Module:
Mental Health in the Community

Week 1
A history of 'madness': Deinstitutionalisation to community care

Topic in Action 1.2
Deinstitutionalisation – Part 2 of 2

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Lecture transcript

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You look at drivers for deinstitutionalisation, some people point to the psychotropic medication revolution. As I said, the very early introduction of chlorpromazine-- the earliest introduction was in 1952 in France. I have pointed to changes in professional attitudes and the role of former military psychiatrists.

We also see the 'open door' movement in mental hospitals, the introduction of occupational therapy, and work rehabilitation into the mental hospitals of the 1950s; that rise in the welfare state; and changes in access to welfare benefits; and then attractive concepts of community care, which had particularly early adopters, such as T.P. Rees at Warlingham Park Hospital, just outside Croydon. In parallel, there have been evolutions in mental health law, and there have been changing ideas about institutions. And finally, we have to say, there's the issue of cost.

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So in terms of ideas-- three important books. Russell Barton, described as a maverick English psychiatrist, published his Institutional Neurosis in 1959. The sociologist Erving Goffman publishes Asylums, a seminal book, in 1961. Somewhat later, John Wing and George Brown publish the three hospital study, Institutionalism and Schizophrenia.

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So Barton describes institutional neurosis-- a syndrome, he calls it-- of apathy, lack of initiative, loss of interest, submissiveness, which is brought on, he says, by asylum life.

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Goffman provides a social critique of the asylum and other 'total institution'.

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Wing and Brown-- from a very different tradition comes a careful, empirical study of the effect of institutional practices on psychiatric disability, particularly the onset of so-called 'negative symptoms' of schizophrenia, which were found to be reactive to the social environment in the

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three hospitals that they studied.

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Actually, none of this is terribly new. S. Weir Mitchell, American neurologist, stated, 'Upon my word, I think asylum life is deadly to the insane.' That's a quote from 1894.

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What about political drivers? Enoch Powell, then Minister of Health, in 1961 gave a speech to the Conservative Party Conference. Powell was a rhetoritician of the highest order, a Greek scholar. 'There they stand, isolated, majestic, imperious, brooded over by the gigantic water tower and chimney combined, rising unmistakable and daunting out of the countryside-- the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault.' The assault, by the way, was his decision to close the mental hospitals.

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So hospital closure-- that occurred early and rapidly in the USA, and that had financial and legal drivers. So mass action suits instructed hospitals to discharge patients en masse, for example.

One of the first mental hospitals to close in England was Banstead in 1986, and the majority of mental hospitals closed in the next 15 years.

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Bit of a puzzle, there-- why did it take 25 years for the closure of mental hospital in England to move from a policy-- the 'Water Tower' speech in 1961-- to practice (the closure, Banstead in 1986)?

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We're going to look at some other drivers for deinstitutionalisation. There's a very nice book called Hospitals in Trouble by Martin, published in 1984-- perhaps an apt date for publication-- and that looked at a series of hospital scandals in the preceding 15 years or so in terms of hospitals for mentally ill people, for the elderly, and particularly for people with learning disabilities. It described common factors in the scandals, and these were factors like isolation; the existence of a closed institution, with poor, often remote top management; locally, poor nursing leadership, and poor not-medical leadership; and a lack of a multidisciplinary working; also, individual units which develop distorted cultures; equally importantly, a lack of the clarity over the task that's particularly relevant to long-stay institutions for people who are not felt to be likely to show any improvement.

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The next set of issues relate to finance. So those large mental hospitals, which, I've described, were running down in terms of bed numbers, had fixed costs irrespective of bed numbers. Hospital sites also had quite significant capital value that could be released on closure. Changes in social security legislation funded replacement community care services, which, of course, is an example of that cost shifting I mentioned from one budget to another.

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Finally, let's look at outcomes of deinstitutionalisation.

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So the hospital closure programme in England began in earnest in 1986. It's still not complete, so some large mental hospitals have remained open, and it's not always been absolute closure. So there's been use of some sites for new General Hospitals and part-use of those sites for new, small, inpatient units. We've also seen the subsequent development of a large number of relatively small, 'secure' hospitals, both within the NHS and the private sector.

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My own hospital closure experience relates to Cane Hill Hospital, which was opened in 1882 and closed in 1992-- although, my bit of it we left in 1991. Cane Hill burned down under slightly mysterious circumstances about 10 years later, and now planning permission has been granted for Cane Hill Park, a nice development of 660 houses.

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Cane Hill had 2,400 patients at its peak in 1954 and about 400 patients in 1987, when I joined as a consultant psychiatrist to close the Camberwell sector of the hospital.

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So what did we do when we closed Cane Hill? Well, we formed a multidisciplinary team to work within the hospital. We took clinical responsibility with the patients. We undertook repeated means assessments and produced plans for the reprovision, which were incidentally altered as circumstances changed. We worked with the patients and inpatient staff from the hospital, and involved existing and developed new NGOs to run replacement services.

So we developed specialist local services. People with dementia developed high support accommodation provided by NGOs-- some social care, some nurse-led. We placed some people in existing NGO and for-profit residential nursing care provision. And I have to say, we moved some people onto remaining long-stay hospitals. Finally and importantly, we evaluated our outcomes.

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Along with all this, and during and after the closure of Cane Hill, we developed comprehensive local community and inpatient mental health services ahead of or in line with metal health policy in England. So for me and my colleagues, the point of deinstitutionalisation was to improve the lives of current inpatients and to develop contemporary community mental health services-- which, to stress, always have had an element of inpatient care as part of them.

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Now, we evaluated our outcomes, but a much bigger study was undertaken by Julian Leff and colleagues into the closure of Friern Barnet Hospital. He and his colleagues in the team for the assessment of psychiatric services have published 46 papers and a book. So that provides a very detailed evaluation of the outcomes of the closure of the hospital, and the findings are in line with other studies such as our own from Cane Hill.

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There were 130 traditional mental hospitals in England and Wales in 1975, and 116 had closed by 2001. Patients who were discharged from Friern moved into supported living settings. They didn't change symptomatically, but they were happier in the new community services. They showed significant improvements in social functioning, and developed larger social networks. There was no homelessness, and there was very little offending behaviour amongst this patient group.

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There were a significant number of hard-to-place patients who presented with challenging behaviours, and these moved into specialist 'hospital facilities' that were much more homely. Again, they showed little symptomatic change, but over 5 years showed improvement in social functioning and marked improvement in the level of challenging behaviours, which allowed 40% of that group to move into non-hospital settings.

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There's a nice phrase, 'Any fool can close a long-stay hospital.' You've seen the outcomes for well-conducted hospital closure programmes in the UK, but probably not in the US-- undoubtedly good for the people leaving the hospital, even though many didn't want to leave. There's another quote, '...it takes more time and trouble to do it--' let's say, close the hospitals-- 'properly and compassionately.' Those quotes, by the way, come from the Parliamentary Social Services Committee report in 1985 on hospital closure and community care.

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Some conclusions: closing the large mental hospitals didn't abolish severe mental illness in the UK. The hospital closure programme, in fact, also had consequences of destabilising acute inpatient services in deprived and urban areas-- in London, for example, where I worked in the early 1990s. In the UK, inpatient beds have been replaced by care and high-support settings-- the so-called 'virtual asylum'. Even with well-developed community services, acute inpatient beds are still required, and some people have continued to need longer term inpatient care in specialist forensic and rehabilitation inpatient settings.