The process of deinstitutionalization: an international overview

Walid Fakhoury and Stefan Priebe

The process of deinstitutionalization has led to the closing or downsizing of former asylums and to the development of community-based mental health care models in many countries, most notably in Western Europe, North America and Australia/New Zealand. The quality of the resulting community mental care systems varies substantially across countries worldwide, depending on various factors such as financial resources and social acceptance of deinstitutionalization. Confinement of those with dangerous behaviours, the right of mentally ill people as members of the community, their successful integration in the community and access to employment and housing are some of the challenges facing countries with advanced deinstitutionalization. In others, the process of de-hospitalization is still under way. Future research may utilize international comparisons to analyse deinstitutionalization processes from a sociological and historical perspective and focus on evaluating new forms of institutionalized care in the community, in particular, models of supported housing. Curr Opin Psychiatry 15:187–192. © 2002 Lippincott Williams & Wilkins.

Unit for Social and Community Psychiatry, Barts and the London School of Medicine, London, UK

Correspondence to Professor Stefan Priebe, Unit for Social and Community Psychiatry, Barts and the London School of Medicine, West Smithfield, London EC1A 7BE, UK. Tel: +44 208 8586 5272; fax: +44 208 8586 5273; e-mail: s.priebe@qmw.ac.uk

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Introduction

It has now been more than four decades since the process of deinstitutionalization of mentally ill people started, shifting the care and support for these people from psychiatric custodial institutions to community-based settings. The closure or downsizing of former asylums has had significant effects on the long-term care of these people throughout Australia, North America, Scandinavia and Western Europe [1••], and also affected psychiatric care in South America [2•]. At the global level, however, the World Health Organization has recently published The World Health Report 2001 on mental health which provided a comprehensive review of what is known about the current and future burden of disorders, examined the scope of prevention and the availability of, and obstacles to, treatment, and dealt in details with service provision and planning [3]. This report indicated that, in many countries, large tertiary institutions with both acute and long-term facilities are still the common form of psychiatric care, with some 38% of countries worldwide having no community-based mental health services. Some countries that promote community care (e.g. the Arab countries, Argentina, China, India, Nigeria, Russia and Turkey) do not have complete coverage, with community mental health services mostly concentrated in urban areas [3]. The deinstitutionalization process, as expected, is advancing at different paces in different countries, depending on the level of available resources. It has been argued that as a movement, deinstitutionalization should not have any limits, if policy makers and clinicians can overcome the limit of institutional thinking [4]. In this paper, we provide an international overview of deinstitutionalization and review related issues as discussed in the current literature.

International overview: the current debate

Deinstitutionalization has led to impressive changes in psychiatric services and to the development of community-based models of care in countries such as Canada [5–7], Italy [8•], the UK [9], and the USA [10••,11••,12,13]. Costs were reported to be generally the same or even less for discharged patients living in the community [1••,7]. Despite sharing common experiences, however, when it comes to deinstitutionalization, different countries may have different problems because of specific traditions, socio-economic situations and funding arrangements.

In the USA, it has been argued that a system of co-ordination among funding sources and implementation

agencies is needed for the deinstitutionalization of people with severe mental illness, who usually have multiple problems that are dealt with by multiple public and private authorities [14•]. Others have noted that deinstitutionalization has put too much of a focus on the locus of care [13], while little attention is given to the humaneness, effectiveness and quality of care [10••]. Most importantly, the emergence of managed care – shifting responsibilities of care for patients with severe mental illness from the public to the private sector – was suggested to have led to fears of under-treatment or lower quality services because of the capitation system, whereby agencies are given a fixed amount of money per patient [14•]. The concern is that this system may reduce patient choice of treatment [14•], which consumer organizations in the USA have expressed concerns about [11••].

In Europe, the situation varies across countries. In the UK, where like in the USA the number of hospital beds has been dramatically reduced in the course of deinstitutionalization [1••], community mental health teams have been established throughout the country, and empirical findings show that community care is feasible [15]. McCulloch *et al.* [9], however, expressed concern that, for community safety reasons, the government will adopt more conservative and safety-oriented care practices, which could only lead to further alienation and stigmatization of mentally ill people. They further stated that resources for community care are overloaded and too few specialized community mental health services exist. In the Netherlands, intensive community-based care has increased five times more than hospital-based care was reduced, thus contradicting the goals set in the Dutch mental health policy that aims at substituting outpatient and other community care for inpatient care and not at expanding mental health services [16]. The current concern is that Dutch community mental health centres may have serviced new and less severely ill patients instead of patients with severe and persistent illnesses, a criticism also reported in the UK and the USA [16]. In Germany, a greater number of patients with mental illness live in institutionalized homes, but with little access to the community and with little empowerment. Deinstitutionalization was reported to have led in many parts of the country to patients staying in renamed sections of hospitals or in homes for the disabled [17]. A lack of community mental health teams and community psychiatric nursing, a shortage of social work back up, and understaffed residential and nursing homes are some of the problems of deinstitutionalization in Germany [18]. Despite this, research has shown that in Germany a large number of former long-stay patients appear to be able to live in the community, albeit in highly staffed settings, with a significant decrease in time spent in hospital [19]. In Greece, the existing number of community-based alternatives to inpatient psychiatric care is considered to still be inadequate to reduce admissions in mental public hospitals and to accommodate the yet-to-be deinstitutionalized long-stay patients [20].

In Sweden, Silfverhielm and Kamis-Gould [21] indicated that the insufficient re-allocation of resources to establish community-based services has led to patients continuing to be hospitalized, but their costs of care are assumed by their local municipality rather than by the county councils. The limited co-operation among the specialty mental health system, primary health care and local social services was reported to demand co-ordination of activities on behalf of patients, and to have the unintended disincentives to serving consumers with multiple needs [21]. In North Finland, Rasanen *et al.* [22] found that patients from smaller counties with fewer resources are more likely to move to alternative community placements, whereas those in larger counties with more resources are more likely to be treated in hospitals. Large Finnish counties seem more able to afford continuous hospitalization of long-stay patients, and thus have less incentive to deinstitutionalize. Successful deinstitutionalization in Finland is argued to be dependent on the availability of alternative types of community placements with more and better trained staff providing community-based support [22].

In Australia, some have claimed that deinstitutionalization was flawed because the shift from institutional to community-based living was not associated with clear systematic planning or adequately placed support systems in the community [23]. The current focus of deinstitutionalization seems to be on providing psychiatric patients with adequate supportive (dependence on one's self) rather than supported (interdependence) housing. Moxham and Pegg [23] stated that deconstructing the prominence of custodial housing structures and systems and re-constructing them to meet the needs of psychiatric patients is currently the prime challenge for agencies working on empowering patients, especially since the current systems to provide patients with affordable housing and appropriate services have limited, if any, institutional links between them. It has been suggested that community mental health care now needs to move beyond the question of hospital or community setting, and focus on eliciting residents' views on what else can be done to improve their quality of life [24].

In New Zealand, although the process of deinstitutionalization started more than two decades ago, its success has not been on pas with other Western countries. If anything, caring for mentally ill people in the community seems to be facing fundamental problems. Wilson [25]

suggested that the shift towards care in general hospital-based inpatient units, aligned with as yet not well-developed community-based services, has seriously affected access to acute beds. Other reported problems include a current shortage of psychiatrists in the islands and a current workforce not fully trained to meet the demands of a community-based service [25].

In several South American countries, progress in deinstitutionalization has been made in the last decade. The total number of psychiatric beds has been decreasing and psychiatric units in general hospitals and other decentralized centres were adopted as an alternative to the psychiatric hospitals [2•]. The greatest decrease in psychiatric beds was in Uruguay and Paraguay, followed by Chile, Brazil, Colombia, Venezuela and Peru, and the greatest increase in psychiatric units in general hospitals was in Brazil followed by Peru, Uruguay, Venezuela and Chile [2•]. Advanced deinstitutionalization, however, has not yet been achieved in South America.

In countries in East Asia, the move towards deinstitutionalization is reported to be limited by social, cultural and political factors. Yip [26] indicated that in Hong Kong mental health care remains largely institutionalized. In addition, a pseudo-community care model, the multipurpose psychiatric service complex, was introduced. The model provides services such as half-way houses, long-stay care homes, a day care centre, a sheltered workshop, all set up within a massive setting, and purposively located away from the community, resulting in less integration of mentally ill people with the surrounding community. Yip [26] mentioned that the development of such a model was due to social, cultural and financial factors. In Japan, Kuno and Asukai [27] also reported that deinstitutionalization is not likely to progress in the near future within the current cultural and social context, which is incompatible with accepting mentally ill people as members of the society. Additionally, the low cost of hospitalization provides little economic incentive to reduce long-term inpatient care [27].

For this review, we used the usual search systems to identify the relevant literature. The result is that the available information is unevenly balanced across the world. Whilst there is extensive literature on the situation in North America, Western and Southern Europe, Scandinavia and Australia/New Zealand, relatively little is published on deinstitutionalization and the current state of community mental health care in many other regions such as Eastern Europe, Africa and Asia.

New challenges

Although deinstitutionalization has prevented long-term hospitalization of patients with long-term illnesses, it has been suggested that in some cases it has led to people being discharged into the community without any preparations or co-ordinated care across agencies [28,29], resulting in neglect for some of them [30•]. Papers often focus on 'losers' rather than 'winners' of deinstitutionalization and critics listed lack of treatment, social isolation, homelessness, incarceration, or other forms of significant loss of quality of life as consequences of deinstitutionalization failure [29]. Some, however, have indicated that, if implemented correctly, deinstitutionalization should not lead to homelessness [31], incarceration [32] or abandonment in the community [33]. With respect to self-injurious behaviour, it has been reported that deinstitutionalization may perpetuate such behaviour, but is not the cause of it [34].

The most common criticism of deinstitutionalization relates to its failure to meet the needs of two groups of patients: the new generation of patients with severe and persistent mental illness, and those patients with high rates of co-morbidity. It has been indicated that the majority of those hospitalized for long periods have been institutionalized to passivity; when their discharge from hospital is feasible and appropriate, they will stay where they are placed and accept the services [14•]. In contrast, the new generation of severely mentally ill patients would have had difficulty just getting admitted to acute care, and even greater difficulty staying there for a long period or any one admission [14•]. The fact that in the USA a significant proportion of this group are living in prisons, on the streets, and in other unacceptable conditions, was seen as an indication that deinstitutionalization has not provided them with adequate care [14•,35].

It has also been pointed out that severely mentally ill patients with high rates of co-morbidity seem to be disadvantaged by deinstitutionalization. Many of these patients are being cared for by the forensic psychiatry system, which may be unable to cope with this development because of structural and personal deficits. Therefore, the system is in danger of being misused primarily as an instrument of social control [36]. Others have suggested that a significant reason behind high rates of incarceration of psychiatric patients may be that psychiatric institutions may have served in the past as a social control function, something that has not been recognized by policy makers since deinstitutionalization [37].

Rothbard and Kuno [1••] stated that the current challenge is the new long-stay patients who make the greatest use of costly emergency room and community hospital beds. People with intellectual disability and mental health needs also seem to have been negatively affected by deinstitutionalization. Service provision to

this group was reported to be ad hoc, with a lack of clarity as to how their mental health needs should be met [38]. It has been suggested that deinstitutionalization should address the need for adequate generic mental health services, for specialist mental health services and for improved inter-connection of services for this group of patients [38].

Confinement

In contrast to deinstitutionalization, there has been increasing consideration of 'confinement' of some patients with severe mental illness in some countries. Forensic care is expanding in several countries, including Austria [36] and the UK. Using two key policy statements issued by the UK Department of Health and associated discussions in the health services management press, Moon [39] noted the emergence of confinement as a consequence of the spatial impact of deinstitutionalization, referring to the visibility of patients, heightened by their perceived spatial concentration in the urban environment and its specific origins in response to violent offences by psychiatric patients. The social acceptance of the need to control dangerous behaviour and the apparent increase in individuals with violent histories may have made confinement more acceptable than was the case less than a decade ago, rejecting the notion that growing emphasis on confinement presages a return to the asylum system [39]. The notion of trans-institutionalization suggests that deinstitutionalization and its failures directly led to the strengthening of the forensic and prison system. Empirical evidence, however, does not support this view [32].

Integration and community opposition

It has been argued that a major problem limiting the success of deinstitutionalization is the lack of a broad conceptual framework of inclusion that, based on a disability paradigm, neither alienates nor requires mentally ill patients to succeed in being fully integrated in the community [40•]. Friendship, reciprocity and hopefulness are seen as important aspects of inclusion that may provide a foundation for efforts toward recovery and empowerment [40•]. The importance of such a paradigm was noted by Mercier [41•] who indicated that the objective of community care, particularly in Canada, has increasingly shifted from reintegrating people back in their communities to upholding their rights and ensuring that they have access to resources, allowing them to assume their responsibilities and roles as citizens. Community mental health professionals could act as mediators and facilitators in successfully re-establishing and re-empowering people. Yet, given the often undesirable social and economic conditions in which mentally ill people have to compete with other members of the community in accessing employment and housing opportunities, significant obstacles still need to be overcome [41•]. The success of re-integration, others have noted, is dependent on efficient community-based services offering appropriate treatment [42].

Deinstitutionalized patients also seem to be facing community residents' opposition to their deinstitutionalization. Wright *et al.* [43•] noted that discharging patients into hostile communities may affect their self-concept, mental health status and success in adjusting to community life. In Canada, lack of support for the development of group homes in the community – which residents thought was motivated by financial considerations either by the government or by group home developers – and a rejection of social integration policies are at the core of the opposition argument [44•]. Community opposition was reported to have important implications for the work of mental health professions, particularly social workers. As a major player in the system of community care, it has been indicated that social workers must as a first step begin to listen to the concerns of community residents regarding deinstitutionalization and then collaboratively begin to develop alternatives [44•].

Full integration in the community, however, is not always a realistic expectation from deinstitutionalized people. Pinfold [45] suggested that in terms of positioning within the wider community, and instead of absolute positions (isolated/not isolated), many individuals in the community often look for a middle ground between isolation and integration, between states of dependency and states of independence.

Research and definitional issues

Current assessments of deinstitutionalization are frequently based on personal accounts of clinicians and reports of legislative changes, bed numbers and other available figures of services. Some papers specifically deal with the experience of the patients concerned [43•,45] and their relatives [28,42,46]. More than 50 years after the beginning of deinstitutionalization, the time may have come for systematic historical research into the political and social processes that have determined national approaches and styles of deinstitutionalization [10••]. This research should be linked to sociological theories and explanations [30•] and may utilize the reported variation between countries for comparative studies, identifying generalizable patterns and specific national factors [1••].

With respect to direct mental health service research, various studies have demonstrated that patients can benefit from deinstitutionalization and that costs are not higher than in hospital settings. That research, however, may now be more of historical than immediate clinical

value since, in most countries, the number of long-term hospitalized patients who may be discharged in the future has dwindled. The challenge now is to establish and expand systematic evaluative research in community mental health care [47]. Several papers point to the particular relevance of evaluating different models of supported housing and the present approaches to take on that challenge [17,19,22,23,48]. Fears have been expressed that some forms of supported housing might become places where patients with long-term mental illness live in poor conditions and get forgotten by the society at large – just as in the old type asylums [17].

The common connotation of the term deinstitutionalization relates to closure or downsizing of former asylums. At a time when in many countries those asylums do not exist in their original form anymore, that connotation might become meaningless [10••]. Deinstitutionalization will either refer to an historical – and in some countries almost completed – process, or adopt a wider understanding of institutions in mental health care. The latter definition would describe the general process of diminishing the role of any institution, that is, including all community-based institutions, in mental health care, in which case it may encompass patient empowerment [11••,40•] and replacement of professional health care by self-help alternatives [11••] and community interventions. So far deinstitutionalization has not diminished the role of institutions albeit based in the community [10••].

Conclusion

This review suggests that the effects of deinstitutionalization depend on national traditions and socio-cultural context [26,27], the availability of resources and financial incentives [2•,3,21,22,27] as well as specific features of the given social welfare and health care systems. As a result, deinstitutionalization varies across countries and seems to encompass policies ranging from having severely mentally ill patients in psychiatric units in general instead of mental hospitals, to having patients in the community in supported/supportive housing or in psychiatric service complexes away from the community. In countries with advanced deinstitutionalization, the discussion currently focuses on ensuring that patients are integrated within the community and have access to employment and housing [22,23,41•,43•,44•].

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