexity of the links in the data and the uncertainty surrounding the form of the underlying real-world process. Based on the highly autocorrelated nature of the time series being examined, an ordinary least squares regression approach was thus chosen which could deal with this problem. The model developed by Cochrane and Orcutt (1949) satisfies this criterion. It provides an iterative, autoregressive scheme for removing first order autocorrelation in the residuals.

If a regression model

$$Y_t = \alpha + \beta X_t + a_t \qquad (4.11)$$

is being examined, and the error terms, a_t, are autocorrelated strongly with the prior value of the error, a_{t-1}, then the Cochrane-Orcutt method assumes the relationship between a_t and a_{t-1} can be described by equation (4.12),

$$a_t = \rho a_{t-1} + \varepsilon_t \qquad (4.12)$$

where ρ is a weight, and ε_t are normally distributed errors.

The Cochrane-Orcutt method initially estimates ρ, the weighting value attached to the past residual, via regression from equation (4.13) which is equation (4.12) substituted into equation (4.11),

$$Y_t = \alpha + \beta X_t + \rho a_{t-1} + \varepsilon_t \qquad (4.13)$$

However, this equation can be rewritten as follows:

$$Y_t - \rho Y_{t-1} = \alpha(1-\rho) + \beta(X_t - \rho X_{t-1}) + \varepsilon_t \qquad (4.14)$$

All the data are then transformed by ρ, regression is performed, coefficients are found, ρ is re-estimated and the procedure is repeated until ρ is stable.

Equation (4.14) thus represents the model form of the Cochrane-Orcutt method to be used in the analysis.

4.4 Summary

This chapter has outlined the data requirements and reviews the appropriate methods that can be applied to the interpretative scenarios developed in the preceding chapter. The three scenarios can be operationalized by studying the trends in the Hamilton Psychiatric Hospital, and by relating these trends to indicators of each scenario in an ordinary least squares regression-type framework. The Cochrane-Orcutt method successfully accounts for the problems of autocorrelation

which are clearly evident in the data collected. In the following analysis, each scenario is tested using this analytical framework.

CHAPTER 5

EMPIRICAL ANALYSIS OF THE POLICY SCENARIOS

5.1 Introduction

This chapter tests the empirical validity of each of the three interpretative scenarios of mental health care policy. Section 5.2 examines Social Control; Section 5.3 examines the dual nature of the functioning of medical Professionals; and Section 5.4 is devoted to State Interventionism.

5.2 Social Control

The need for social control stems from the wider needs of the state to maintain a smoothly functioning capitalist economy. We would therefore expect that, if the asylum is a social control mechanism, flows in and out of the asylum would be related in some way to the economy (Foucault's (1973) idea that the asylum "mopped up" the idle and unemployed to make the economy efficient is a useful parallel here). Thus, according to this view, hospital indicators should be lagged responses to changes in the economy, and the asylum indicators should be related to crises in the economy.

Two simple descriptive indicators of the economy, the provincial rate of unemployment and the national consumer price index (Figure 5.1), reveal that over the period 1960-1969 the economy of Ontario was experiencing a relative boom, as the CPI rose only slowly and unemployment fell. The reverse is the situation from 1969-1978. Stagflation conditions of rising unemployment and prices/wages characterize this as an economic recession - a crisis in the economy.

Dear *et al.*, (1979) relate these two indicators to hospital indicators; however, they notice that using the CPI as a surrogate for government supply leads only to speculation on the influence of government spending as a variable. In response to this, a better indicator of government supply was sought, and the operating expense within Hamilton Psychiatric Hospital was considered to be a reasonable surrogate for government spending with respect to that hospital (Figure 5.2). Another indicator considered was a more global representation of government supply to *all* mental institutions in Canada in order to match CPI and UN (Figure 5.2). While Hamilton Psychiatric Hospital expenditures remain stable, the early 1970's marks the fall in total operating expenses for all mental institutions in Canada, which is thus a surrogate for a fall in government expeditures on mental institutions.

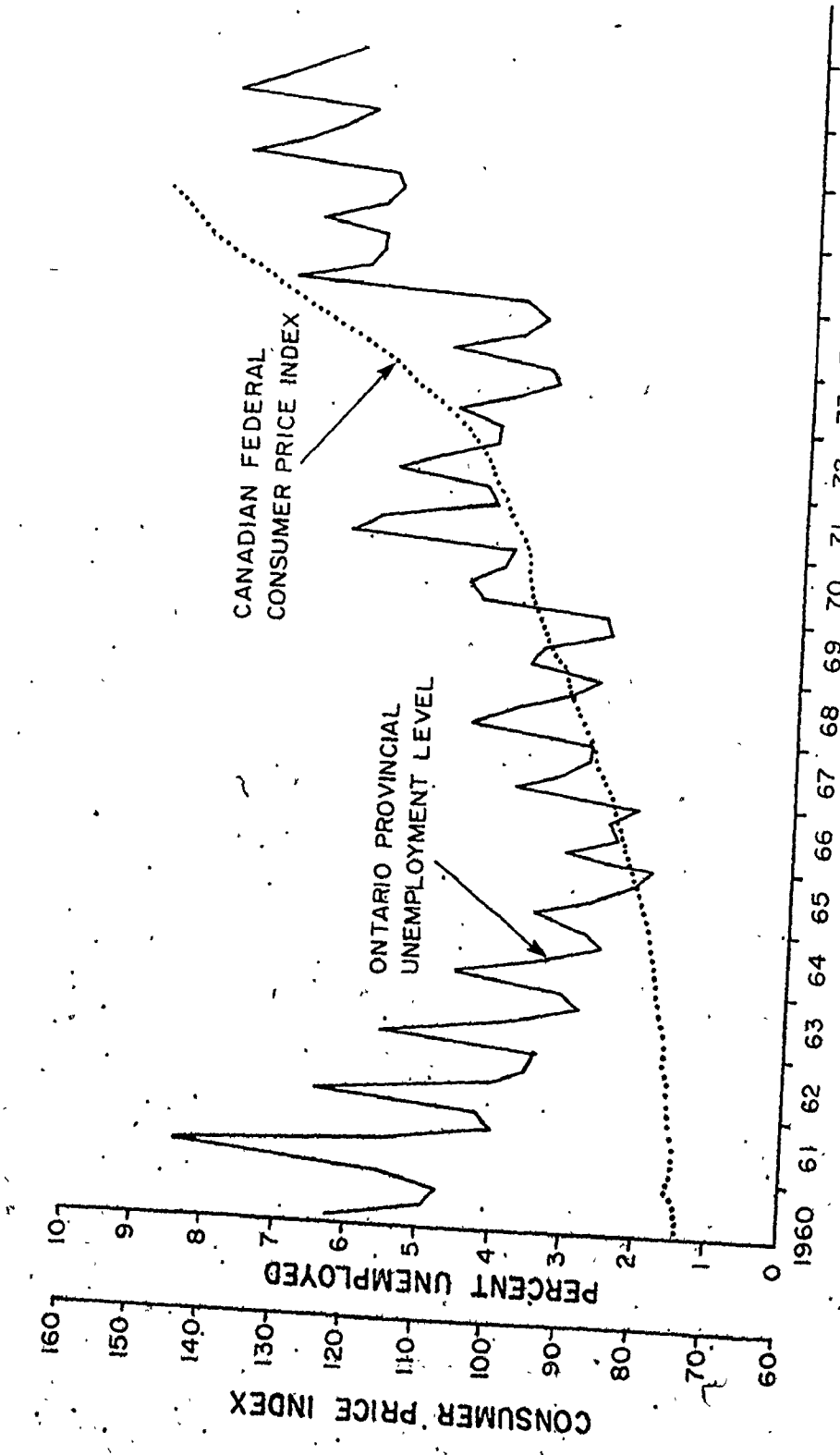

Figure 5.1 Unemployment and Consumer Price Index trends, 1960-1978.

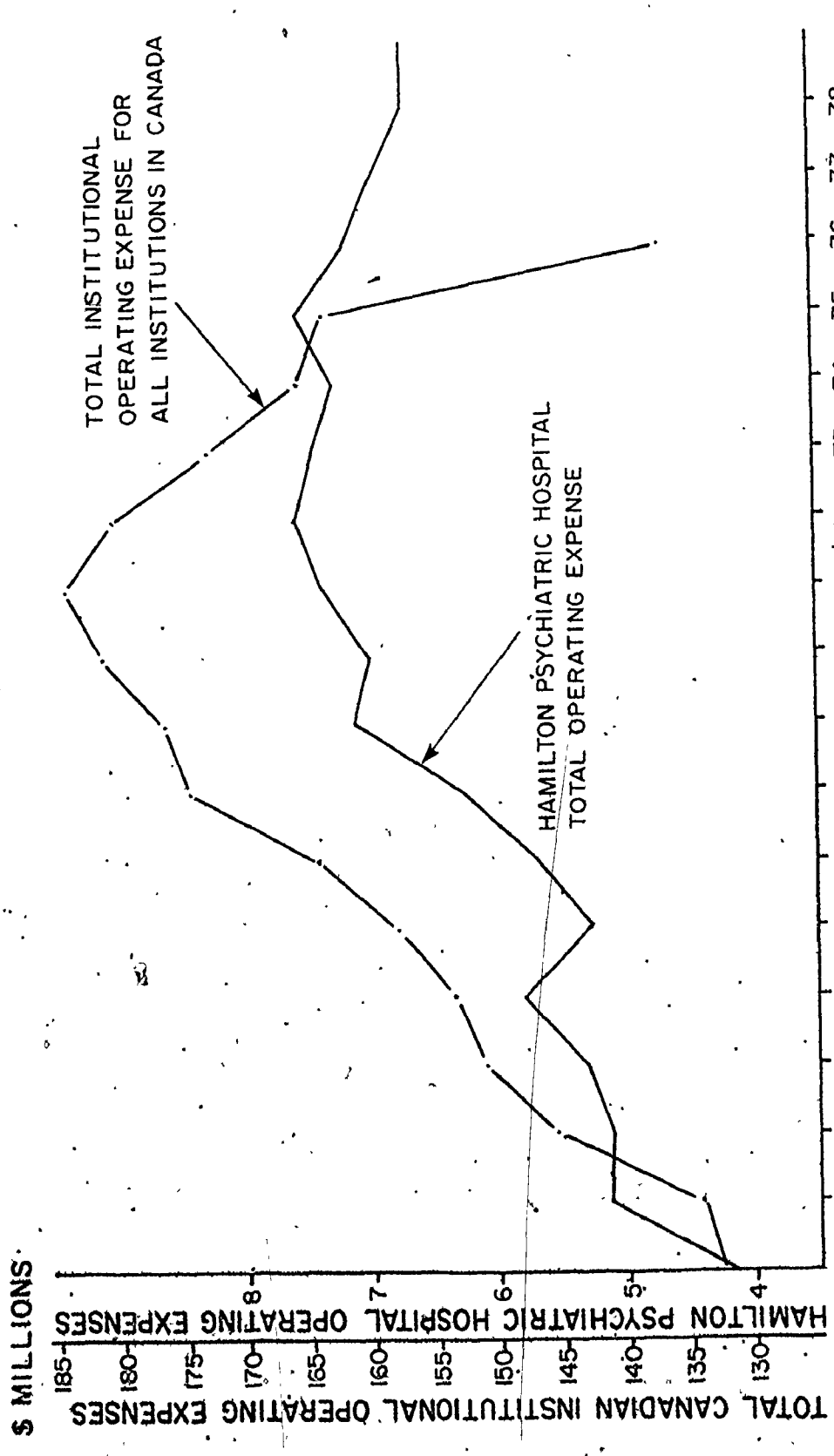

Figure 5.2 Trends in Hamilton Psychiatric Hospital Operating Expenses (HPH) and in Total Operating Expenses (TOTOPEX) for all institutions excluding outpatient care in Canada, 1961-1978.

The trends for NOB, ADM, DIS and POB have already been described in Figure 3.1 and 3.2. Each of these hospital indicators will be used as dependent variables and regressed against UN, CPI and HPH in one regression; and against UN, CPI and TOTOPEX in another (cf. Table 4.1 for a list of variable names). Using equation 4.14, the specific model should be as follows. For the first regression:

$$Y_t - \rho Y_{t-1} = \alpha(1 - \rho) + \beta_1(UN_t - \rho UN_{t-1}) + \beta_2(CPI_t - \rho CPI_t) + \beta_3(HPH_t - \rho HPH_{t-1}) + \varepsilon_t \quad (5.1)$$

For the second regression:

$$Y_t - \rho Y_{t-1} = \alpha(1 - \rho) + \beta_1(UN_t - \rho UN_{t-1}) + \beta_2(CPI_t - \rho CPI_{t-1}) + \beta_3(TOTOPEX_t - \rho TOTOPEX_{t-1}) + \varepsilon_t \quad (5.2)$$

where Y_t, the dependent variable, equals NOB, ADM, DIS and POB respectively at time t for each regression.

The first regression uses monthly data but is restricted by the availability of the HPH data to an examination of the recession only (1969 onwards), but the number of observations (n) is large (n=104) - see Table 5.1.

TABLE 5.1 OLS REGRESSION ESTIMATES (USING THE COCHRANE-ORCUTT METHOD) OF THE RELATIONSHIP BETWEEN MENTAL HEALTH INDICATORS AND ECONOMIC ACTIVITY USING HPH AS A SURROGATE FOR GOVERNMENT SUPPLY. MONTHLY DATA, 1969-1977.

	α	β_1 $\log_1$ UN	β_2 $\log_2$ CPI	β_3 $\log_3$ HPH	R^2	ρ	d	STANDARD ERROR OF ESTIMATE	TEST OF NORMALITY OF RESIDUALS	F VALUE
log NOB	11.879* (0.983)	-0.016 (0.034)	-1.057* (0.208)	-0.019 (0.025)	.973	.954	2.03+	0.029	No	1325.0
log ADM	11.887* (0.918)	-0.115 (0.144)	-1.531* (0.359)	0.027 (0.156)	.741	.484	2.22+	0.154	Yes	98.7
log DIS	10.761* (0.863)	-0.220 (0.140)	-0.991* (0.402)	-0.141 (0.185)	.682	.312	2.11+	0.177	No	72.2
log POB	12.742* (0.844)	-0.007 (0.033)	-1.313* (0.180)	0.017 (0.703)	.978	.943	1.90+	0.028	No	1562.5

*Significant at the 95% level; figures in brackets are estimates of standard errors.
n = 104
d = Durbin Watson Statistic
The test of residual normality is a Chi square test, No indicates nonnormality, yes indicates normality at the 95% level
+ indicates no positive or negative serial correlation in the residuals

TABLE 5.2 OLS REGRESSION ESTIMATES (USING THE COCHRANE-ORCUTT METHOD) OF THE RELATIONSHIP BETWEEN MENTAL HEALTH INDICATORS AND ECONOMIC ACTIVITY USING TOTOPEX AS A SURROGATE FOR GOVERNMENT SUPPLY. YEARLY DATA, 1961-1976.

	α	β_1 log UN	β_2 log CPI	β_3 log TOTOPEX	R^2	ρ	d	Standard Error	Test of Normality	F value
log NOB	21.279*	-0.138	-1.612*	-0.562*	.988	-0.322	2.06+	0.084	Yes	360.0
	(2.08)	(0.088)	(0.118)	(0.188)						
log ADM	0.061	-0.385*	-0.741*	0.831*	.965	0.286	1.88+	0.095	Yes	114.3
	(3.443)	(0.127)	(0.181)	(0.299)						
log DIS	0.884	-0.428*	-0.657*	0.842*	.961	0.315	2.00+	0.109	Yes	106.3
	(4.000)	(.146)	(.210)	(.346)						
log POB	29.372*	-0.142	-1.934*	-1.110*	.978	0.028	1.89+	0.081	Yes	205.0
	(2.466)	(.099)	(.134)	(.219)						

*Significant at 95%; Figures in Brackets are estimates of Standard Errors
n=17; + no positive or negative serial autocorrelation in residuals.

The second regression however, using yearly data, enables interpretation of trends over the entire study period (Table 5.2), but n=17 only. Both regressions have satisfactory test statistics (R^2, d, Standard Error, F) but the regression coefficients are of more interest. In both cases the significance of the CPI is evident, and the inverse relationship between unemployment and inflation and hospital indicators is clearly evident. While the HPH variable adds little to the first regression, the trends for TOTOPEX are more interesting. Admissions and discharges tend to follow the changes in total operating expenses; however, an inverse relation exists between the total operating expense (Canada-wide), and the number of beds and patients on books in the Hamilton hospital. This latter situation may be explained by two facts. First, NOB and POB for Hamilton Psychiatric hospital fall continuously from 1960 whereas total Canadian numbers do not reduce until the 1970's -- Hamilton Psychiatric Hospital thus seems to defy nationwide trends for these two variables (see Table 5.3 for bed comparison of Ontario and Hamilton Psychiatric Hospital). Secondly, expenses in hospitals tend to be weakly related to numbers of beds and patients, since approximately 80% of all expenses are staff salaries (see Section 5.3). Thus if expenses increase, it is not contradictory that the number of beds and patients should increase.

However, what do these analyses reveal about the hospital and social control? Preliminary guidance can be made with this question by examing Benner's (1973) claim that,

TABLE 5.3 BED CAPACITY, ONTARIO AND HAMITLON PSYCHIATRIC HOSPITAL 1961-1975.

YEAR	CAPACITY IN ONTARIO	PERCENTAGE INCREASE (+) OR REDUCTION(-) IN CAPACITY COMPARED TO 1961 LEVELS	HAMILTON PSYCHIATRIC HOSPITAL CAPACITY	PERCENTAGE INCREASE (+) OR REDUCTION (-) IN CAPACITY COMPARED TO TO 1961 LEVELS
1961	23,906	-	1,851	-
1962	23,364	-2.2	1,583	-14.4
1963	24,265	+1.5	1,608	-13.1
1964	23,563	-1.4	1,588	-14.2
1965	23,968	+0.2	1,586	-14.3
1966	24,318	+1.7	1,484	-19.8
1967	24,698	+3.3	1,317	-28.8
1968	25,335	+5.9	1,127	-39.1
1969	22,597	-5.4	1,148	-37.9
1970	21,342	-10.7	1,141	-38.3
1971	19,362	-19.0	833	-55.0
1972	19,392	-18.8	812	-56.1
1973	19,293	-19.2	800	-56.7
1974	18,079	-24.3	747	-59.6
1975	17,546	-26.6	637	-65.9

SOURCES: MENTAL HEALTH STATISTICS, VOL. III; HAMILTON PSYCHIATRIC HOSPITAL ADMISSIONS RECORDS

> "... as economic activity decreases and the economy contracts... overall social stress increases and therefore mental hospitalization should increase" (Brenner, 1973, 7).

It appears that economic activity *is* related to trends within the Hamilton Psychiatric Hospital; however, as the economy contracts, hospitalization contracts. This does not contradict Brenner's claim, because within all institutions over this period, mental illness numbers increase (cf. Table 1.3). It does raise questions, however, as to whether the release of hospital patients into a stressful environment was a humanitarian policy, and this in turn has implications for the relationship of mental health care to the economy.

Policies for mental health are formulated by the government on behalf of the state and in the interests of the capitalist economy. If the interest of care for the mentally ill was a primary focus of state concern, then serious doubts must be raised about the care aspect of the policy to deinstitutionalize during a period of stress. The fact that this did happen, implies that the 'problem' of the mentally ill is *not* a major state concern. It does *not* have "pervasive ramifications" within capitalism (recall Roweis, 1975), and thus it tends to be pushed to the background of state priorities. This implies that it is *other* forces and crises in the economy that may direct mental health policy.

The relationship of contemporary mental health policy to the economy is thus *mediated* by other, more serious crises within capitalism (cf. Wright, 1978, 23). This differs from the past history of mental health care when policy related *directly* to the economy and its crises. Mental health, in the nineteenth and part of the twentieth centuries was a major state concern; its control was an integral part of the continued survival of the economy. However, it appears that as crises in the capitalist economy have changed, mental health care has (1) lost its initial economic significance; and (2) has thus lost its necessity for formal control by the state.

In summary, the practice of social control of the mentally ill seems to have changed in form and meaning. Originally, the control of mental health care was an integral part of economic management, and control was repressive and institutionalized. However, now that mental illness no longer poses a direct threat to the functionings of capitalism it has lost its significance relative to other problems and crises in the capitalist economy. Mental health policy thus seems to be only indirectly related to the economy in contemporary society. Other crises mediate the relationship between the economy and mental health policy, removing the direct relationship which once existed. Subsequently, 'control' within mental health care is able to do without repressive supervision, and more subtle forms of state apparatuses (e.g. welfare, professional ideologies) appear to have become the control

mechanisms of the state during deinstitutionalization.

5.3 Professionalism

Some researchers (Robson, 1977; Scull, 1976) claim that professionals practice social control in pursuance of their own and the state's interests. The hospital, being the professionally supervised environment in which 'control' is possible, is thus the focus of state control activity. Therefore, an attempt was made to develop an index of hospital 'activity' (in terms of flows in and out), and compare it to various indicators of crises that required the use of social control.

This index should aim to capture the peaks and troughs of movement in and out of the asylum and incorporate all previous indicators (ADM, DIS, NOB, POB) into one index. This would then be a surrogate for the social control aspect of professionals in the asylum. Ideally the index would want to

(i) indicate large changes in admissions and discharges;

(ii) indicate the relationship between admissions and discharges; and

(iii) show large changes in the number of patients and available beds.

The incorporation of all measures into a single indicator is, however, complicated. A very simple indicator of gross movements -- the sum of net admissions and net discharges per year -- was thus chosen and compared to crisis indicators such as

(1) unemployment

(2) inflation

(3) interest on the public debt -- an indication of fiscal pressure (see Tables 5.11 and 5.12)

(4) total budgetary expenditure -- it was hoped to have separate indications of government expenditure on *production* and *reproduction*. Government accounting procedures, however, prevented the collection of such data. The total expenditure is thus the only series of sufficient time length available, and it is a crude surrogate for required expenditure to ensure production and reproduction (Figure 5.3).

The dependent variable, HINDEX, represents 'changes' data, since variations from year to year are examined. In the first regression, these 'changes' data are related to 'levels' of UN, CPI, PD and TOT using the Cochrane-Orcutt method. The following regression model was thus tested,

$$HINDEX_t = \alpha + \beta_1(UN_t - \rho UN_{t-1}) + \beta_2(CPI_t - \rho CPI_{t-1}) +$$

$$\beta_3(PD_t - \rho PD_{t-1}) + \beta_4(TOT_t - \rho TOT_{t-1}) + \varepsilon_t \qquad (5.3)$$

and the results for 1961-1976 are as follows (n=16):

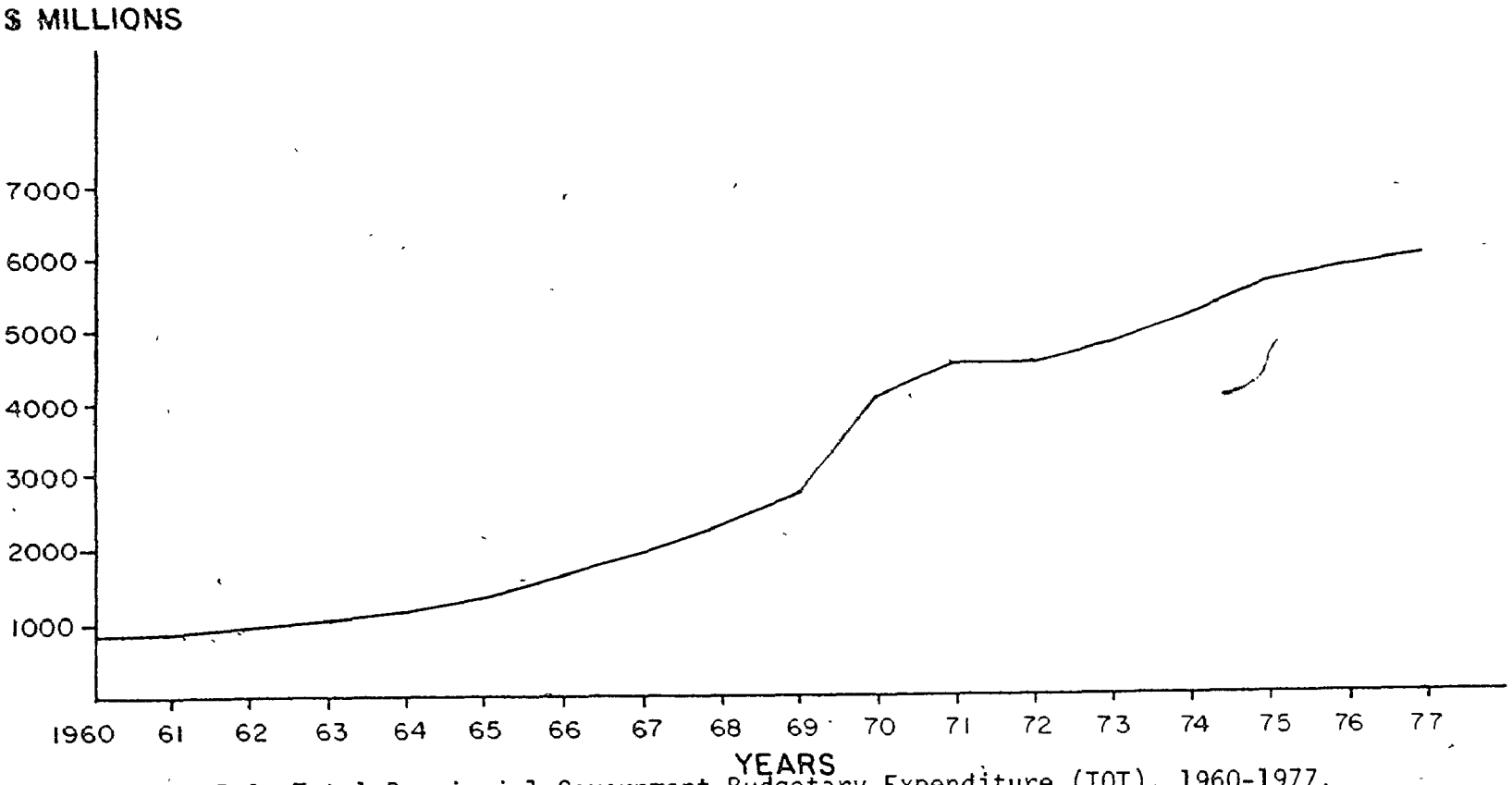

Figure 5.3 Total Provincial Government Budgetary Expenditure (TOT), 1960-1977.

α	β_1	β_2	β_3	β_4	ρ	F	R^2	d	STANDARD ERROR	RESIDUAL χ^2 TEST
9.50 (26.13)	4.16* (2.30)	-2.71 (6.33)	2.11 (4.70)	-1.02 (3.63)	-0.4	3.38	.551	2.31	2.07	Yes

*Significant at 95%; Figures in brackets are estimates of standard errors.

The results are obviously poor, the errors being unacceptably high. This could be the result of attempting to relate relatively smooth 'levels' data to more abrupt 'changes' data.

A second regression of 'changes' in HINDEX against 'changes' data in UN, CPI, PD and TOT was thus performed. The latter variables were differenced before being entered into equation 5.3 for application of the Cochrane-Orcutt method. The results for 1961-1976 are as follows:

α	β_1	β_2	β_3	β_4	ρ	F	R^2	D	STANDARD ERROR	RESIDUAL χ^2 TEST
9.90* (3.40)	0.90 (0.69)	-0.13 (0.63)	0.23 (0.45)	-0.91 (0.68)	-0.56	1.57	0.36	2.72	1.80	Yes

*Significant at 95%; Figures in brackets are estimates of standard errors.

These results, although improving upon the standard errors, do not reveal any significant parameters, and auto correlation still remains a problem. The Cochrane-Orcutt method in this case could not remove first order auto-correlation. Further attempts with this regression were not pursued however, because (1) the data set is too small for the consideration of a Box-Jenkins type approach which deals with 'changes' data more effectively; and (2) the question of how to remove auto correlation remains a problem which requires model experimentation. This did not seem to be warranted considering the lack of substitute data.

The notion of professionals practicing social control remains intuitively appealing however, but we suspect that professionals have their own agenda which may differ from state-motivated social control. Whether professionals' actions are deliberately designed (as Illich *et al.*, 1977; and Illich, 1977, would suggest), or merely reflect enlightened self-interest, is an issue which does not detract from the fact that such a motivation exists. What has been the result for professionals during deinstitutionalization? Has the movement been entirely in patients' benefits, or have professionals benefited as well? In order to assess these questions, some simple descriptive data were examined, beginning with an examination of trends exogeneous to the Hamilton Psychiatric Hospital.

The deinstitutionalization movement stressed a decentralized non-institutional, regional network of care facilities. Outpatient care centres, such as psychiatric units of public hospitals, and community mental health facilities became more numerous (see Table 1.2). There was a tremendous rise in the number of patients treated in these establishments since 1963 (Table 5.4 and 5.5).

The rise in patient numbers may imply that mental illness has been 'manufactured' to the benefit of medical professionals. This manufacturing either occurred through the practice of releasing patients into a hostile economic environment thereby reinforcing their illness, or by removing the stigma attached to seeking psychiatric help. The community mental health facilities represent a far less formal method of treatment, encouraging patients to use facilities without fear of

TABLE 5.4 BED CAPACITY, PATIENT LOAD FOR PSYCHIATRIC UNITS OF PUBLIC HOSPITALS 1963-1976

	BED CAPACITY	ADMISSIONS	DISCHARGES	ACTIVE CASES AT DECEMBER 31	AVERAGE DAILY POPULATION
1963	591	6,851	6,789	544	485
1964	620	7,783	7,724	550	548
1965	662	8,515	8,458	617	586
1966	725	8,687	8,645	645	612
1967	804	9,253	9,222	660	677
1968	1,077	11,118	10,919	910	865
1969	1,238	14,591	14,465	1,052	1,047
1970	1,351	18,914	18,820	1,118	1,191
1971	1,502	22,211	22,064	1,268	1,307
1972	1,492	23,005	22,985	1,225	1,298
1973	1,502	23,434	23,390	1,218	1,273
1974	1,712	25,795	26,702	1,355	1,430
1975	1,735	28,157	28,064	1,414	1,316
1976	1,798	28,441	27,643	1,343	1,454

SOURCES: HOSPITAL STATISTICS, 1976

TABLE 5.5 PATIENT LOAD AND MOVEMENT: OUTPATIENT COMMUNITY MENTAL HEALTH CENTRES, 1963-1976

	ADMISSIONS	TERMINATED	ACTIVE CASES DECEMBER 31
1963	18,670	17,836	9,361
1964	18,209	18,389	9.837
1965	17,319	16,421	10,042
1966	17,994	16.501	11,450
1967	20,569	18,704	12,315
1968	28,605	21,794	19,126
1969	31,515	25,028	25,368
1970	37,536	33,729	28,156
1971	43,689	36,070	33,931
1972	46,651	36,257	44,237
1973	N/A	N/A	N/A
1974*	44,895	38,729	49,753
1975	49,410	38,563	63,346
1976	50,332	43,115	70,661

SOURCE: HOSPITAL STATISTICS 1976

*Note that figures for 1974-1976 are figures for community sponsored clinics only, these represent approximately 90% of all clinics. Figures prior to 1974 contain community sponsored and provincially sponsored clinics.

hospitalization. This may have thus accounted for the rise in patient numbers. One also suspects that a side effect of this patient rise may have been a substantial boost to the drug industry.

Patient numbers, however, are confounded by relatively high rates of readmission[1]. If these rates are comparable in outpatient care, then the actual number of new mentally ill patients is substantially reduced. The total levels in all institutions, even accounting for a 50% readmission rate, however, still point to an increase in mental illness. The high rate of readmissions also implies the patient cannot cope in the community. This again questions how humane the policy has in fact been, and also points to these patients' probable dependence upon welfare as a means of subsistence. Social control through welfare may thus be a result of deinstitutionalization.

No matter whether there has been an overall increase in mental illness or not, professionals certainly seemed to have benefited at least in terms of clientele. The increased turnover and total number of cases treated may have created employment opportunities for professionals also, thus boosting the profession; however, data on this

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[1]For example, in the Hamilton Psychiatric Hospital readmissions have reached 61% of total admissions in 1979 - see below:

YEAR	READMISSIONS	TOTAL ADMISSIONS	% OF TOTAL THAT ARE READMISSIONS
1975	543	1052	51.6
1976	439	837	52.4
1977	409	736	55.6
1978	554	916	60.5
1979	521	846	61.6

Source: Hamilton Psychiatric Hospital Accounts Data.

were only available within the Hamilton Psychiatric Hospital (see Table 5.6).

These data cannot possibly test the suspicion that professional numbers have increased in the entire mental health field but since we do know that hospitals have been closed and bed numbers reduced, have hospital professional numbers been affected in a similar manner? It is interesting to note that despite the fall in bed numbers from 1960-1970 (at least in Hamilton Psychiatric Hospital) personnel in fact continued to rise over this period (and at least for the period 1966-1970 for Hamilton Psychiatric Hospital). Only in the recession period did total numbers decline.

This total however, disguises another interesting trend. If clinical staff are treated as a surrogate for professionals (i.e. the elite 'class' within the hospital) and nurses, administrators and other staff are treated as a surrogate for lower 'class' in the hospital (cf. Navarro, 1976) then it is interesting to note that the elite class are in fact the last class to feel the reduction in staff numbers. Clinical staff numbers continued to rise until 1973, and began to fall from 1974; whereas nursing and administration numbers began to fall in 1970, and other staff in 1971. This reflects both the importance of the clinical class and the fact that lower classes tend to be the first to be 'squeezed' in times of recession (Table 5.6).

Despite the fall off in staff numbers, total raw wages paid between 1970 and 1979 have been increasing (Figure 5.4). However, clinical "class" wages have been rising faster than nursing "class" wages.

TABLE 5.6 FULL TIME PERSONNEL IN ALL HOSPITALS IN ONTARIO AND IN THE HAMILTON PSYCHIATRIC HOSPITAL, 1961-1979

	PERSONNEL IN HOSPITALS IN ONTARIO*	STAFF IN HAMILTON PSYCHIATRIC HOSP**				
		TOTAL	CLINICAL	NURSING	ADMIN.	OTHER
1961	11,873	-	-	-	-	-
1962	12,621	-	-	-	-	-
1963	13,485	-	-	-	-	-
1964	13,658	-	-	-	-	-
1965	14,147	-	-	-	-	-
1966	15,293	953	56	562	94	241
1967	16,377	1,053	68	615	107	263
1968	18,234	1,093	73	626	116	276
1969	18,532	1,083	64	626	112	258
1970	18,444	1,083	115	595	80	293
1971	18,894	1,026	129	547	75	275
1972	19,550	1,015	146	412	81	269
1973	19,893	986	151	492	80	257
1974	19,938	972	143	490	87	246
1975	19,136	891	130	441	86	226
1976	-	787	126	358	79	234
1977	-	764	125	350	75	210
1978	-	747	121	339	87	290
1979	-	735	121	337	85	192

*SOURCE: ONTARIO ECONOMIC COUNCIL: ISSUES AND ALTERNATIVES, HEALTH 1976

** SOURCE: HAMILTON PSYCHIATRIC HOSPITAL ACCOUNTS

-DATA NOT AVAILABLE

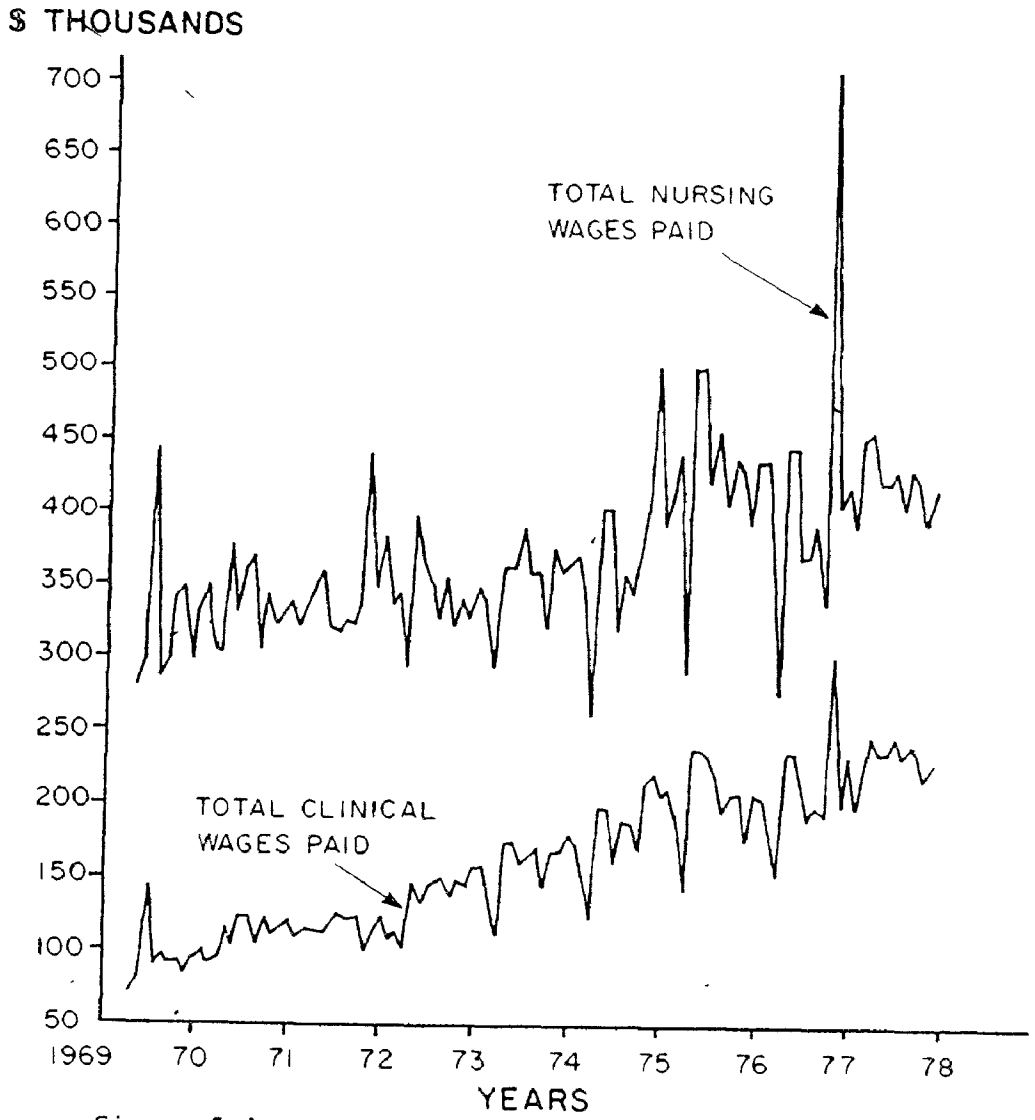

Figure 5.4 Trends in Total Paid Wages for Clinical and Nursing Staff in the Hamilton Psychiatric Hospital, 1970-1979.

Notice also that the variance in raw nursing wages is more pronouced than that for clinicians' wages. This indicates that nurses' wages are subject to more drastic changes than clinicians' wages, and seems to coincide with the idea that the lower echelons in the medical hierarchy tend to bear the brunt of changes more severely than the higher levels. Taking account of the decline in numbers, average clinical wages still appear to be rising at a greater rate than average nursing wages (Figure 5.5).

Table 5.7 indicates that in eleven years, the ratio of patients to clincians has fallen from approximately 27:1 to 4:1, whereas the patient to nursing ratio has approximately halved.

The patient to clinician ratio could mean many things, but two opposing viewpoints seem prevalent. First, it could be that this ratio was always too high and that the lowering of it has been humanitarian and in the best interests of treatment. Secondly, it could reflect the increasing value of clinicians to the state as legitimizers of state policy. It is interesting to note that deinstitutionalization *has* received strong legitimation on medical grounds. This suggests that the retention of clinicians has been necessary for the state. It also hints that this legitimation is a facade hiding other state priorities.

The total evidence for Hamilton Psychiatric Hospital may thus indicate that professionals (clinicians) have been given preferential treatment over other hospital staff even in these times of *falling* patient numbers. If this is so, we can only speculate that in the new

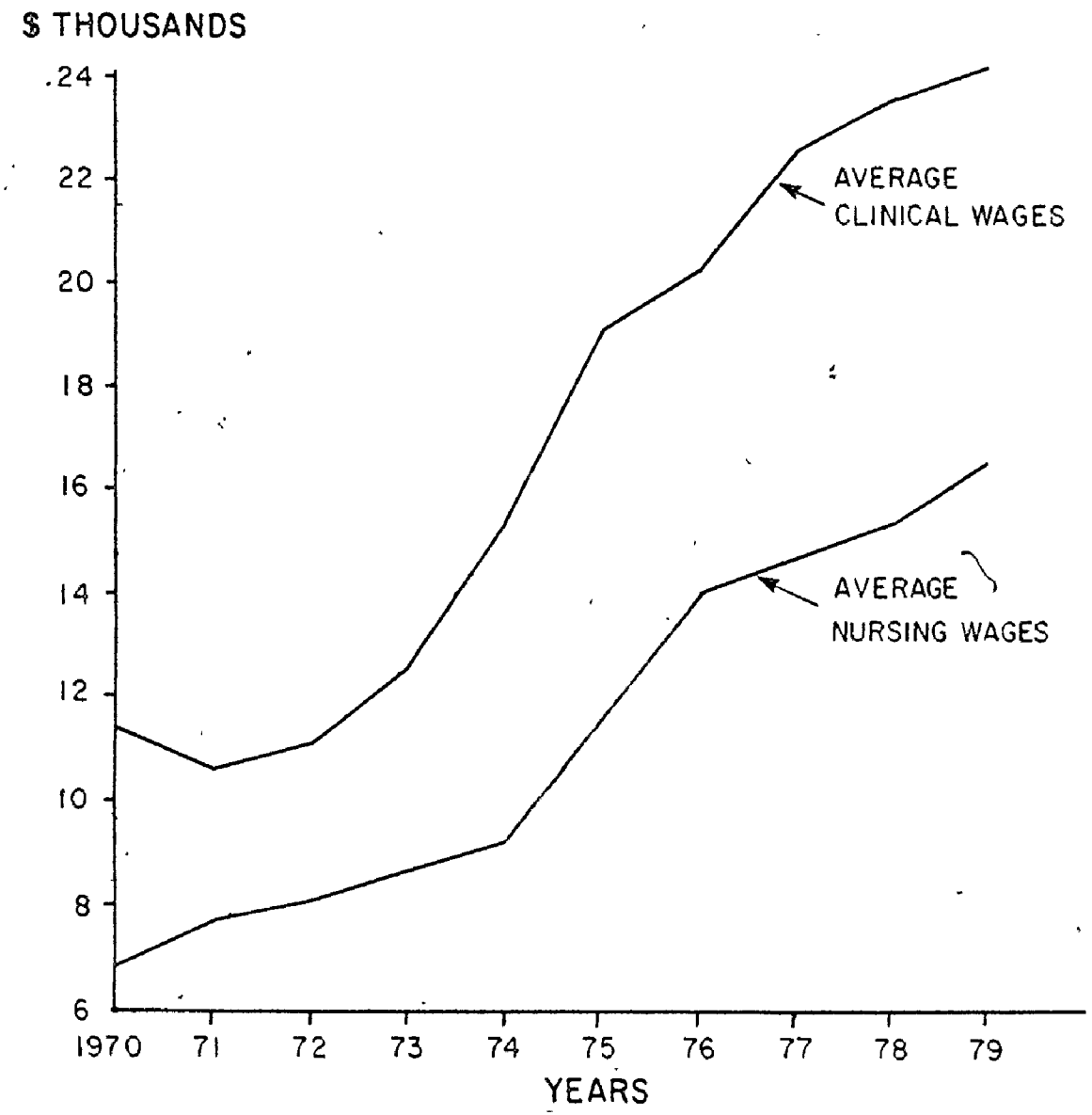

Figure 5.5 Trends in Average Yearly Wages for Clincial and Nursing Staff in the Hamilton Psychiatric Hospital, 1970-1979.

TABLE 5.7 PATIENT TO STAFF RATIOS FOR THE HAMILTON PSYCHIATRIC HOSPITAL 1966-1977.

	AVERAGE YEARLY PATIENTS ON BOOKS	CLINICAL STAFF	NURSING STAFF	PATIENT NUMBERS PER CLINICAL STAFF	PATIENT NUMBERS PER NURSING STAFF
1966	1,504	56	562	26.86	2.68
1967	1,343	68	615	19.75	2.18
1968	1,081	73	626	14.81	1.78
1969	1,063	64	626	16.61	1.70
1970	1,065	115	595	9.26	1.79
1971	810	129	547	6.28	1.48
1972	789	146	512	5.40	1.54
1973	746	151	492	4.94	1.52
1974	698	143	490	4.88	1.42
1975	568	130	441	4.37	1.29
1976	502	126	358	3.98	1.40
1977	456	125	350	3.65	1.30

Source: Hamilton Psychiatric Hospital, Admissions and Personnel Data

and emerging fields of community mental health, where patient numbers have been *rising*, professionals are doing even better. Hence, the conclusions from the analysis of this scenario are that:

(1) Professionals may have benefited, or at least performed comparatively better than lower medical 'classes' during deinstitutionalization;

(2) Social control through welfare may be a result of deinstitutionalization; and

(3) The humanitarian claim of this treatment shift may be false, or at best, illusory.

5.4 State Interventionism

Section 5.2 hinted at state activity in economic control by referring to hospital operating expenses as surrogates for government interventions. However, data on government revenue and grants for all mental institutions (GG), and provincial government transfers to all hospitals (PT), refer to *specific* state expenditure, and thus promise a further insight into state intervention.

The indicator GG, has 95% of its grants funded by the provincial government, and hence it is representative of provincial government grants to mental institutions (see Figure 5.6). Provincial government transfers (PT) to all hospitals is a rising series (Table 5.8). As in GG, however, it is difficult to interpret what these transfers mean in isolation. When compared to provincial government expenditure on goods

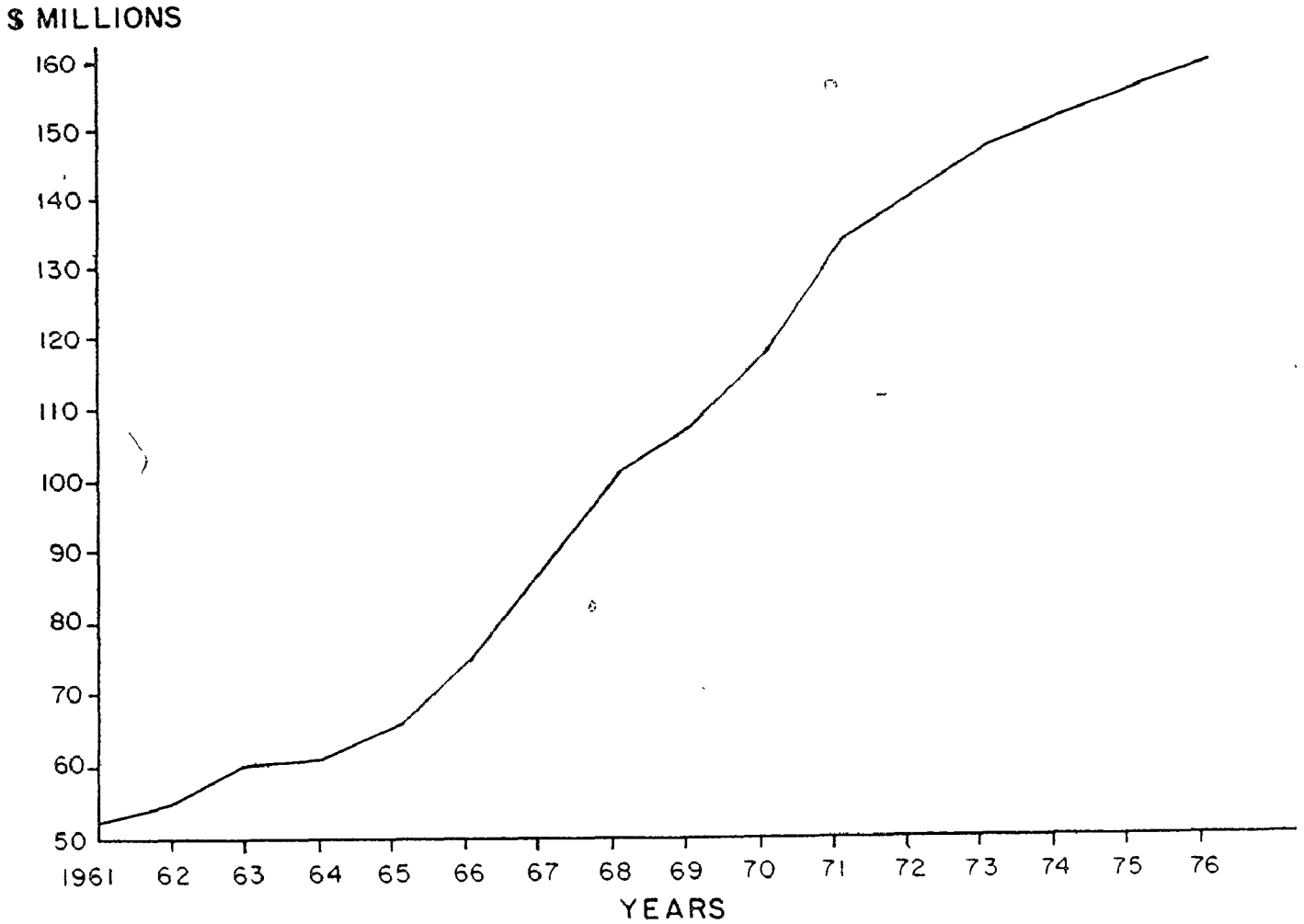

Figure 5.6 Trends in Provincial Government Revenue and Grants (GG) for all mental institutions, 1961-1976.

TABLE 5.8 PROVINCIAL TRANSFERS, AND TRANSFERS AS A PERCENTAGE OF PROVINCIAL GOVERNMENT EXPENDITURE ON GOODS AND SERVICES, 1961-1976; ($ millions)

YEAR	PROVINCIAL TRANSFERS TO ALL HOSPITALS	PROVINCIAL GOVERNMENT EXPENDITURES ON GOODS AND SERVICES	PROVINCIAL TRANSFERS AS A PERCENTAGE OF PROVINCIAL EXPENDITURE ON GOODS AND SERVICES
1961	248	308	80.5
1962	271	329	82.3
1963	303	367	82.5
1964	337	388	86.8
1965	374	471	79.4
1966	435	577	75.3
1967	517	716	72.2
1968	630	948	66.4
1969	726	1,042	69.6
1970	792	1,601	49.4
1971	886	1,717	51.6
1972	1,034	1,913	54.0
1973	1,101	2,079	52.9
1974	1,384	2,483	55.7
1975	1,653	3,175	52.0
1976	1,958	3,193	61.3

Source: System of National Accounts: Provincial Expenditure

and services (PGS) (hospital transfers make up one part of this total), provincial transfers to hospitals actually fall *relative* to all other expenses (see Table 5.8). Government grants (GG) are thus used in a regression to test absolute government expenditure; and provincial transfers as a percentage of government goods and services expenditure (PT/PGS) is used to test relative expenditure.

Once again, using the Cochrane-Orcutt method, account must be taken of the first order dependence of the residuals in the regression. Hence, according to equation 4.14, the model form for the first regression is expressed as:

$$Y_t - \rho Y_{t-1} = \alpha(1 - \rho) + \beta_1(UN_t - \rho UN_{t-1}) + \beta_2(CPI_t - \rho CPI_{t-1}) + \beta_3(GG_t - \rho GG_{t-1}) + \varepsilon_t \qquad (5.4)$$

and for the second regression:

$$Y_t - \rho Y_{t-1} = \alpha(1 - \rho) + \beta_1(UN_t - \rho UN_{t-1}) + \beta_2(CPI_t - \rho CPI_{t-1}) + \beta_3\left(\frac{PT}{PGS_t} - \rho \frac{PT}{PGS_{t-1}}\right) + \varepsilon_t \qquad (5.5)$$

where Y_t, the dependent variable, equals NOB, ADM, DIS, and POB respectively at time t for each regression (See Table 4.2 for full details of variable names). The variables UN and CPI were again chosen to represent important aspects in the economy, together with government expenditure (Tables 5.9 and 5.10).

The results are not only similar between regressions, they also show similarity to Tables 5.1 and 5.2 where surrogates for government expenditure (HPH and TOTOPEX) are used. As regards the government supply variable, the coefficients are very small, and only patient flows in and out relate significantly to government expenditure. Once again, the inverse relationship of government grants to the number of beds and patients seems to reflect the lack of consideration of staff numbers as a mediating variable here.

State intervention thus appears to affect conditions within the hospital; however, the analysis can only suggest that the relationships are weak, and that over time, intervention in the form of finance to hospitals has been decreasing. This seems to lend credence to Roweis' (1975) suggestion that there is a widening gap between expenditures on social policy (eg. health etc.), and other more capital-oriented fields. At least within hospitals, cut backs are evident (this is significant since 60% of the health budget is hospital expense). These trends seem to reflect the penetration of capital into state policy which directs investments into pervasive, crisis-avoiding sectors at the expense of other sectors which are cut back.

TABLE 5.9 OLS REGRESSION ESTIMATES (USING THE COCHRANE-ORCUTT METHOD) OF THE RELATIONSHIP BETWEEN MENTAL HEALTH INDICATORS, ECONOMIC AND GOVERNMENT ACTIVITY, USING GG AS AN INDICATOR OF GOVERNMENT SUPPLY. YEARLY DATA, 1961-1976.

	α	β_1 log UN	β_2 log CPI	β_3 log GG	R^2	ρ	d	STANDARD ERROR OF ESTIMATE	NORMALITY TEST OF RESIDUALS	F
log NOB	15.152*	-0.006	-1.783*	-0.001	.957	0.083	1.91+	0.100	Yes	90.1
	(0.619)	(0.117)	(0.165)	(0.010)						
log ADM	10.648*	-0.446*	-0.654*	0.0217*	969	0.506	1.98+	0.119	Yes	140.7
	(1.102)	(0.162)	(0.268)	(0.012)						
log DIS	10.415*	-0.479*	-0.594*	0.028*	.958	0.444	2.10+	0.125	Yes	105.3
	(1.079)	(0.168)	(0.266)	(0.012)						
log POB	16.122*	-0.088	-1.950*	-0.002	.988	0.762	1.84+	0.100	No	360.4
	(1.352)	(0.139)	(0.309)	(0.009)						

*Significant at 95% level: Figures in brackets are estimates of Standard Errors n=16
+No positive or negative serial correlation of residuals

TABLE 5.10 OLS REGRESSION ESTIMATES (USING THE COCHRANE-ORCUTT METHOD) OF THE RELATIONSHIP BETWEEN MENTAL HEALTH INDICATORS AND ECONOMIC AND GOVERNMENT ACTIVITY USING PT/PGS AS AN INDICATOR OF GOVERNMENT SUPPLY. YEARLY DATA, 1961-1976.

	α	β_1 $\log^1$UN	β_2 $\log^2$CPI	β_3 $\log^3\frac{PT}{PGS}$	R^2	ρ	d	STANDARD ERROR OF ESTIMATE	NORMALITY TEST OF RESIDUALS	F VALUE
log NOB	15.181* (.594)	-0.011 (.118)	-1.802* (1.50)	0.005 (.207)	.960	.108	1.90+	0.100	Yes	103.9
log ADM	10.383* (1.169)	-0.437* (.169)	-0.588* (.277)	0.045 (.030)	.970	.549	1.97+	0.123	Yes	144.0
log DIS	10.039* (1.147)	-0.470* (.178)	-0.501* (.275)	0.062* (.033)	.959	.485	2.10+	0.131	Yes	104.7
log POB	16.156* (1.34)	-0.087 (.139)	-1.960* (.306)	-0.002 (.024)	.988	.768	1.83+	0.100	No	359.4

*Significant at 95% level; Figures in brackets are estimates of standard errors
+no positive or negative serial correlation of error terms
n=16

The current crisis facing the state is a fiscal crisis. It is the result of a gap that has developed in state finances between expenditure and revenue. The severity of the crisis in Ontario is well represented by the interest on the public debt (Table 5.11) which is the interest on the amount owed by the government to the public from whom it has borrowed. The figures indicate the increasing nature of the debt, indicating that the government, especially the provincial government, has been forced to increasingly borrow from the public to pay for 'necessary' expenses (i.e. for the well being of capitalism).

One of the expenditures that initially required state attention, was the socializing of the costs of various social policy fields (including health, and welfare) in order that they maintain their important functions. State intervention of this sort, thus created quasi-public institutions out of those institutions (e.g. medicine) which had previously remained private. However, this contributed to the fiscal crisis, which has in turn required more state intervention. The latest intervention into quasi-public institutions such as medicine, appears to be an attempt by the state to gain further control over such institutions so that (a) the state will have claim to some of the revenue; and (b) the state can oversee the entire operation and attempt to reduce costs. Within the entire field of health for example, costs at least have been slightly reduced (Table 5.12).

TABLE 5.11 INTEREST ON THE PUBLIC DEBT IN ONTARIO BY LEVEL OF GOVERNMENT, ($ millions), 1961-1976

	LOCAL GOV'T		PROVINCIAL GOV'T		FEDERAL GOV'T		TOTAL INTEREST
	ACTUAL	AS % AGE OF TOTAL	ACTUAL	AS % AGE OF TOTAL	ACTUAL	AS % AGE OF TOTAL	ACTUAL
1961	86	15	73	13	414	72	576
1962	93	15	79	13	450	72	625
1963	104	15	85	13	484	72	676
1964	107	15	93	13	513	72	716
1965	126	16	97	13	542	71	768
1966	131	16	112	13	588	71	834
1967	154	17	142	15	630	68	929
1968	163	15	183	17	736	68	1086
1969	177	14	232	19	831	67	1244
1970	212	14	288	19	974	66	1479
1971	229	14	359	22	1026	63	1619
1972	227	12	463	25	1188	63	1882
1973	259	12	612	27	1357	61	2232
1974	282	11	714	27	1630	62	2631
1975	296	9	825	26	2047	65	3173
1976	315	8	1058	27	2522	65	3900

Source: Provincial Economic Accounts

TABLE 5.12 HEALTH EXPENDITURE OF THE PROVINCIAL GOVERNMENT IN ONTARIO, 1970-1978 ($millions)

FISCAL YEARS	ACTUAL HEALTH SPENDING ($ million)	HEALTH SPENDING AS A PERCENTAGE OF TOTAL SPENDING ON "SOCIAL" EXPENDITURES	HEALTH SPENDING AS A PERCENTAGE OF TOTAL BUDGETARY EXPENDITURE
1970-71	1,597	45.4	30.6
1971-72	1,792	44.7	29.7
1972-73	1,886	42.4	29.4
1973-74	2,023	41.5	28.0
1974-75	2,494	43.1	28.6
1975-76	2,945	43.3	28.1
1976-77	3,349	43.7	28.5
1977-78	3,624	42.3	28.1

Source: Ontario Budget

Within mental health, it appears that the intervention *was* stimulated by the fiscal crisis for the following reasons. First, there has been an attempt to cut costs (in hospitals at least). Secondly, there has been an attempt to rationalize service delivery to

(a) make the system more efficient and thereby cut costs;

(b) extend professional ideological control to a more local and spatially dispersed level; and

(c) create new 'production' in mental health or in associated fields (e.g. drug industry).

Thirdly, there have been 'control' shifts within mental health care to enable better state control.

On this latter subject, Lemieux (1977) notes that the provincial government was the primary government apparatus of the state for overseeing mental health care for a long period, until the beginning of federal government cost sharing programs. The partial removal to a federal level of a provincial financial burden afforded by these cost sharing programs, could reflect an attempt to reduce the growing fiscal crisis of the provincial government (Table 5.11). However, despite the cost sharing, the provincial government continues to spend more than it receives by increasing amounts each year. This is indeed curious, since if the provincial government is owing increasingly more, then what is it spending the money on, and how does mental health care manage to *lose* funding from this government? The trends for the provincial and federal government debts (Table 5.11) could represent a delegation of

fiscal control from the federal to the provincial government apparatus. State intervention seems to imply that financial control over mental health is shifting to the federal government apparatus, leaving the provincial government apparatus increasingly free to pursue 'other' intervention into more pervasive sectors.

In summary, state intervention into mental health care thus seems to show all the signs of an effort to reduce the contribution of this sector to the fiscal crisis. In an attempt to cut costs, rationalize service delivery, and gain more state control over mental health care, levels of state intervention, especially concerning government apparatuses, have changed. Fiscal control has been partially delegated to the federal government apparatus of the state; the provincial government appears to be increasingly relieved of its responsibilities in mental health; and, local governments have become involved in community mental health care either for efficiency, production or ideological reasons. State intervention into mental health care thus reflects the use of increasingly more state apparatuses.

5.5 Summary

The analysis has been conducted according to the three scenarios of Social Control, Professionalism, and State Interventionism. Although these have been identified as separate spheres of interest, and the analysis has focussed on each sphere in turn, the results are significant and complementary.

The Social Control scenario, by focussing upon the relationship between the economy and mental health care, reveals that a relationship seems to exist between these two fields. The relationship, however, is mediated by other crises within capitalism. The solution to the problem posed by mental illness is thus no longer *directly* related to the solution of crises within capitalism. Mental health care has thus lost its economic significance, and policies therefore tend to reflect the importance of other crises, including for example, the fiscal crisis. The relative importance of client goals is also called into question in this scenario. The scenario also suggests that because of the non-pervasive nature of mental health demands in contemporary society, control by the state has been able to change from repression to more subtle informal control.

The Professionalism scenario suggests that this informal control maybe welfare control, and hints also at the apparently inhumane nature of the deinstitutionalization policy. Professionals appear to have gained from the rise in total patient episodes in all treatment centres, and they appear to have been given preferential treatment in the hospital as its function has decreased. This hints at the importance of the professionals to the state as legitimizers of state policy.

A closer examination of the state in the State Interventionism scenario suggests that professionals' legitimation may be necessary to enable the state to reduce the fiscal crisis which it currently faces, and to which mental health care partially contributes. All the signs exist within contemporary mental health care to suggest that the fiscal crisis of the state is a prime policy motivator. Cost cuts, rationalization of service delivery, and more state control are all evident. State intervention into mental health care also reflects the increasing number of state apparatuses that are becoming involved in mental health care. The federal government apparatus is implicated in fiscal arrangements; the local government apparatus is involved due to the decentralization of services; the entire field of health care has become involved with service delivery; and professional ideologies and welfare apparatuses appear to be increasingly important.

The scenarios are each closely interrelated, the state and it crises being the linking factor. It appears that the fiscal crisis has stimulated state intervention into mental health care. The outcome, a new form of social control, is mediated by professionals' desires and motivations. Thus, outcomes in mental health care are related to state actions to avoid or lessen the fiscal crisis. The state intervention which occurs is also influenced by the motivation of professionals.

CHAPTER 6

CONCLUSIONS

6.1 Summary

It was proposed in this study to examine the role of the state in influencing spatial outcomes for the mentally ill. This was stimulated primarily through the paucity of studies into decision making bodies, the realization of the importance of the state in social service outcomes, and the lack of attempts to link the theory of state behaviour in the capitalist economy to the observed spatial outcomes of services controlled by the state. Mental health care, as a growing field in goegraphical research, was chosen as a social service to be studied because of recent state intervention to 'deinstitutionalize' the mentally ill and thus totally rearrange the service provision in that field.

In studying the observed pattern of service provision for the mentally ill, the central epistemological principle followed was that there is a need to distinguish between the level of appearance in mental health care and the underlying structural causes influencing those appearances. To understand the spatial configuration of mental health service provision thus requires a focus upon these structural causes which is best achieved through the adoption of the historical-hermeneutic approach. This implies that community mental health care

must be embedded within wider capitalist social relations, and that current level of appearances must be understood from an historical perspective.

A consideration of the wider societal forces that influence mental health care provision leads initially to capitalist society and its inner functions. The state is implicated as a crucial element in the continuation of a smoothly functioning capitalist economy and it is defined as that composite of government and supportive public and quasi-public institutions. Thus, since health and mental health are institutions of the state, the study of how the state acts towards mental health care is a study of intra-state relations. In the search for further elucidation on the state, theories of the state were examined. The materialist theory of the state stresses that the state is bound up in the process of capital accumulation, a process which is of vital importance to capitalism. The state contributes to this process through production and reproduction, simultaneously legitimizing its actions to the populace.

Historical evidence points to the inherently crisis-producing nature of the capitalist system which has forced the state to become a crisis-avoider. The state, however, usually *reacts* to crisis, and this has required increasing rounds of state intervention to control the political nature of each crisis. Increasing state intervention has necessitated the growth of a whole range of state apparatuses

including public institutions such as government and quasi-public institutions such as medicine. The government, as a state apparatus, is vested with the formal exercise of state power; however, the government and the state are *not* synonomous. Rather, the government gains its directions from the wider concerns of the *entire* state, and hence its policies towards other state institutions (e.g. mental health) reflect these wider state concerns.

The causal chain linking the state to mental health policy thus flows through the government and the mental health profession. The true purpose of state actions in mental health is thus disguised by two 'filters': first, the mental health profession,which legitimizes state action and exerts an ideology to reduce potential conflict to the level of the individual, and (thus) less harmful level; and secondly, the government which uses more formal control (e.g. bureaucracy) to disperse conflict over state action. The medical profession also has its own private agenda which may clash with state policies in medicine.

A closer examination of the historical course of mental health care reveals in fact the existence of three factors in influencing the changing nature of mental health care: increasing state intervention; increasing need for state control over crises; and the existence of professionals' self-interested motivations. Each of these scenarios holds part of the truth in explaining the changes in mental health care. In order to test the validity of each scenario, trends in the Hamilton Psychiatric Hospital were examined. Indicators of

changes within the hospital were thus related to indicators of the trends described by each scenario in a regression framework. The time series nature of the data set restricted modelling searches to ordinary least squares regression approaches or statistical Box-Jenkins time series procedures. Within the former group, the Cochrane-Orcutt method was chosen due to its ability to deal with autocorrelated residuals of the first order. Supplementary descriptive data were also assembled to evaluate each scenario.

Despite the segmented nature of the analysis and the division of interrelated factors into separate analytical cateogries, the analysis highlighted the connected nature of the three scenarios. In particular, the importance of the state and its relation to the conditions in the wider capitalist economy, was recognized as the integrating factor amongst all the results.

The fiscal crisis of the state, and the effort of the state to lessen this crisis, appears to be the major driving force of the policy to deinstitutionalize the mentally ill. The resulting outcome -- community mental health -- thus reflects the efforts of the state to manipulate mental health care in the interests of the wider functionings of the capitalist economy. This emphasizes the non pervasive nature of the social demands of mental illness in capitalism.

The efforts to avoid or lessen the fiscal crisis to which mental health care partially contributes, has necessitated the involvement of increasing state apparatuses in mental health care. This has primarily involved shifts in control over mental health care within the government apparatus of the state. Support for this has been provided by the legitimating powers of the medical and mental health profession. Formal control has become more of a federal government responsibility whereas informal control has spread to a local level. With the spatial dispersion of mental health care, the ideology of mental health professionals has spread spatially also. The integration of service with the entire medical profession has also implicated the ideology of medical professionals as well. A side effect of the change in treatment mode appears to be the creation of benefits for the mental health professionals. This, however, does not appear to be the result of a conspiracy by this class. Rather, it seems to reflect a circumstantial coincidence of interests of the entire state and those of mental health professionals, in the pursuance by the state of a reduction of the fiscal crisis. It also points to the fact that state policies may contradict the best interests of individual health merely to ensure economic health.

Thus it appears that the claims of treatment benefits of community care, advances in drug therapy, and a concern for patients' civil rights are only part of the professionals' and states' agenda.

They are claims that seek to legitimize the policy to the public whilst simultaneously disguising the underlying structural causes of the policy.

Mental health care outcomes thus relate strongly to the wider functionings of capitalism through the state and mental health professionals. The outcomes appear not only to represent concerns for the mentally ill, but more directly they reflect the underlying hidden forces of capitalist society.

6.2 Evaluation

This work differs from much geographic research because of its epistemological stance which insists on a formal research design to link theory to practice through historical and empirical evidence. However,

> "It is one thing to make the epistemological claim that explanation requires the decoding of hidden contradictions; it is another to develop a strategy for studying the social world which allows one to link systematically such underlying structural processes to empirically observable phenomena".
> (Wright, 1978, 12)

Such a strategy has been attempted in this thesis, but to what measure of success?

The first major issue concerns theory. The historical-hermeneutic approach requires a clear articulation of theory, such that propositions concerning the real world can be empirically tested. However, much of the theory (especially regarding the state) is either Marxist theory, or is generated from it. According to Wright (1978, Chapter 1), this has created at least two problems:

(1) Marxist theory tends to become very ideological and immutable to transformation from empirical study, giving the impression in research that all of the answers are pre-given or known prior to the research; and

(2) Marxist research often becomes purely descriptive, with empirical work using Marxist categories but not Marxist theories; the dialectical nature of the theory is lost in the process.

The research in this thesis does not claim to be Marxist research; the very adoption of techniques of 'critical' science rules out this possibility. There is no doubt, however, that Marxist concepts have been used. Nevertheless, it appears that reasonable explanation was achieved. This does not imply that the 'concepts' tested, and supported, the theory. It may be that the concepts used were simply no different from 'definitions' and hence remained immutable to historical investigation throughout the empirical work. As Wright (1978) notes,

> ".... it is critical to distinguish... between ... premises which are not subject to transformation by historical investigation, and propositions which are; and it is important to distinguish between definitions of concepts and propositions about those concepts."
> (Wright, 1978, 13)

It may be that in stressing the total research design, the Marxist concepts drawn from the theoretical examination were no different to "immutable premises". Certainly the historical findings of Chapter Three, regarding forces underlying changes in mental health care, were already resonably predicted from the theory in Chapter Two. Were the answers thus pre-given, or have advances been made?

It is difficult to know whether in fact this research examines "definitions about concepts" or "propositions" about the actual dynamics of society, since there is a fine line between the two, and each is closely related to the other. The direction given by the literature in this regard is not explicit. Wright (1978) claims that it is necessary to lay out explicitly the logic of relations to be explored; I believe that intra-state relations were laid out sufficiently before investigation began. Perhaps it is not the question of 'concepts' and theory that require this interrogation. Perhaps it is the claims made from the results, the data, and the methods used that make it appear as though 'success' has been achieved. Empirical investigation taps

data from the 'level of appearances' and represents 'effects' of underlying 'causes'. Perhaps effects were linked to causes too readily, considering the surrogate and diverse nature of the data used? This is a distinct possibility considering the trends shown in the data. In this regard, I believe that the regression modelling was far too naive to yield much useful information. Apart from challenging intuition, it appears that with this particular type of investigation, where too many exogeneous factors cannot be controlled for, the results can only achieve a very limited amount of explanation. Depending on the particular problem, modelling is of course not ruled out; however, it seems to impose too rigid a framework upon relations which are clearly more complex. Unless modelling design can be improved (perhaps the causal modelling of path analysis is worth some investigation) I would suggest its limitations are counter-productive.

This does not, however, rule out empirical investigation. On the contrary, I believe much potential remains in the collection of comprehensive data to examine structural relations. This is clearly one limitation of this particular study. First, lengthy time series data often were too difficult to assemble. Secondly, the realizations of exactly which data were necessary did not become manifest until much of the work had been done -- particularly investigating the trends within the mental health profession. Thirdly, data collection tends to be a spiralling process -- the more is found, the more one needs, as the other subsidiary fields of interest become involved.

This appears to be a major problem in this type of work. Desiring to study "the totality" makes the investigation of one particular problem a frustrating task. It is tempting to try to package the problem into a neat compartment with all exits sealed. This, however, is simply not possible when so many links remain unexplored, but necessary to the total consideration. This type of research therefore *must* suggest further propositions and highlight its own criticisms.

This particular study abounds with continuing questions, especially regarding the state and its importance in directing urban spatial outcomes. The particularly restrictive nature of the sample in this research played a major role in suppressing explicitly spatial concerns; however, the desire was to begin an investigation into the influence of state hoping that spatial implications would follow. The theoretical concern for the state and the historical course of social relations in mental health care were essential pre-requisites for more explicit research into spatial relations. For example, understanding how the state functions spatially first requires an understanding of what the state does in general. The literature on this latter point has only recently emerged from a lengthly debate on this question. The former question has, as a result, only become a recent concern of theorists. It requires a full elucidation of the question of 'levels of state control', and state apparatuses which function spatially.

This research suggests briefly what the changing levels of control have meant for spatial outcomes in mental health care. Recall that the state apparatus of government, practising the formal exercise of state power, shifted fiscal responsibility to a higher, more centralized (federal) level during deinstitutionalization. The exact reverse happened with respect to mental health institutions which practice the informal exercise of state power. The system of care delivery became decentralized, with responsibility shifted to the local level and local communities. If we believe that mental health institutions output an ideology which is supportive of capitalism, then the decentralization of mental health care can be seen as the diffusion of an ideology through space out of the necessities of capitalism. In particular, since ideological control is an essential part of the reproduction of capitalist social relations (recall Althusser, 1971) this shift of state control represents the need of the state to gain tighter control over the reproductive spheres in society. Spatial aspects are thus implicit in this study.

6.3 Future Research Themes

This study suggests the appropriateness of the historical hermeneutic approach for many geographic questions. However, it also hints that theory must be made very explicit prior to empirical investigation. Thus, geographical theoretical inquiry into structural

causes underlying spatial patterns is desirable. Similarly, geographical empirical work under the historical-hermeneutic approach requires closer scrutiny. This however, requires a strong theoretical base to guide the data search and the interpretation of the data. Both the theoretical and empirical aspects of historical-hermeneutics thus deserve geographical attention.

More specifically, the thesis implicates the fiscal crisis as a major force influencing social service spatial outcomes. Consideration of this and other crises in capitalism must therefore exist in future work on social service outcomes. The fiscal crisis also implicates the state and its changing apparatuses as crucial elements influencing policies and outcomes. It appears in mental health care that the question of the local state is becoming of paramount importance as state control shifts over time. The local state represents one of the most spatially dispersed forms of the state, and as such, its role in influencing urban spatial outcomes should concern geographers. The state, the local state, and the links between these two, are therefore areas of importance for future geographical research.

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