

Editorial

Institutionalization revisited – with and without walls

The rise of psychiatry as a medical speciality was closely linked with the establishment of asylums. The conditions in most of these asylums deteriorated significantly over time. As a result, a large number of mentally ill patients spent their life in ‘total institutions’ under conditions that were not compatible with basic human rights (1). Since the 1950s, de-institutionalization led to the closure or downsizing of asylums and formerly long-term hospitalized patients were discharged. Thus, people with chronic illnesses nowadays live in the community, although often in deprived and socially disadvantaged areas – as the paper by Lögdberg et al. in this issue demonstrates for schizophrenia patients in Malmö (2).

However, we may have already entered a new era of mental health care: re-institutionalization. Like de-institutionalization, this new process is an international phenomenon (3). It is characterized by increasing numbers of forensic beds, legislative initiatives to facilitate involuntary treatment in the community, and a large – and still increasing – number of places in residential care and supported housing. As a result, many patients end up in conventional institutions again. These institutions, i.e. hospitals and residential care facilities, are defined by bricks and mortar.

Institutions, however, do not necessarily have walls. There are new services in the community that may be seen as part of de-institutionalized care, but can still display aspects of institutionalization. For example, teams for assertive outreach aim – with the best intentions – to provide treatment to people who do not seek it themselves and engage them in a close relationship with services. Over time these also can develop phenomena of institutionalization such as forms of persistently bizarre interactional behaviour between staff and patients (4, 5). A leader of one of the first assertive outreach teams in England called his service a ‘ward in the community’.

As with former asylums, the discharge of patients is often resisted with staff being convinced that patients cannot live without their service. Such

services in the community often provide an alternative ‘institutionalized’ environment, and are less geared towards integrating patients into independent living and regular employment.

For patients who can actively seek treatment and pay for it, there is more choice of treatment options than there has ever been, and these treatments may or may not be provided in institutions – for which as yet there is no universally agreed definition. The critical issues concern patients who do not always actively seek treatment and who are – at least potentially – harmful or annoying to the public. In many Western societies they appear to be increasingly subjected to the forms of institutionalization outlined above.

There are a number of concerns with this: first, some of the new services are very expensive. Secondly, there is arguably little research evidence demonstrating the effectiveness of institutionalized forms of care, and often patients are referred to these services, not for specific therapeutic input, but because clinicians do not know what else to do. Thirdly, the standards in the new services can be low. For example, when former hospital wards were – as it happened in parts of Germany and Italy – turned into residential care facilities, the quality standards monitored by health authorities were lowered, and patients received poorer care than before. Some chronic patients in residential care live in poor and deteriorating conditions (6), and their care might – just as in the era before de-institutionalization – raise ethical concerns. Fourthly, these services can make patients dependent and prevent rather than promote further autonomy. For instance, sheltered employment schemes have been shown to maintain patients in their institution, but not re-integrate many into regular employment (7). Fifthly, the relative neglect of patients with chronic and severe mental illnesses has been reflected by a diminished attractiveness of jobs in mental health care in general and in services for patients with severe mental illness in particular. Many European countries struggle to recruit and retain qualified staff, and the poor and stigmatizing treatment of a large group of the clientele does not

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make the speciality psychiatry particularly appealing.

Amongst the drivers for new institutions are provider organizations. Private providers have an obvious profit motive in more services. So-called 'voluntary' organizations also have an interest to secure the jobs of their employees, the influence of the organization and the status of their leader. Even in statutory provider organizations there is a tendency to pursue capital development and professional expansionism, so that they often propagate the provision of more rather than less institutionalized care.

Whilst mental health professionals may generate income and status from working in institutions, patients have been found to prefer forms of care that provide as much autonomy as possible. Will user movements drive to overcome institutionalization? There is a risk that current policies in this area, e.g. for user representation in committees, will mean that chronic patients lose us out again, because they are less vocal, less skilled in communication and less assertive in social contacts than those who typically act as user representatives. So far, user involvement and user empowerment – however defined – have not yet led to a significant shift in policies on institutionalized care.

There is currently little public or professional debate on future visions for mental health care, no coherent spirit of reform, and hardly any political momentum to drive the mental health care agenda forward. What can be done by mental health professionals in such a situation? Professional groups can proactively seek a debate on the ethical foundation and values for mental health care. They might refocus professional attention on the fate of patients with chronic illnesses, and emphasize the social inclusion of their patients into 'normal' environments.

This short editorial has inevitably over-simplified the issues. It has also been based more on personal impression and anecdotal evidence than systematic research. This reflects the relative dearth of such research on institutionalization. Specific research in this area should provide more precise

data on institutionalized care and investigate how life for the patients concerned might be improved. It probably requires new concepts and methods, but above all an interest in the issue of both research groups and research fund providers (8).

Professional mental health care is probably impossible to conceive without institutions. Whatever the reasons for new forms of institutionalization, important questions remain. How do these institutions contribute to the social inclusion of patients? Can they help to maintain the autonomy of patients with severe disabilities? Do they provide beneficial care even for the most vulnerable and least assertive group of patients? The answers to these questions are central to the future of mental health care, because people with severe and chronic mental illnesses are at the heart of our specialty.

Acta Psychiatrica Scandinavica
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