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De-institutionalisation in psychiatry – both sides of the coin

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De-institutionalisation refers to the depopulation of large psychiatric institutions, which was an important component of mental healthcare policy beginning in Europe and the USA in the middle to late 20th century.

Growth of the psychiatric institution

Interestingly, there seems to have been little need for institutional care in Europe before the 18th century. The first purpose-built psychiatric institution in the UK, The Priory of Saint Mary of Bethlehem (later known as Bethlem or 'Bedlam'), was founded in 1247, but in 1700 was still the only public asylum in Britain, with 100 inmates.

The next two centuries, however, saw a radical change, with the development of institutional confinement as the principal way of dealing with individuals who were deemed to be mentally ill, and by 1900 the total number of inmates in psychiatric institutions in the UK exceeded 100 000.^[1] Initially, these places offered little more than confinement. However, in time, more humane treatment began to arise and it has been asserted that the institutions were the birthplace of psychiatry. This has implications for how psychiatry is viewed to this day, with a powerful and negative association of mental illness with removal to the 'loony-bin'.

De-institutionalisation

With little effective treatment (therefore few discharges) and rapid population growth, the demand for institutions began to exceed available funding by the early to mid-1900s. Conditions deteriorated and the institutions became notorious as places of overcrowding, neglect and abuse. By the end of the 20th century, particularly in the USA and Europe, the number of inpatients in psychiatric hospitals had been radically reduced – in the USA the population of state and county psychiatric hospitals fell from 553 979 in 1954 to 61 722 in 1996, and 120 hospitals were closed.^[2] The reasons for this precipitous change in the practice of psychiatry are complex, but a number of factors have been cited:^[3]

- the advent of effective antipsychotic medication
- the growing wave of public antipathy towards psychiatric institutions as the abuses and poor conditions became more widely known
- the growth of mental healthcare user/survivor groups and the development of disability activism
- an assumption that community-based care would be more humane
- a variety of political arguments that span the spectrum – from concerns about the human rights of the mentally ill to financial imperatives driven by growing costs and the perception that community care would be cheaper.

Consequences

Undoubtedly, the most positive outcome of de-institutionalisation was the disappearance of the huge asylums of old and with them the potential for human rights abuses. This coincided with an expanded psychopharmacological armamentarium, a widened scope of practice

outside asylums, and the diversification of care. Delinked from the negative association with the institutions, psychiatry has steadily gained recognition as a medical discipline, and psychiatric treatment has become socially more acceptable.

It is clear, however, that the consequences for those suffering from severe mental illness were not entirely positive, as the enthusiasm for cost-cutting hospital closures has not been matched in the development of alternatives to hospitalisation. The most obvious negative consequence has been the emergence of large populations of homeless people with severe mental illnesses,^[4] and the increase in the number of mentally ill persons in prisons,^[5] or those housed in poorly regulated, smaller facilities outside the healthcare system. In particular, it has been argued that those who were meant to benefit most from the closure of the old institutions, the indigent severely mentally ill, have fared worst as a result of the new reforms.^[6]

The reasons why this has happened have become clearer in retrospect:

- What has emerged is that the successful placement of a person living with a chronic mental illness in a community setting requires substantial effort and resources which, when properly assessed, do not translate into any substantial financial saving over a long-term hospital admission.^[7]
- Co-morbid substance dependence has emerged as a major problem that complicates rehabilitation.
- Social spending has generally been reduced, with fewer funds available for social support.
- The emergence of structural unemployment has made vocational rehabilitation extremely difficult.
- In some areas community resistance has emerged as a significant factor.
- Urbanisation and smaller families also reduced social support.

Lessons learned

Perhaps, more than anything else, we have learned the true meaning of the biopsychosocial approach to mental illness from the experience of de-institutionalisation. It has become clear that real recovery requires more than just attending to the biological needs of an individual, such as medication, food and shelter. It demands that if people with chronic mental illness are to do more than just survive, attention must be paid to their individual circumstances, needs and hopes. Additionally, it demands that we see care from a social context, that attends to the wide range of social factors that affect a person with mental illness, such as stigmatisation and various forms of structural discrimination.

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