Isr J Psychiatry Relat Sci Vol 45 No. 4 (2008) 272–277

New Institutionalization as a Rebound Phenomenon? The Case of Israel

Moshe Z. Abramowitz, MD, MHA,[1] Alexander Grinshpoon, MD, MHA, PhD,[1,3]
Stefan Priebe, FRCPsych,[2] and Alexander M. Ponizovsky, MD, PhD[1]

[1] *Mental Health Services, Ministry of Health, Jerusalem, Israel*
[2] *Unit for Social & Community Psychiatry, Queen Mary, University of London, London, U.K.*
[3] *Tirat Carmel Mental Health Center, Tirat Carmel, Israel*

Abstract: Objective: To explore whether the history of significant deinstitutionalization in Western European countries since the 1950s, and in Israel more recently, may have led to the establishment of new alternative institutions as a "rebound" phenomenon. *Methods:* Data on service provision in Israel are analyzed and compared with published data from Europe. We considered five commonly used indicators of mental health services to reflect trends in institutionalization in psychiatric hospitals, the forensic system and supported housing. *Results:* In Israel, there has been a substantial increase in placement in supported housing (by 307%), psychiatric treatments in the prison population (by 61%), and a reduction of psychiatric hospital beds (by 42%) between 1991/2 and 2002/3. The changes are consistent with trends observed during the same decade in European countries with a different history of psychiatric institutionalization. However, increases in involuntary admissions in Israel, England, the Netherlands and Germany have not been shared by Spain, Italy and Sweden. *Conclusion:* The appearance of possible new forms of institutionalization also occurs in Israel and appears not to depend on a history of large asylums and deinstitutionalization since 1950s. Thus, it cannot be explained as a mere "rebound" phenomenon, and may be influenced by other societal factors that are shared by various European countries.

Introduction

The term "reinstitutionalization" has been used to describe the current trend (1) of a proliferation of new institutionalized forms of mental health care. This may suggest a type of rebound phenomenon following significant deinstitutionalization since the 1950s, which might have gone too far (2).

Recent research shows that new institutionalized forms of mental health care have increased significantly in European countries since 1990 (3–7). In particular, substantial increases of forensic beds and placements in residential care and supported housing have been reported. At the same time, prison populations have also been rising, while changes in involuntary hospital admissions have been inconsistent and the number of mental hospital beds has rather fallen. Although the findings have sparked a debate on whether current directions of mental health policy are on the right track, the reasons for the tendency to establish more places of institutionalized mental health care remain poorly understood. The question is whether the new tendency can be understood only against the background of the specific history that most Western European countries share (i.e., the establishment of large asylums in the 19th century and the subsequent wide reaching deinstitutionalization in the second half of the 20th century), or whether current trends are independent of the history of massive deinstitutionalization. This question can be tested in Israel, whose history of psychiatric services is distinct from that of European countries.

As a former part of the British Mandate, Israel shares a similar tradition with Britain pertaining to health policy and legislation, and the licensing of hospitals (including psychiatric hospitals) in Israel to this day is based on a Mandatory Directive from 1940. By the time the State was established in 1948, there was a total of 1,200 psychiatric beds (8).

The unrestricted, mass immigration in the early years of the State (1948–1955) included elderly per-

Address for Correspondence: Moshe Z. Abramowitz, MD, MHA, Mental Health Services, Ministry of Health, 29 Rivka Street, POB 1176, Jerusalem 91010, Israel. E-mail: moshe.abramowitz@moh.health.gov.il

sons, concentration camp survivors, and the infirm and disabled. The fledgling State established psychiatric hospital beds, both general and psychiatric, by improvising solutions such as the conversion of old British army barracks to mental hospitals. These mental health hospitals run by the state formed a system of care parallel to the "sick fund" (the equivalent of a health maintenance organization — HMO), which already had well-equipped and developed general hospitals. As a result, the number of psychiatric hospital beds ballooned to approximately 7,900 in the mid-1980s.

Reform in mental health services has come in the form of the reduction of the number of hospital beds, and has shifted personnel and money to the community for rehabilitation programs, supported housing and halfway-houses (9, 10). In 2000, the Knesset passed the Community-Based Rehabilitation of the Mentally Disabled Act, setting up an integrated organizational framework to secure sufficient funding for the long-term rehabilitation for the mentally ill (11).

Summarizing, the current social and health care system and various other societal features in Israel are similar to those in Western and Central Europe, while its history of mental health care is distinct: other countries had large asylums until major reforms started in the 1950s, while mental health facilities in Israel were private and small, and had a marginal impact until the 1950s (8). Thus, in this paper we analyze changes in health care provision in Israel and compare them with data reported for countries in Western Europe during the decade 1991/2–2002/3 (5).

Methods

For the comparison of data across countries, we considered five indicators of mental health services to reflect trends in institutionalization (5): 1) the number of forensic psychiatric beds; 2) the number of mentally ill persons treated in prison outpatient facilities; 3) the number of involuntary psychiatric hospitalizations (by district psychiatrist order and court order); 4) the number of places in community supported housing and hostels for former psychiatric inpatients; and 5) the number of beds in psychiatric facilities.

Data sources

The data were extracted from three sources: 1) the National Psychiatric Hospital Registry (NPHR), which includes basic demographic and clinical information on all psychiatric hospital admissions (voluntary and involuntary) and discharges since 1950; 2) an administrative database containing information on community hostel and supported housing residents; and 3) an administrative database containing information on all outpatient psychiatric facilities and treatments including those in prison.

The NPHR was used for counting involuntary psychiatric admissions (12). The Israeli NPHR, maintained since 1950, was enacted into law in the Treatment of Mentally Ill Act of 1955 and reaffirmed in the updated 1991 version of the law. Institutions with psychiatric admissions are required to file a report of each admission with the Ministry of Health (MOH).

Israel's NPHR, which covers a population of over seven million, is perhaps the world's largest. An annual report is provided online by the Department of Information and Evaluation of the Mental Health Services in the MOH (13).

Operational definitions

Forensic beds refer to the inpatient facilities in prisons run under the auspices of the MOH.

Patients treated in prison outpatient facilities include all outpatient treatments of prisoners in the correctional facilities. The outpatient clinic is located in close proximity to the prison, and delivers services to those incarcerated in the system.

Involuntary hospitalization (IH) is defined as a restrictive intervention aimed at treating a patient at a critical period (14). The legislative criteria for involuntary admissions overlap with those in other countries (6): 1) psychotic state; 2) physical danger to oneself or others; and 3) the presence of a causal link between the psychiatric disorder and the dangerous behavior. Patients with a psychiatric illness and deemed incompetent are committed by court order to a high-security facility attached to a mental health center, under the auspices of the MOH. Patients with a psychiatric illness but deemed criminally responsible are committed by court order to a special psychi-

atric ward under the auspices of the state penitentiary system, with the professional personnel provided by the MOH (15).

Community hostels are defined as a dwelling place in the community where former psychiatric inpatients reside. Typically, a hostel houses 20–25 residents. Hostel activities include domestic, social and self-care skills, and vocational rehabilitation. The criteria for placement are as follows: absence of a definite clinical indication for hospital stay, the presence of psychiatric disability of at least 40% as determined by a medical board at the National Insurance Institute, and a potential to work in a community setting (9).

Supported housing is typified by former psychiatric inpatients living in an independent setting, responsible for their routine and house upkeep. They too have a psychiatric disability of at least 40% as determined by a medical board and are assisted by supervisors and counselors on a regular basis (9).

Overall psychiatric beds are the number of licensed hospital beds on December 31st of any given year (13).

Table 1. *Number of forensic beds, involuntary hospital admissions, places in residential care or supported housing, psychiatric hospital beds, and prison population in mental health care in Israel and 6 Western European Nations in 1991/2 and 2002/3. Values are numbers per 100,000 population unless stated otherwise (data of European Nations extracted from Priebe et al., 2005).*

Service provision	Israel	England	Germany	Italy	Netherlands	Spain	Sweden
Forensic beds	Beds (Patients)[1]						
1990	0.98 (0.47) (1991)	1.3 (1991)	4.6	2.0	4.7 (1991)	1.2 (1992)	9.8 (1993)
2002	0.98 (0.55)	1.8[3] (2001)	7.8	2.2 (2001)	11.4	1.5	14.3 (2001)
Change (%)	– +17	+38	+70	+10	+143	+25	+46
Involuntary admissions							
1992	50.4	40.5 (1991)	114.4	20.51	16.4	33.8	39.0
2001	70.7	50.3	190.5	18.14[4]	19.1[5] (1999)	31.8[6]	32.4[7]
Change (%)	+40.3	+24	+67	-12	+16	-6	-17
Places in supported housing							
1996	18.2	15.9 (1997)	8.9 (1990)	8.8 (1992)	24.8 (1992)	5.1 (1994)	76.0 (1997)
2003	74.0	22.3 (2002)	17.9 (1996)	31.6[4] (2000)	43.8 (2001)	12.7[6]	88.1 (2002)
Change (%)	+307	+40	+101	+259	+77	+149	+15
Psychiatric hospital beds							
1990	140.5 (1991)	131.8	141.7	4.5 (1992)	159.2	59.5 (1991)	168.6
2002	114.5 (2003)	62.8 (2001)	128.2 (2000)	5.3[4] (2000)	135.5 (2001)	43.0 (1999)	58.3 (2001)
Change (%)	-18.5	-52	-10	+18	-15	-28	-65
Prison population	(Outpatient in care)[2]	Total population					
1992	0.99	90	71	81	49	90	63
2002	1.59 (2003)	141 (2003)	98 (2003)	100	100	136 (2003)	73
Change (%)	+61	+57	+38	+23	+104	+51	+16

[1] Number of psychiatric patients in forensic wards
[2] Imprisoned psychiatric patients
[3] Data refer to restricted patients admitted to all (high security and other) hospitals.
[4] Data for Emilia-Romagna, a region in northern Italy with a population of 4 million.
[5] Data for Drenthe, a rural area with 450,000 inhabitants.
[6] Data for Andalucia, the second largest region in Spain, with a population of 7 million.
[7] Discharges from treatment under the Compulsory Care Act during a six month period.

Results

Table 1 shows changes in mental health service provisions in Israel (1991/2–2002/3) in comparison with corresponding figures for six European countries over the same period of time extracted from a recent published report (5).

During the observation period, the number of psychiatric hospital beds in Israel was reduced by 42%, while the number of places in supported housing in the community rose threefold. Although the number of psychiatric beds in prisons did not change, the number of patients treated in both prison psychiatric outpatient and hospital facilities rose by 61% and 17%, respectively. Similar trends can be seen in all countries compared.

An increase in the number of involuntary psychiatric hospitalizations in Israel (by +40.3) followed the trends found in England, the Netherlands and Germany, but not in Spain, Italy and Sweden, where a decline in involuntary admissions has been observed during the same period.

Discussion

Despite substantial differences in history, cultural background and legislation, Israel's trends are similar to those in England and other European countries. Several Western European countries are undergoing rapid structural changes in their mental health systems. What all have in common is a reduction in the number of psychiatric hospital beds. This reduction may be motivated by the interest of health care providers to reduce costs of expensive acute treatments. Alternatively, this may be in line with the original intention of mental health care reforms to shift care from hospitals to the community with an increase in care, housing and rehabilitation services in the community.

In Israel, mental health reform with initiatives to establish services in the community came relatively late. The appropriate legislation was in place only in 2000 (11). The number of psychiatric beds has slowly but steadily dwindled, following similar patterns in Western Europe, although the beds had never been part of a large chain of asylums dating back to the 19th century.

The disproportional increase in supported housing places in Israel within one decade may reflect the search for alternative solutions to hospitalization, a pressure on community services to care for difficult patients, or a tendency to establish new institutions. In any case, these forms of care are expensive and less extensively researched. The international comparison shows that those countries with a relatively high baseline figure in 1990, such as Sweden, experienced a mild increase, while supported housing rose more in countries with a low baseline figure. This might indicate a general tendency to establish a similar rate of supported housing places. Whether there will be a "ceiling" effect preventing further increase once a threshold figure has been reached remains to be studied in the future.

The trend toward a reduction in the number of psychiatric hospital beds, which Israel shares with other European countries, may explain other international trends such as a substantial increase in involuntary hospitalizations (6). Bed unavailability might cause delay in treatment potentially leading to worsening of the disorder and resulting in poorer adherence to medication, a higher frequency of criminal acts, and a more frequent history of violence (16). All of these phenomena can lead to a further deterioration of the given mental disorder and emergency situations which frequently justify involuntary hospitalization in cases where this could have been prevented by timely voluntary admission. This explanation is suitable for some countries where bed reduction has been taking place during a short period of time, e.g., England (16) and also Israel (15).

Various other factors may also have contributed to the trend of new institutionalization in mental health care, most of which, however, are beyond the scope of this paper. Such factors might include the difficulty of many patients to maintain independent lives in the community, the inability of community-based services to provide sufficient support, underfunding of services in the community, family disintegration and a societal focus on individualism, hedonism and personal success with which mentally ill people may struggle to cope.

However, while witnessed in some countries (i.e., England, the Netherlands and Germany) this trend is not present in others (Spain, Italy and Sweden). Konrad sees this pattern of the incarceration of the mentally ill as a type of "new asylum" (17). One

might hypothesize different explanations for this phenomenon, for example, an increase in involuntary admissions in countries where the family unit is not able to handle the discharged patient at home. An alternative explanation might be a different perspective on medico-legal issues in different countries, such as the recommended psychiatric risk-management of the marginally dangerous patient not in an institutionalized setting. Finally, the possibility of comorbidity with psychoactive substance abuse and mental illness may cause an increase in involuntary admissions in some countries and a reduction in others.

Our analysis has several limitations: The definitions of service types vary substantially between countries and differences between countries in absolute figures are difficult to interpret. Yet, definitions remained consistent for changes over time within each country. The data are related to one period of time since 1990 and do not specify more detailed changes in shorter periods of time. Thus, it is not clear whether all trends have continued in more recent years. The data focus only on service provision, and precise information on characteristics of patients in those services and treatment outcomes is missing. Such information would help to identify clinical patterns behind patients' pathways into institutionalized care.

Despite these limitations, the findings show that a tendency for new institutionalization in mental health care does not depend on a history of large asylums and subsequent massive deinstitutionalization since the 1950s.

One might argue that Israel, despite not having had traditional asylums, still had forms of hospital care and some deinstitutionalization of care along the lines referred to by Munk-Jørgensen (2). However, the processes are likely to depend more on factors that are shared by Israel and the other countries with reported deinstitutionalization. These might include: a) a change in morbidity possibly due to increasing social fragmentation and an increasing rate in the use of illegal drugs; b) a more conservative attitude to risk containment which — rationally or irrationally — leads to political and clinical decisions resulting in more institutions for the mentally ill, albeit in the general community; and c) a tendency of private, voluntary and public providers of mental health care to lobby for more services and generate corresponding revenue (4).

Future directions

The current trend towards new forms of institutionalization may continue in Israel and elsewhere. At its core is the increase of supported housing provision with halfway houses and other forms of housing services in the community. One might conclude that the idea to integrate most patients with severe mental illness into independent accommodation and regular employment has — if it ever existed — failed and that various institutionalized forms are required to care for a substantial number of these patients. Another indirect outcome of this trend has been the preparation by the Israel Ministry of Health of new specialized types of facilities in the community, such as facilities for older inpatients, and different types for younger patients without an institutional history (11).

The observed trends raise a philosophical question about the future of psychiatry as a distinct branch of medicine. Historically, psychiatry acquired the status of discipline in its own right when it distinguished itself from neurology and found its own physical enclave, namely, the large asylums of the previous century. In parallel to heavy deinstitutionalization since 1950, psychiatry lost some of its independent status and now seeks to reintegrate itself into the medical mainstream (i.e., to merge with neurology and brain sciences). New institutionalization described in this study may be considered a social trend, perhaps not deliberate, in which mental illness, its stigma and the public's ambivalence towards it create the establishment of a new "psychiatric territory" in the community as compensation.

There are three conclusions for the future directions: More research and comprehensive data are required on changes in mental health care provision and on the effects of new institutions and housing services. These are particularly under-researched areas (18). Also, further research is needed to examine whether new community-based facilities reproduce institutional styles of care and functioning, and whether further progress in rehabilitation is encouraged so as to gradually reintegrate the users into the community.

More specific research should help to develop more active and effective forms of reintegrating patients with severe mental illnesses into the community, beyond the traditional approaches of rehabilitation. An example is the "place and support" strategy that replaced the conventional method of stepwise vocational rehabilitation (19). In England, assertive outreach and crisis teams are designed to better reintegrate patients into a somewhat hesitant community (20). Finally, there should be a professional and public debate on the future of mental health care encompassing underlying values, scientific evidence and economic considerations.

Acknowledgements

Dr. A.M. Ponizovsky was partly supported by the Ministry of Immigrant Absorption.

References

1. Priebe S, Turner T. Reinstitutionalisation in mental health care. BMJ 2003;326:175–176.
2. Munk-Jørgensen P. Has deinstitutionalization gone too far? Eur Arch Psychiatry Clin Neurosci 1999;249:136–143.
3. Domino ME, Norton EC, Morrissey JP, Thakur N. Cost shifting to jails after a change to managed mental health care. Health Serv Res 2004;39:1379–1401.
4. Priebe S. Institutionalization revisited — with and without walls. Acta Psychiatr Scand 2004;110:81–82.
5. Priebe S, Badesconyi A, Fioritti A, Hansson L, Kilian R, Torres-Gonzales F, Turner T, Wiersma D. Reinstitutionalisation in mental health care: Comparison of data on service provision from six European countries. BMJ 2005;330:123–126.
6. Salize HJ, Dressing H. Epidemiology of involuntary placement of mentally ill people across the European Union. Brit J Psychiatry 2004;184:163–168.
7. Vázquez-Barquero JL, García J, Torres-González F. Spanish psychiatric reform: What can be learned from two decades of experience? Acta Psychiatrica Scandinavica 2001;104:89–95
8. Mark M, Rabinowitz J, Feldman D, Gilboa D, Shemer J. Reform in Mental Health Services in Israel: The changing role of government, HMOs and hospitals. Administr Pol Ment Health 1996;23:253–259.
9. Grinshpoon A, Shershevsky Y, Levinson D, Ponizovsky A. Should patients with chronic psychiatric disorders remain in hospital? Results from a service inquiry. Isr J Psychiatry Rel Sci 2003;40:268–273.
10. Haver E, Baruch Y, Kotler M. The structural reform of mental health services. Isr J Psychiatry Relat Sci 2003; 40:235–237; discussion 238–239.
11. Grinshpoon A, Zilber N, Lerner Y, Ponizovsky A. Impact of rehabilitation legislation on the survival in the community of long-term patients discharged from psychiatric hospitals in Israel. Soc Psychiatry Psychiatr Epidemiol 2006;41:87–94.
12. Lichtenberg P, Kaplan Z, Grinshpoon A, Feldman D, Nahon D. The goals and limitations of Israel's Psychiatric Case Register. Psychiatric Serv 1999;50:1043–1048.
13. Mental Health in Israel, Statistical Annual 2004, Ministry of Health Mental Health Services, Department of Information and Evaluation, Government Publications Office, Jerusalem, 2004. Available at: http://www.health.gov.il/download/mental/ annual2004/pp.32–65psychiatrichospitalization.pdf. Last accessed February 21, 2007.
14. Mental Health Law, the State of Israel, 1991.
15. Bauer A, Grinshpoon A, Rosca P, Khawaled R, Mester R, Ponizovsky AM. Trends in involuntary psychiatric hospitalization in Israel 1991–2000. Int J Law Psychiatry 2007;30:60–70.
16. Wall S, Hotopf M, Wessely S, Churchill R. Trends in the use of the Mental Health Act: England, 1984–96. BMJ 1999;318:1520–1521.
17. Konrad N. Prisons as new asylums. Curr Opin Psychiatry 2002;15:583–587.
18. Fakhoury W, Murrey A, Shepherd G, Priebe S. Research in supported housing. Soc Psychiatry Psychiatr Epidemiol 2002;37:301–315.
19. Drake RE, Becker DR, Clark RE, Mueser KT. Research on the individual placement and support model of supported employment. Psychiatr Q 1999;70:289–301.
20. Johnson S, Zinkler M, Priebe S. Mental health service provision in England. Acta Psychiatrica Scandinavica 2001;104:47–55.