Deinstitutionalization and reinstitutionalization: major changes in the provision of mental healthcare

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Abstract
The care of patients with mental illness has undergone major changes over the last two centuries. In the 19th century, large asylums were built throughout industrialized countries to provide care for patients with mental illness. Conditions in these asylums worsened during the 20th century and since the 1950s an increasing deinstitutionalization movement has resulted in their closure. Various services in the community were established to provide an alternative form of care. Recently however, reports about new forms of institutionalization have suggested 'reinstitutionalization' in mental healthcare is occuring. This contribution traces the changes from asylums to care in the community and describes the process of deinstitutionalization and its shortcomings worldwide. It discusses recent evidence and explains the debate on reinstitutionalization.

Keywords community care; deinstitutionalization; European data; history; mental illness; reinstitutionalization

The rise and fall of asylums

The first asylums

The origins of modern psychiatry as a medical specialty date back to the Age of Enlightenment. It emerged around 1800 and its development was closely linked to the establishment of large asylums. There were several reasons for societies to invest in asylums, as detailed below.

Social welfare movement: the developing movement for social welfare was also applied to the mentally ill, and their quality of care tended to reflect the responsibility of states to care for 'feeble' people in society. Thus many asylums were built with a degree of architectural splendour and with good living conditions.

Urbanization: during industrialization, families moved from rural environments to large towns which were growing rapidly. In the new towns they no longer had the material means to look after and care for a mentally ill family member, so asylums stepped in to provide accommodation and basic care.

Location: psychiatrists assumed that urbanization would lead to increased morbidity and an increase in mental illness. Subsequently, removing patients from urban environments was seen as a therapeutic intervention, and almost all asylums were built in leafy and pleasant areas outside the industrialized towns.

Morality: Victorian life was ruled by strict moral codes, and mentally ill people with bizarre and odd behaviour were perceived as inconsistent with the ideal of elegant and morally correct town life. As people with mental illness were more widely visible in towns than they had been when living within large rural families, there was a tendency to remove them to the remote locations provided by asylums.

Conditions within asylums

By the beginning of the 20th century, the conditions in many asylums had changed, with ever-increasing admissions resulting in serious overcrowding. At times of economic hardship industrialized societies reduced funding for the asylums substantially, and during wartime in particular many patients starved to death. Over time, asylums became notorious for poor living conditions, lack of hygiene, overcrowding and repeated cases of ill-treatment of patients.

Closure and downsizing

The first alternatives to asylums, with services based in the community, were suggested and tentatively implemented in the 1920s and 1930s. Yet by the 1950s there were more patients in asylums worldwide than at any other time. The trend of increasing patient numbers and the unacceptable standard of care in these places led professionals and the public to consider alternatives and, as a result, substantial mental health reforms were initiated throughout the industrialized world. However, due to political and economic drivers, the focus of the prevailing public argument, time of onset, and pace of these reforms varied across countries.[1]

These differences were also linked to national traditions, socioeconomic situations, cultural factors and specific funding systems. Nevertheless, reforms eventually resulted in the widespread closure or downsizing of asylums and the development of some form of community mental health service. The process of shifting the care and support for patients with mental illness from custodial asylums to community-based settings was often described as 'deinstitutionalization'. Yet it was also suggested that deinstitutionalization should go beyond replacing asylums, and should promote care with as little institutional input as possible, preferring self-help to any professional support, outpatient care to sheltered places or partial hospitalization, and sheltered places/partial hospitalization to hospitals.

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Deinstitutionalization

Outcomes

Deinstitutionalization has led to dramatic and, some would say, long-desired changes in psychiatric services. Health systems in North America, Europe and Australia in particular have embraced the philosophy of community mental healthcare.[1–4] Costs have been reported to be generally the same as for inpatient hospitalization, or even lower for discharged patients living in the community,[5] although costs for different forms of care clearly depend on political decisions affecting how well funded each service is. Patients formerly in long-term hospital care were moved to supported housing schemes providing full or semi-supervision, or were cared for by specialized teams in the community.

It should be noted that deinstitutionalization is – although international – limited mainly to Western industrialized countries. In many developing countries, institutionalized mental healthcare hardly exists; for example, with only one psychiatric hospital in Uganda there is very little scope for deinstitutionalization.

In Japan, the number of hospital beds has risen steadily over the last few decades. In Hong Kong, a pseudo-community care model provides services such as half-way houses, long-stay care homes and a day-care centre, all within a setting located away from the community, resulting in less integration of patients with the surrounding community.[6] In several South American countries, the total number of beds in asylum-type institutions has decreased as these have been replaced by psychiatric inpatient units in general hospitals and other decentralized settings.[7]

Criticisms

Although there is widespread consensus that deinstitutionalization has successfully led to the prevention of long-term hospitalization of patients with chronic mental illness, its implementation has also been criticized and several shortcomings have been suggested.

Inadequate preparation before discharge: patients were often discharged into the community without sufficient preparation, support or coordinated care. As a result, significant numbers of mentally ill people ended up either without treatment, homeless or even in prison.[8] Evidence shows that widespread homelessness among the mentally ill in Europe was avoided after deinstitutionalization, but it certainly occurred in some states in the USA.

Suggested increased rates of homicide: it has been claimed that deinstitutionalization may have led to increased rates of homicides in the community committed by people with mental illness. However, existing evidence suggests that this is not the case.[9]

Insufficient levels of care for some patients: while deinstitutionalization was first concerned with discharging long-term hospitalized patients, there now is a new generation of severely ill patients for whom community services provide insufficient care. Those patients – sometimes termed the 'new long-stay' patients – usually use various services at the same time or none at all.[10]

Lack of social integration: original expectations that community care would lead to the full social integration of people with severe mental illnesses have not been achieved.[11] The majority of patients with severe illness are still without work, have limited social contacts and often live in sheltered environments. Services in the community sometimes provide a new 'ghetto' for the mentally ill, where patients meet each other but have little contact with the rest of the community. It has been argued that instead of 'community psychiatry', reforms established a 'psychiatric community'.

Re- or transinstitutionalization

Although the number of conventional psychiatric hospital beds has continued to decrease in most Western industrialized countries, recent data suggest that we may already be witnessing a new phenomenon of 'reinstitutionalization'. Table 1 shows changes in the numbers of conventional psychiatric hospital beds, beds in forensic psychiatry, places in supported housing, involuntary hospital admissions and people in prison in six European countries.[9] Although each country has different traditions and healthcare systems, they show remarkably similar trends. The provision of supported housing, the number of forensic beds and the prison population increased significantly in all countries. The number of conventional psychiatric beds tended to decrease, while changes in involuntary hospital admissions were inconsistent.

Whether this process should be described as reinstitutionalization or transinstitutionalization (suggesting a mere shifting of placements from one context to another) is an open question. The answer depends on the national balance between a further decrease in hospital beds on the one hand and newly established institutionalized care on the other. For example, in England, Spain and Sweden, the number of conventional psychiatric beds that were closed is greater than the total combined number of additional forensic beds and places in supported housing that were established during the same period. Yet one might argue that significant numbers of patients who would have been hospitalized 50 years ago are now being cared for by teams in the community, whilst others are probably part of the drastically increasing prison population. Thus, the total number of patients in institutional care is likely to have increased. This is even more obvious in Italy and The Netherlands, where the increase in forensic beds and supported housing has been much greater than the decrease in conventional psychiatric bed numbers (in Germany the balance is approximately equal).

Explanations for reinstitutionalization

Possible explanations for the phenomenon of reinstitutionalization, some of which are similar to the reasons for establishing asylums in the 19th century, include the following.

Higher incidence or severity of mental illness: the need for institutionalized care may have increased because more people are suffering from mental illness, or from more severe mental illnesses (or both), possibly because of increasing illegal drug use. In addition, social changes may be associated with a new intensity of urbanization, resulting in higher morbidity, particularly for psychotic disorders.

Decreased capacity for care in the family: in many families, both parents are in employment. This results in a decreased capacity to care for a mentally ill child or other family member, which may require new institutions to step in.

Number of forensic beds, involuntary hospital admissions, places in residential care or supported housing, psychiatric hospital beds and prison population in 6 countries, 1990–1991 and 2002–2003 (values are numbers per 100 000 population unless stated otherwise)

Countries, by time interval	Forensic beds	Service provision involuntary admissions	Places in supported housing	Psychiatric hospital beds	Prison population
England					
1990–1991	1.3	40.5	15.9	131.8	90
2001–2002	1.8[a]	50.3	22.3	22.3	141
Germany					
1990–1991	4.6	114.4	8.9	141.7	71
2001–2002	7.8	190.5	17.9	128.2	98
Italy					
1990–1991	2.0	20.5	8.8	4.5	81
2001–2002	2.2	18.1[b]	31.6[b]	5.3[b]	100
The Netherlands					
1990–1991	4.7	16.4	24.8	159.2	49
2001–2002	11.4	19.1[c]	43.8	135.5	100
Spain					
1990–1991	1.2	33.8	5.1	59.5	90
2001–2002	1.5	31.8[d]	12.7[d]	43.0	136
Sweden					
1990–1991	9.8	39.0	76.0	168.6	63
2001–2002	14.3	32.4[e]	88.1	58.3	73

[a]Data refer to restricted patients admitted to all (high security and other) hospitals.
[b]Data for Emilia-Romagna, a region in northern Italy with a population of 4 million.
[c]Data for Drenthe, a rural area with 450 000 inhabitants.
[d]Data for Andalucia, the second largest region in Spain, with a population of 7 million.
[e]Discharges from treatment under the Compulsory Care Act during a 6-month period.

Table 1

Increased risk aversion: there may be an increasing tendency towards risk aversion in societies, influencing political decisions to fund institutional care and clinical decisions to admit patients to such care.[12] This tendency, whether rational or irrational, is underlined by the substantial increase in the general prison population in all countries.

Funding: healthcare is an expanding sector of the economy, and the provision of institutional care can be seen as attractive business. Statutory, voluntary and, particularly, private providers may successfully lobby and campaign for the commissioning and funding of more institutions.

Why might reinstitutionalization be a problem?

Funding: institutions are rather expensive forms of care, therefore funding might be spent more efficiently, particularly as most patients prefer care with the highest possible level of autonomy.

Lack of patient autonomy: institutions can make patients dependent on their care, thus hindering further autonomy.

Variations in quality of care: the quality of institutionalized care in Europe varies. For example, housing services have been described as ranging from the 'return of the private madhouse' (with unacceptable living conditions) to a 'golden cage' (with pleasant, but expensive care discouraging any move towards greater independence).

Lack of evidenced-based care: few of the new institutions base the care they provide on research evidence.

A split of mental healthcare could occur between mainly institutionalized and containing forms of care for people with severe mental illness who might be viewed as a risk to the public (i.e. a social control function of mental healthcare), and a widening private market of attractive services for all those who actively seek treatment and – directly or indirectly – pay for it (i.e. a therapeutic function of mental healthcare).

So far, we have discussed institutions as defined by bricks and mortar. However, intensive outpatient services in the community, such as assertive outreach, might also be seen as institutions. All of the reasons for and concerns about new institutions

described above also apply to these community-based forms of care.

Conclusion

Deinstitutionalization has dominated and marked major changes in mental healthcare provision in the second half of the 20th century. We now face the new phenomenon of re- or transinstitutionalization, which is international, expensive and ethically problematic. This calls for both specific research on the provision, costs, potentials and effects of different forms of institutions, including the experience of patients in them, and a professional and public debate on the values, aims, ethics and principles of mental healthcare, particularly for patients with severe mental illnesses. ◆

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