Fleeing the city within: a mental health perspective

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Abstract: This paper examines the mentally ill as a subculture residing within the alternative cultural landscape of Byron Bay. The positioning of the mentally ill as a subculture is an intentional feature of the investigation which aims to view the mentally ill as culturally unique. Drawing on the work of Baldwin, Longhurst, McCracken, Ogborn and Smith (1998), and focussing specifically on their treatment of subcultures, the paper will explore the relationships which exist between the mentally ill and mainstream society.

Key terms: mental health, subculture, alternate, Byron Bay, cultural diversity.

Introduction

Byron Bay has long been home to those seeking an alternative lifestyle, but not everyone who flees the city does so with a clear mind. This paper focuses on the mentally ill, a subgroup within the broad range of peoples who arrive in Byron Bay every year, and who appear to be seeking much the same things as everyone else: freedom from the pressures of the city. However, whilst many of Byron Bay's newcomers might be described as 'dropping out,' having given up the hustle and bustle of their city lives for a quieter and more laid-back lifestyle, the mentally ill appear to be 'dropping in'. In other words, armed with the implicit knowledge that they already embody an alternative inner life, they seek an alternative culture, believing it will provide the peace and acceptance they so desperately crave. Such a supposition is the main focus of this paper.

Baldwin et al. (1998, p 316) define a subculture innocuously as a subgroup of a wider culture, although they acknowledge that pioneering research into subcultures placed an emphasis on deviance:

> The influential literature on subculture developed at the Birmingham Centre for Contemporary Cultural Studies had some of its roots in American work that attempted to explain the behaviour of young, male 'deviant' (especially criminal) groups ... [T]he assumption that subcultural adherents are in some sense 'deviants' from the mainstream culture, or different from the 'rest of us,' has run through a great deal of subsequent work (Baldwin et al. 1998, pp 317-318).

The mentally ill form a subgroup as a result of an initial deviation from the mainstream, plus the medical model defines deviance - in absolutist terms - as 'a disease that may be described and defined by the presence of various symptoms' (Heitzeg 1996, p 1). Together these suggest that the construct of deviance is incorporated as part of the social process, diagnosis, and subsequent treatment of the group of people defined as mentally ill. However, an immediate outcome of the redefinition of the mentally ill as a subculture is the subjugation of the deviant label. Deviation becomes reconfigured to represent movement and change rather than the failure to conform. Deviation, and its production of subcultures, can also be viewed as a counter device to large scale conformity. For example, Franklin, Lury and Stacey (2000, p 3) point out that 'while globalisation suggests increasing uniformity, it is also seen to depend upon the exportability of local difference, and above all on the interrelation of local diversities within global scapes or flows'. Thus, whilst the birth of a subculture is the result of a deviation from the dominant culture, the continued production of localised cultural diversity is perceived as an imperative measure in the prevention of cultural homogenisation (Franklin, Lury and Stacey 2000).

Cultural identity

> In a broad sense, the term culture is applied to all features of an individual's environment, but generally refers to its non-material aspects that the person holds in common with other individuals forming a social group (Fernando 1991, pp 9-10).

Enabling mental illness to be viewed within a cultural context requires a set of cultural parameters. These parameters are expansive, incorporating the myriad distinctive practices which are prevalent, accepted, and normative within Byron Bay's society. The depiction of Byron Bay's social and cultural milieu is foundational to the discussion, providing a framework within which the socio-cultural needs of the mentally ill can be understood.

Byron's characteristic cultural diversity is a result of the tension between its subcultures. As micro-environments, each subculture interacts within the overarching culture already predetermined by the coexistence of different lifestyle choices. But not all choices are welcomed. Abhorring the 'McDonaldisation of society' (Ritzer 1996), Byron boasts an actively vocal population whose famous victories include the ousting of Alan Bond from the Ocean Shores property development site, the prevention of the Pizza Hut chain from opening a franchise, and the successful opposition to a Development Application by Club Med. Noosa is cited as an example of rampant development; freedom of choice is tempered by the mandate to remain as local as possible; and the local paper, the *Byron Shire Echo*, sits as testament to the vigilance with which issues are raised and debated (see Martin and Ellis in this issue). But, given the level of diversity and activism, why do the mentally ill gravitate to Byron Bay, and once arrived, how do they fit in?

According to Durkheim (cited in Featherstone 1991, p 145) modern culture is a 'flexible generative structure which permits differences to exist'. In Byron, these differences include a plethora of alternative forms of health-care, a broad spectrum of schooling, and a divergent mix of religious and spiritual practices. Employment opportunities are equally diverse and range from the tourism industry to the rural cattle and growing communities. But with high unemployment (see Gibson in this issue) a prerequisite for many new arrivals is self-employment. This requirement almost certainly contributes to the emergence of an unofficial artistic community. Many Byron Shire residents are artists, carpenters, musicians, writers, and

performers; people who can work from home, or who choose to call Byron 'home' but whose work takes them elsewhere. The most obvious display of Byron's cultural diversity is its range of social types: hippies, straights, surfies, Haris, Sanyasins, Mauris. People are tattooed, pierced, tanned, laidback, colourful, weird, shaved, dread locked, shoed and barefoot. Being a highly individualistic community, whose choices reflect a larger optional component compared to the more traditional society (Barry 2001, p 19), it is an environment where eccentric behaviour fits within the normative social fabric.

Mental illness, whilst encompassing its own broad scale of diversity, can be culturally categorised. In this respect, the field of cultural studies offers a new site for engaging with mental illness and exploring it as a subculture. First, cultural studies enables culture to be defined simply as a 'way of life,' second, it offers a perception of mental illness which, rather than regarding it solely as a health issue, embraces it as a subset within the vast character of human culture (Baldwin et al. 1998), and third, it is a subjective discipline, characterised by its interest both in the relationship of culture to individual lives, and in the cultural effects of social inequality on the individual (During 1999, p 1).

Subculture

> In modern societies, the most fundamental groups are the social classes, and the major configurations will be, in a fundamental though often mediated way, 'class cultures'. Relative to these cultural-class configurations, *sub-cultures* are sub-sets - smaller, more localised and differentiated structures, within one or other of the larger cultural networks (Clarke et al. 1976, cited in Baldwin et al. 1998, p 331).

One of the major factors uniting the mentally ill as a group is socio-economic class: 'Poverty is the major issue for people suffering from a mental illness' (Lambert 2000, p 57). Thus, the mentally ill are more likely to achieve subculture status not via an appropriation of, or resistance to, the dominant culture, but through a combination of economic and health factors. The suggestion that subcultures construct identities relative to the dominant culture (Hebdige 1979) assumes that, at some level, there exists an element of choice. This all but ignores the plight of the mentally ill, whose world is possibly at odds with their ability to choose. For a group whose identity is marred by financial hardship and mental instability, choice is an objective term which fails to address the subjective realities distinguishing the lives of the mentally ill.

Hence, the simplicity of the term *subjective culture* (Triandis 1976, cited in Cox 1993) distinguishes itself as a definition because of what it does not assume. By referring to 'a group's typical patterns of viewing the environment' (Cox 1993, p 56), the term refutes the prospect of a shared worldview whilst enabling the possibility for it to exist on some level. The distinctive nature by which the mentally ill are characterised is thus encapsulated within an overview - a subculture - which is formed through its typicalities rather than a set of identifiable measures based on shared values or norms.

Deinstitutionalisation

The government's groundbreaking Richmond Report, released in 1983, was a pivotal step towards the moving, en masse, of the mentally ill into the community. Prior to this, the mentally ill often faced long periods of institutional care. Institutionalisation,

'often considered as fostering dependency to the institution, leading to progressive loss of social and vocational competencies' (Shu et al. 2001), prescribed, in rigid terms, the way in which the mentally ill lived their lives. With the release of the Richmond Report a process of deinstitutionalisation was implemented, affecting the treatment, living arrangements and life-styles of the mentally ill. According to the Mental Health Briefing Paper (Manning 1976), the key components of the Richmond Report were:

> the expansion of community services so that services are delivered on the basis of a system of integrated community based networks, backed up by specialist hospital or other services as required; the relocation of acute admission centres from psychiatric hospitals to general public hospitals; and the reduction in the size of specialised psychiatric hospitals, with services provided in such hospitals to be more specialised (Manning 1996).

Central to these recommendations was the integration of the mentally ill into the community. The process of deinstitutionalisation essentially gave the mentally ill the freedom to live where they chose. However, while the Richmond Report was a propitious step towards a mental health philosophy which sought greater personal autonomy for the mentally ill, freedom came at a price. One of the major criticisms of the deinstitutionalisation process was its failure to adequately resource patients' entry into the community (Manning 1996, p 5). Accommodation was, and still is, one of the main problems facing the mentally ill, with the lack of accommodation cited as leading directly to hospital readmissions (Burdekin 1993, p 339). One of the findings of the Burdekin Report which is echoed in The Public Health Association of Australia Homelessness Policy (1994) is that 'the predicament of homeless mentally ill people...represents a failure in the provision of mental health services'.

Ostensibly free to choose where to live, the mentally ill continue to be restricted by the lack of adequate resources, with unemployment or very low incomes prohibiting or restricting their housing choices (Lambert et al. 2000). Further confined by society's expectations of *how* to live, the mentally ill commonly receive little empathic understanding, and their seemingly abhorrent behaviour continues to be viewed by mainstream society with suspicion and fear (Mulvey and Fardella 2000). Whilst, on the one hand, many groups agreed with the concept of freedom and deinstitutionalisation, in practice it is often a case of 'not in my backyard'. For the mentally ill, homelessness further isolates an already marginalised subcultural group from mainstream Australia, and exacerbates their struggle towards health and wellbeing. The Burdekin Report (1993, p 337) states, 'Living with a mental illness - recovering from it - is difficult even in the best of circumstances. Without a decent place to live it is virtually impossible'.

The transient traveler

> Byron Bay is a stunning spot on the NSW North Coast where the rich and beautiful go to live and play. And it is also home to an increasing number of homeless people who doss down on the beach or in their cars and frequent the local soup kitchen (Doogue 2000).

For the mentally ill there are a number of motivating factors behind the compulsion to travel - such as homelessness, instability, escapism and restlessness (Hacking 1999). But it was the introduction of EFTPOS in the 1980s that provided the mentally ill with the necessary means. EFTPOS, by replacing the pass-book with a plastic cash-card which has 24 hour access to an inordinate number of banking facilities

country wide, is a variable which positively enhanced the lives of many mentally ill persons by providing a level of mobility not previously contemplated. Given that mental illness is a poorly paid full-time career which attracts no benefits such as holidays or long service leave, many sufferers experience a life accompanied by repetition and boredom. Coupled with an internal environment that is frequently bizarre, frightening, and seemingly unable to be changed, the opportunity to travel - and the means to do so - becomes attractive.

Equally inviting is the prospect of travelling to an area where a plethora of subcultures already exist and cultural diversity thrives. Extensive media coverage of its attraction, combined with free train travel within NSW, makes Byron Bay an obvious choice for many seeking an alternative life. According to Hacking (1999, pp 98-101) the transient (mentally ill) traveller finds "ecological niches" in different places. These ecological niches exist within the social conditions, which in Byron Bay are expansive enough to accommodate the complexities of mental illness. It often takes a trained eye, or the very astute, to differentiate between the bizarre behaviour of the eccentric, and that generated by an unstable mind (Robertson 1996, p 156), and it is precisely this lack of definition that proves emancipating for those with a mental illness. The ever lurking spectre of stigma, which isolates people with a mental illness (Healey 1994, p 12), dissipates, and with their behavioural symptoms given tacit acceptance, the mentally ill are able to find their niche as 'one of the crowd'.

Although the idea of fleeing the city is not unique to this group, it is often a unique set of criteria which besets the plight of the mentally ill and which contributes to their reasons for leaving. Often free-floating, and suffering neglect, isolation and impoverishment, the mentally ill have few avenues of support. Even for those living with their family - whose members frequently suffer as a direct result of their loved one's mental illness (Gravitz 2000) - their environment may act as a stressor. Community support is under-resourced, and whilst 'living skills' programs, soup kitchens, and group houses grant opportunities for the members of this subculture to gather together, this is a vastly different prospect compared to other subcultures who actively seek strength through their cultural ties. For example, in his discussion regarding the practice of exclusion and inclusion of migrants, Sarup (1996) states:

> Any minority group, when faced with hostile acts, does several things. One of the first reactions is that it draws in on itself, it tightens its cultural bonds to present a united front to its oppressor. The group gains strength by emphasising its collective identity (Sarup 1996, p 3).

This example highlights a marked difference between two subcultures. Both groups - the mentally ill and migrant - can experience discrimination, fear and misunderstanding. However, the mentally ill are unable to present a united front against adversity. For the mentally ill, affiliation with their subculture is difficult to muster because the markers that define their specific grouping are either impossible or too uncomfortable to interpret. Moreover, for those who wish to fit into mainstream society, stability and acceptance are not to be gained through an emphasis on their collective difference. Collective cultural identity is a structure born out of social relationship and meaning (Baldwin et al. 1998, p 329). But for the mentally ill, the struggle to locate or moderate their present identity, or the effort entailed in maintaining continuity - whilst not overriding their yearning to fit in - may well vanquish any conscious link to their own cultural subgroup

The ephemeral nature of mental illness may well exacerbate any attempt by its sufferers to create subcultural ties: 'Mental illness is often transient and can come

and go in people's lives. Some people have only one episode and will recover completely. For others, it recurs throughout their lives and requires ongoing treatment' (Schizophrenic Fellowship of Victoria 2000, p 2). Hence, the transient traveller is one who, whether suffering from a short-term episode or from a chronic mental illness, decides to travel as a means of finding solace. Solace appears to exist, for some, in the discovery that there is more than one set of ideas or cultural forms in society (Baldwin et al. 1998, p 330). This reveals a search for tolerance of cultural plurality - rather than subcultural identity - to be the driving force behind the quest for mental health.

Safe harbour

> Confirmation - the perception that one is noticed, respected and regarded as a valuable person...is the core constituent of mental health (Hedelin and Strandmark 2001, p 7).

On any Friday and Saturday night, around 8pm, the Sydney train pulls into Byron Bay. Onto a platform already bustling with activity, the new arrivals alight to the din of a rock band playing next door at the Railway Friendly Bar. People from the various hostels tout for business while mini-buses and taxis wait to transport the weary. Soaking up the atmosphere, the mentally ill slip, blissfully unnoticed, into the crowd. The mentally ill may have felt like isolated individuals in the city - and from the point of view of mainstream society they might have appeared to exhibit a form of 'cultural drift,' perceived as being 'cut off in small communities with little or no communication with their parent group' (Glover 1988, p 177) - but on arrival in Byron they are given tacit acceptance and understanding. In a culture which reconstructs unusual behaviour as originality - a highly valued characteristic - the mentally ill are able to contribute and participate to their limit without the degree of inhibiting measures imposed by a more controlled environment.

Byron also provides a safe harbour, for whilst many area mental health services throughout Australia are extremely patchy (Manning 1996, p 9), Byron Bay is well serviced with a hospital, a round-the-clock mental health crisis team, and an infrastructure capable of handling the diverse needs of the mentally ill. Anecdotal reports from within the Byron Shire support the notion that there is a generalised acceptance of mental illness in the community. This tolerance is evidenced through the support of caravan parks which provide sanctuary to a large alternate population, and extends to the police whose compassion and understanding - underpinned by a 'memorandum of understanding' between the police force and mental health services, and which states the process for dealing with the mentally ill - is especially valuable, considering the police often act as 'first contact' for persons suffering a mental illness.

The mentally ill are a subculture which is motivated to seek freedom from their isolation and find a supportive culture. Trapped within a city environment which appears both chaotic yet highly structured, and which harbours little room for the unusual (save for some inner city areas and culturally acceptable exceptions like the Gay and Lesbian Mardi Gras), the mentally ill are drawn to an environment such as Byron Bay, which offers a stable diet of cultural diversity. 'It is readily apparent,' state Stafford and Furze (1997, p 37) 'that not all members of a culture share the same experiences and values or behave in the same ways'. In Byron, cultural diversity is the norm, and conformity is an option.

Conclusion

This paper has focussed on two themes: mental illness and subcultures. It has argued that cultural diversity, embedded within the social fabric of Byron Bay, and visible in the presentation of its cultural milieu, presents an appealing alternative to many aspects of the city, especially for the mentally ill, whose own diverse subculture is often marked by isolation, particularly as a result of the widespread homelessness caused by the policy of deinstitutionalisation. The paper has addressed some issues surrounding the mentally ill by positing a subculture of mental illness within a framework of cultural diversity, identity, freedom and restriction. We would argue that the *subculture* of the mentally ill is nevertheless an outsider's view of their experience. As an analytic category, the term subculture is invaluable in that it removes the stigma of deviance, but it remains an objective viewpoint - a label - as opposed to probing the subjective inner experience and its relationship to the social context, to explore the cultural dimensions of mental illness.

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