The contingent object of psychiatry.

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Wilson and Adhead's plea that the British Government's proposed new mental health legislation might entail a misappropriation of psychiatry's true mission will strike a chord in numerous jurisdictions. Many European countries during the last northern summer will adopt mental legislation that moves in the opposite direction to the United Nations Convention on Human Rights for persons with disabilities, and will allow for compulsory mental health treatment. In this author's home state of Victoria, Australia, the *Mental Health Act* has five criteria which must be met for someone to be made an involuntary patient - in an institution or hospital, in the community, or in one's home (Victoria, 2003, s.6). One of the criteria is that the person is judged to be at risk of danger to themselves or others. Once made an involuntary patient one looses the right to refuse medical treatment. At present, in various parts of the world, medical practitioners are being required to assess a person's level of dangerousness with immediate consequences for that person's liberty.

From the point of view of a historian of the human sciences, this event propels psychiatry into a dialogue with its recent past. The project of Western psychiatry is usually characterised as a breaking down of the walls of the old asylum that contained the lunatic in its dark recesses, and the subsequent unveiling of the mental patient thanks to the rational, liberatory practices of medicine. But modern psychiatry has also been shaped by the coming into being of particular conceptions of mental illness. This entailed the removal over time of the mental defective and the mental deficient, the moral imbecile, the epileptic, the alcoholic and the chronically insane, and so on, from spaces in which psychiatry would seek to define it object - populations that psychiatry would determine to be 'not amenable to treatment'. If we were to see this shaping in a Foucauldian sense, we would also want to include earlier 18th and 19th century separation of the lunatic and the criminal (Foucault, 1965; Foucault, 1979). Moreover, we might want to insist that the marking out of the modern mental health patient is first and foremost an administrative act - an act of separation and management within a bounded population - which then serves as a condition of possibility for the emergence of knowledges in psychiatric medicine, with the latter following rather than preceding the arrangement of bodies in the asylum.

The psychiatrist in public medicine may well be required to shape a new mission according to the requirements of an administration concerned with managing dangerousness. A shift in the social vocation of the psychiatric expert has been observed over several decades, and may represent a profound departure from the traditions of mental medicine (Castel, 1991). Those 'dirty words' - risk assessment - involve new strategies where face-to-face relations between carer and cared are displaced by an activity of calculating abstract factors deemed liable to produce risk - 'a transition from the clinic of the subject to an "epidemiological" clinic' (Castel, 1991, 282). The broad contours of this shift sees the specialist medical carer take a back seat while the manager / administrator assumes a more autonomous role of allocating individuals into various categories of risk. It is in this sense that the psychiatrist does not make a *diagnosis* as such, but rather contributes to a list of factors compiled in order to measure a level of riskiness. Risk assessment forms part of social surveillance that dispenses with the actual presence of the carer and the cared and provides for a form of systematic predetection, rather than treatment. As Castel (1991, 288) presents it

> (t)here is, in fact, no longer a relation of immediacy with a subject *because there is no longer a subject*. What the new preventative policies primarily address is no longer individuals but factors, statistical correlations of heterogeneous elements. They deconstruct the concrete subject of intervention, and reconstruct a combination of factors liable to produce risk. Their primary aim is not to confront a concrete a concrete dangerous situation, but to anticipate all the possible forms of irruption of danger. 'Prevention' in effect promotes suspicion to the dignified scientific rank of a calculus of probabilities.

Much of the early colonial legislation throughout Australia was modelled on the New South Wales *Dangerous Lunatics Act* (1843) which established reception house for 'dangerous lunatics' and 'dangerous idiots'. The former was one defined as needing safe custody especially for the sake of prevention of crime, including suicide. The *Act* also functioned to limit its application, in the sense that it prohibited constables from dragging every idiot son out of the farmhouse kitchen. Dangerousness had lingered since the invention of the asylum, but it has progressively shifted to the periphery of the space where the project of modern psychiatry takes shape. In the early 19th century, for example, the gradual removal of mechanical

restraint helped to produce a new category of person in the institution – the mental patient – while at the same time the dangerous or refractory patient came to be placed at the outer edge, sometimes with the use of cells, at some distance from the main work of the asylum, in the borderland of medicine proper. Later in the century the incurable and the imbecile were moved to other sites partly as a consequence of the appearance of the Receiving House, which had replaced the gaol as the main administrative arm of separation and management. In early 20th century Australia, modelling on developments in the United Kingdom, reception houses and wards became place for the observation of the 'doubtful insane' and for early treatment; the 'mental hospital' separated from 'hospital for the insane' (the old asylum) became a place for the chronic and was repositioned conceptually and geographically on the periphery of medical practice (McCallum, 2001).

As already suggested, the kinds of separating practices that gave psychiatry its modern object of inquiry defy any linear model of progressive enlightenment. In the formal interactions between medicine and law, the appearance of new categories of person tend to problematise the object of psychiatry and its historical contingency. The Butler Report in England in 1975 recommended changes to the provisions originally laid down in the *Mental Health Act* (1959), where in the UK the term 'psychopathic disorder' first appeared. Changes were recommended including abandonment of the term psychopath and replacing it with 'personality disorder'. The recommendations came to nought, but problems persisted. Many psychiatrists then (as now) declared that personality disorders were not a treatable mental illness (Dell, 1984, 66; Ashworth and Shapland, 1980. 679). The United States experienced related sets of concerns around the successful plea of insanity by John Hinckley, would-be assassin of President Reagan, who had used the American Penal Code test (known as ALI) for insanity which gradually supplanted the McNaghten test. The ALI came into its own in the 1960s and 1970s based on an increased confidence that psychiatry and psychology had made volition knowable and testable, in both science and law (US House of Representatives, 1983, 30). In Australia, in a landmark case (*Attorney-General v. David*), a mental health review board had refused to rule that a prisoner was mentally ill, but rather determined that he suffered from anti-social personality disorder. The Victorian State government then enacted the *Community Protection Act* (1990) giving the Supreme Court power to detain one individual beyond the expiration of his sentence.

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