Module:
Mental Health in the Community

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

Topic in Action 1.2
Deinstitutionalisation – Part 1 of 2

Dr Frank Holloway
Emeritus Consultant Psychiatrist SLaMNHSFT

Lecture transcript

Slide 4

So this talk is about deinstitutionalisation. Remember that community care is a process that goes on in parallel. I'm going to talk about deinstitutionalisation, and the allied phenomena of transinstitutionalisation. Deinstitutionalisation is an international phenomenon, and we've got loads of data on that. I'm going to talk in some detail about the hospital closure movement-- its ideology, its technology, its economics-- and with particular reference to a landmark study carried out in London called TAPS, Team for the Assessment of Psychiatric Services.

Slide 5

So deinstitutionalisation can be captured by two pictures. One is at Colney Hatch asylum. Remember where the Mental Aftercare Association was born, which later after various name changes became Friern Barnet hospital. It opened in 1851, and at its maximum it had 3,500 residents about. It boasted the longest hospital corridor in Europe, and it was sold off in 1993 to a luxury housing developer, and it's now Princess Park Manor. So the imposing gates which used to keep the inmates in now keep the hoi polloi of North London out.

Slide 6

Defining deinstitutionalisation: it's a process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with mental disorder or developmental disability, and it works in two ways. The first focuses on reducing the population size of mental institutions by releasing patients, shortening stays, reducing both admissions and readmission rates, and the second is a focus on reforming the mental hospital's institutional processes so as to reduce or eliminate reinforcement of dependency, hopelessness, learned helplessness, and other maladaptive behaviours.

How do I know this? I know this because Wikipedia tells me so, and actually that's quite a good definition; and importantly, it reminds me that deinstitutionalisation is a phenomenon that is also relevant to what it calls developmental disorder. So the mental illness hospitals closed, but actually first came the closure of the large mental handicap hospitals.

Transcripts by 3Playmedia

Slide 7

So this definition has two elements-- running down the hospital by improving throughput, and improving practice within the psychiatric hospitals, and the preamble implies a third element: developing community-based alternative services.

Slide 8

Deinstitutionalisation is not without its critics. So here we have a critical view from within psychiatry from a book by E. Fuller Torrey called Out of the Shadows: Confronting America's Mental Illness Crisis:

'Thus deinstitutionalisation has helped create the mental illness crisis by discharging people from public psychiatric hospitals without ensuring that they receive the medication and rehabilitation services necessary for them to live successfully in the community. Deinstitutionalisation further exacerbated the situation, because once the public psychiatric beds had been closed, they were not available for people who later became mentally ill, and the situation continues up to the present.' That's 1997. 'Consequently, approximately 2.2 million severely mentally ill people do not receive any psychiatric treatment'.

Slide 9

Fuller Torrey goes on to say, 'For a substantial minority, however, deinstitutionalisation has been a psychiatric Titanic. Their lives are virtually devoid of dignity or integrity of body, mind, and spirit. Self-determination often means merely that the person has a choice of soup kitchens. The least restrictive setting frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies.'

Now Fuller Torrey of course, is writing from the perspective of the United States of America, which is a completely different health and social care system where deinstitutionalisation, although it started at the same time, proceeded much faster and further than the United Kingdom.

Slide 10

Now there's an allied phenomena to deinstitutionalisation I mentioned, transinstitutionalisation, and this is described as 'a process whereby individuals supposedly deinstitutionalised as a result of community care policies in practice end up in different institutions rather than their own homes. For example, the mentally ill who are discharged from, or no longer admitted to, mental hospitals are frequently found in prisons, boarding houses, nursing homes, and homes for the elderly'. That comes from Addiction in Sociology by Marshall published in 1998.

Slide 11

We see that in practice, in papers relating to the NHS; such as the NHS, the private sector, and the virtual asylum, documenting that process of substituting inpatient beds for other forms of care and support and perhaps sometimes no support at all. And similarly, the European-wide paper by Stefan Priebe and collegues-- Reinstitutionalization in Mental Health Care: Comparison of Data on Service Provision from Six European Countries.

Slide 12

Now Fuller Torrey was a critic from right within the mainstream of psychiatry. Under Scull, who I've mentioned before, is a critic from a very different perspective, a sociological historical perspective, and in his book Decarceration, first published in 1977, (republished in 1984), he provides a complex polemic involving the motivation to close mental hospitals, which he states were to save money, to shift costs from one budget leading to another, to encourage private sector for-profit providers - nothing there you'll see about for the good of people - and he writes,

‘Evidence of benefits to deinstitutionalised psychiatric patients, especially those hospitalised over long periods, is not to be found anywhere in the psychiatric literature.’

Slide 13

Actually, he’s wrong. We know that now. We know after the TAPS and other studies of deinstitutionalisation in England that people actually improve in good quality community settings, and deinstitutionalised hospital setting replacements as well.

Slide 14

Approaches to deinstitutionalisation: we got Fuller Torrey saying deinstitutionalisation has resulted in people getting no care at all, both those discharged from the closing mental hospitals and those newly presenting with severe mental illness. Marshall says that deinstitutionalisation is a fiction-- what changed was the location of people’s institutionalisation. Scull goes a bit further and says that deinstitutionalisation is a conspiracy. There is, however, a more optimistic view in that more people are now living successful lives out of hospital following a diagnosis of severe mental illness, and receiving appropriate treatment and community support.

Slide 15

What happened, why and how?

Slide 16

Well, the ‘what’ in a sense is quite clear. So I’ve already mentioned this long term fairly steady decline in bed numbers that we’ve seen in England from 1952 onwards.

Slide 17

In the USA and England, the mental hospitals first of all got smaller. There was an expansion of psychiatric units in general hospitals, and later the development into free standing new small psychiatric hospitals, and then the large mental hospitals began to close.

Slide 18

When you’re looking at the data, you’ve got to take reported bed numbers with a pinch of salt- - even England and Wales, which is well-documented. Many accounts look at official data very uncritically. So even now if you look at NHS bed data from official returns, KH03 return, that actually ignores NHS-funded private sector beds, about 4,000 in 2016. There’s a very substantial gap from the stated numbers.

There’s undoubtedly been a steady reduction in bed numbers since 1954 in the face of a rising population, and a recently upturn in a graph I did is actually an artefact of mine, in now including purchased private sector beds in the total bed numbers.

Slide 19

Now the international trends are very clear and very similar, although the time courses vary. So across Europe, all European countries have now less beds than they had in the 1970s.

Slide 20

The UK started particularly high and ended up particularly low. The detailed story of Europe’s mental health services is extremely complex, as it is across the world, and we have worldwide

data from this thing called Project Atlas undertaken by the World Health Organisation. That shows us that the UK deinstitutionalised more aggressively than most other high-income countries. So a six-fold reduction to 2004 from 1954, and a nine-fold reduction to 2015.

Slide 21

If you look at high-income countries, the mean bed numbers are about 75 per 100,000 population. In the UK in 2004, there were 58 per 100,000. And now including purchased beds, we have 42 per 100,000, which is low in international comparisons. There are some countries that are equally as low, but not proud to say that many.

Slide 24

The time series data shows that the bed number decline continues, and even at the time of low bed numbers.

Slide 25

So what's the story? Internationally, peak bed numbers were reached at different times from the end of the 1940s onwards. All advanced countries had begun the process of deinstitutionalisation by the 1970s, except Japan, which is a very interesting cultural exception where it's continued to grow beds.

There's a marked variance in the rate and extent of deinstitutionalisation in England, Australia, New Zealand, in the forefront. There's also a particularly interesting and well-documented Italian experience which is based on a radical movement purported to close all psychiatric institutions from 1978.

Slide 26

So we know what happened, but what about the why? Well, that's quite complex and contested.