

# Deinstitutionalization in Mental Health Policy: from Institutional-Based to Community- Based Mental Healthcare Services

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## ABSTRACT

*In the 19th and early 20th century, psychiatric hospitals served as the main institution of mental healthcare for individuals with severe mental illness as well as a care center for the homeless and needy population. On the other hand, provision of mental health services has been transformed from the institutional-based services to the community-based services as a result of deinstitutionalization movement in the policy of mental health. The term of deinstitutionalization in mental health policy can be defined essentially as that the closing down and downsizing of large psychiatric hospitals and the introduction of smaller mental health care centers within the community. As well as in the most of the Western European countries including Germany, France, and the United Kingdom, the scope of psychiatric hospitals has been restricted in the United States and other Western countries i.e. Italy and Spain since the 1960s. On this regard, today, the type of mental healthcare provision can be divided into two sections; inpatient & residential care and outpatient care. While the inpatient & residential care includes mental hospitals, psychiatric wards, and community-based residential care facilities, outpatient care involves hospital outpatient departments, mental health outpatient clinics, community mental health centers (CMHC) including day-care treatment centers. In this paper, the main focus is about different ways of deinstitutionalization in three selected countries; in the United States, in the United Kingdom, and in Italy, respectively. In this point, what are different ways of deinstitutionalization in mental healthcare provision constitutes my core research question in this article.*

**Keywords:** Deinstitutionalization, psychiatric hospitals, mental health policy, community-based mental health, mental healthcare service provision

## Ruh Sağlığı Politikasında Kurumsuzlaştırma: Kurum Temelli Hizmetlerden Toplum Temelli Ruh Sağlığı Hizmetlerine Geçiş

### ÖZ

*19. yüzyıl ve 20. yüzyılın başlarında, akıl hastaneleri ağır ruhsal hastalığı olan bireylerin yanı sıra, evsiz ve muhtaç nüfus için bir bakım merkezi olarak, temel sağlık hizmeti kuruluşu olarak hizmet etmiştir. Öte yandan, ruh sağlığı hizmetlerinin sağlanması, kurumsal temelli hizmetlerden, toplum temelli hizmetlere, ruh sağlığı politikasındaki kurumsuzlaştırma hareketinin bir sonucu olarak dönüşüme uğramıştır. Ruh sağlığı politikasında kurumlaşmanın sona ermesi terimi, büyük psikiyatri hastanelerinin kapatılması ve küçültülmesi ve yerine toplum içinde daha küçük ruh sağlığı merkezlerinin açılması olarak tanımlanabilir. Almanya, Fransa ve Birleşik Krallık dâhil Batı Avrupa ülkelerinin çoğunda olduğu gibi, psikiyatri hastanelerinin kapsamı Amerika Birleşik Devletleri'nde ve diğer Batı ülkelerinde, yani 1960'lardan beri İtalya ve İspanya'da da kısıtlanmıştır. Bu bağlamda, bugün, ruh sağlığı hizmeti sunumu yatışlı ve ayaktan tedavi olarak iki bölüme ayrılabilir. Yatışlı hasta bakımı akıl hastaneleri, psikiyatri klinikleri ve toplum temelli yatılı bakım tesislerini içerirken, ayaktan tedavi, hastanede ayaktan tedavi verilen bölümleri, ruh sağlığı polikliniklerini, günlük tedavi merkezlerini de içeren toplum ruh sağlığı merkezlerini (TRSM) kapsamaktadır. Bu makalede, ana odak olarak seçilmiş üç ülkede, Amerika Birleşik Devletleri, İngiltere ve İtalya, uygulanan kurumsuzlaştırmanın farklı yollarıyla ilgilidir. Bu noktada, ruh sağlığı hizmet sunumunda*

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*kurumsuzlaştırmanın farklı yolları nelerdir sorusu bu makaledeki temel araştırma sorusunu oluşturmaktadır.*

**Anahtar Kelimeler:** Kurumsuzlaştırma, psikiyatri hastaneleri, ruh sağlığı politikası, toplum temelli ruh sağlığı, ruh sağlığı hizmet sunumu

## I. INTRODUCTION

### a) What is deinstitutionalization of mental health care provision?

With the advancement of medical science, the understanding of mental illness has changed and the capability of medical treatments for severe mental illnesses has been improved. Running parallel to the medical science, the concept of mental health has transformed from the absence of mental illness to the state of well-being of every individual. As a holistic view, World Health Organization (WHO) defined the term of health as follows “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1946). In this regard, it can be indicated mental health requires a sum of cognitive, social and emotional skills with a balanced relationship network of an individual. On the other hand, the category of mental illness has composed of about 200 forms of mental illness and their scopes and effects have shown up differently in every single patient. Some of them are anxiety disorders, autism spectrum disorder, bipolar disorder, borderline personality disorder, major (clinical) depression, obsessive-compulsive disorder, and schizophrenia. In addition to these, sleep-related problems and Alzheimer's disease are also classified within mental illnesses, because it has been considered that they are related to the brain.

Over the last two decades, the provision of medical treatment and care for individuals with mental illness has evolved from large asylums in cities to smaller community-based mental healthcare centers in those cities as well as in towns. In terms of historical background, in the 19th century, there was a construction movement in mostly outside of industrialized cities for patients with severe mental illnesses; the emergence of modern psychiatry had linked closely with the idea of isolated and large asylums in that sense. The effect of social welfare movement has been referred as one of the core reasons in the establishment of large asylums, because of the increase in the role of states to provide ‘care’ for those mentally ill persons in a society. In addition to social welfare movement, with increases in urbanization and internal migration, the level of protection and care of families in both urban and rural areas had decreased and the need for an institution to provide accommodation, nutrition and basic care for individuals who were chronically mentally ill and/or needy (Fakhoury, Priebe 2007). When it comes to the first quarter of 20th century, both the size and number of asylums within borders of cities continued to rise inevitably; however, financial resources of those asylums had been reduced because of destructive wars and other economic difficulties. Gradually, the term of asylum was notable with unethical medical treatments, lack of hygiene and unsanitary living conditions as well as overcrowding and malnutrition. In connection with other developments and transformations in the medical world over the last fifty years, the understanding towards mental illnesses has changed. These internal changes within contemporary psychiatry were not only about the advancement of medical researchers, therapies, and treatments but also; they were related to institutional transformation in the provision of mental healthcare services. Apart from internal changes, there were other factors in which led to deinstitutionalization of mental healthcare provision. They can be summarized under three headlines; the role of civil rights movement, the effect of ‘chlorpromazine’ as an effective antipsychotic drug and lastly, the increase of costs of individuals with mental illnesses for their accommodation, nutrition, and care. In this point, the notion of ‘psychiatric reforms’ has been based on the need for

change in traditional-institution based psychiatric care and, by the contribution of World Health Organization (WHO), this idea was adopted as an international consensus in the world. These reforms began in the United States and England in the 1950s, and they have expanded within Scandinavian countries, and Continental and Southern Europe from that time (Novella 2008). Nowadays, this movement has been supported by World Health Organization (WHO) and the European Union (EU) (WHO 2003; 2005; EU 2015). In the reports of WHO, it has emphasized that “Mental health care should be provided through general health services and community settings. Large and centralized psychiatric institutions need to be replaced by other more appropriate mental health services.” (WHO 2003).

The above-mentioned transformation from institution-based mental health services to community-based one can be summarized as the closing down and downsizing of psychiatric hospitals and the introduction of smaller mental health care centres within the community; its process is termed as deinstitutionalization (Fakhoury, Priebe 2007; Chow, Priebe 2013). Bachrach (1976) highlights two principles that are important to the deinstitutionalization movement: the first one is abstention from the use of traditional institutions for the care of the mentally ill, and concurrent expansion of community –based mental health care facilities for them. In addition to them, according to Brown (1975), deinstitutionalization is basically about the prevention of inappropriate admissions to mental hospitals. On the other hand, deinstitutionalization is also defined as a protest movement which has polemical and empirical critiques of mental hospitals (Bennet, Morris 1983). In this point, three essential components of this process are ranked as 1) the reduction of inappropriate mental hospital admissions, 2) the change of place in the provision of mental health care, and 3) the introduction of community care.

Today, the movement of deinstitutionalization have resulted in long-termed changes in service provision of mental healthcare. The health systems in the United States, Canada, Western and Southern Europe as well as the United Kingdom and Scandinavia have adopted the community-based mental healthcare system in provision with different levels. Individuals with severe mental illnesses have been moved from isolated mental hospitals to supported houses, community-based residential facilities and nursing homes.

On the other hand, there have been so critical reviews of outcomes of deinstitutionalization movement. It has been argued that this trend led to major gaps in existing service provision for chronically mentally ill and this gap have been filled by non-traditional institutions including private institutions, nursing homes, day-care centers and community-based residential facilities (Hudson, Cox 1991). In this regard, the most critical review is focused on the inadequacy of a number of community-based mental healthcare centers and its results across countries. The other counter-arguments related with deinstitutionalization can be summarized in four main headlines as follows inadequate preparation before discharge from mental hospitals, suggested increased rates of homicide, insufficient levels of care and medical treatment for especially some group of patients, insufficiency of social integration as well as the criminalization of the mentally ill (Barbato 1998; Fakhoury, Priebe 2007). Especially in the United States’ context, the discussion of homelessness problem has been carried out with focusing on deinstitutionalization movement. Opponents of deinstitutionalization in the United States have argued that there is a growing rate of homeless population and proportion of chronically mentally ill within this rate has also increased. The rate for having psychiatric symptoms and taking psychiatric treatments among homelessness population in the United States have raised apparently, after closure and downsizing of mental hospitals (Ostrow 1989; Rochefort 1997). In other respects, the Italian deinstitutionalization reform has been criticized because of the family burden. Based on the statistical data of the Italian reform, the percentage of returning to

families among patients with mental disorders has reached to 70% in especially the Southern part of Italy and patients' families have indicated that they had to leave their work or change their living standards in order to cope with their patients (EU 2015).

## **II. MENTAL HEALTHCARE PROVISION IN THE UNITED STATES**

The period of Kennedy administration has been described as a sum of unfilled promises in national policymaking by the most of historians and political scientists (Rochefort 1997). The Community Mental Health Centers Act of 1963, announced by President Kennedy on October 31, 1963, has been accepted as one of the milestones in both mental health policies within the state and the history of American psychiatry. Before that, in the first decade of 20th century, the movement of mental hygiene and the child guidance had influenced over preventing mental illness through the application of psychiatry as well as psychology in the United States. The mental hygiene movement was based on providing a science-based and qualified mental health treatment to individuals with mental illness. With the National Mental Health Law of the 79th Congress in 1946, there were provided a generous financial support to both research and education studies for mental health and mental illnesses and the responsibility of the National Institute of Mental Health in providing mental healthcare and treatment was declared. The mission of the mental hygiene movement had finished with the organization of mental healthcare services under the state control (Kriegman et al. 1975). The National Mental Health Act of 1946 and the Mental Health Study Act of 1955 can be given as two pioneers for federal intervention in the mental healthcare. In this regard, the act for community-based mental healthcare centers can be seen as a result of these developments since the World War I and, this act resulted with a dramatic reduction in the number of chronically mentally ill (Hudson, Cox 1991). A number of major changes in the existing understanding of mental illnesses have played a role in this transformation in the provision and they can be divided into two sections as professional dynamics and social and intellectual bath background. The destructive effect of World War II, the concept of community as a more humanitarian approach and the civil rights movements with debating involuntary admission constituted non-professional dynamics behind deinstitutionalization of mental healthcare services. On the other hand, the spreading critical reviews about mental health hospitals as well as unethical medical treatments, the developments in antipsychotic drugs and rising in epidemiological studies within medical science can be given as triggering causes for new beliefs related with the social aspects of mental illness within the world of American psychiatry (Rochefort 1997). In this era, the conservative structure of clinical psychiatry came under criticism from a branch of the American Psychiatric Association; they were mentioned as "the Group for the Advancement of Psychiatry". This opposition movement had questioned the boundary of existing treatments for curing mental illnesses and they defended a cumulative and coherent working principle within the provision of mental healthcare services. It means the increasing role of psychiatric nurses, social workers, the clinical psychologist and later, therapists. Obviously, these critics coming from professionals in the medicine world were serious and respectful in the eyes of society and, both the levels of information and the context of public opinion about mental illnesses had changed, dramatically. After this community-based local centers act, the term of deinstitutionalization has been used to describe the limitation of large-isolated asylums and increasing in the number of mental healthcare centers in both cities and towns. The emergence of psychoanalysis in the 1910s and 1920s and the introduction of psychotropic drugs in the 1950s came before the deinstitutionalization trend and in this context; they have led to the introduction of deinstitutionalization idea as the third great revolution of contemporary psychiatry in the 1960s (Rubins 1971).

Right after the assassination of President Kennedy on November 22, 1963, the political agenda of the United States changed immediately, however, the maintenance of Democratic

Party government after the 1964 election and the effective political leadership of Lyndon B. Johnson as a new President paved the way for a sustainable ground for domestic reforms during the 1960s. Actually, President Kennedy's plan was based on "50 percent reduction"; he launched that "it will be possible within a decade or two to reduce the number of patients now under custodial care by 50% or more" (Kennedy 1963). When it came to 1975, this number was surpassed, strikingly; the number of inpatient individuals with chronically mentally ill had declined more than 50 percent and this rate reached to almost 62 percent reduction from Kennedy's speech (Rochefort 1997). According to the statistical databases for resident patients and state and country mental hospitals in the national level, the total number of inpatients fell from 512,501 to 101,402 in between 1950 and 1989; and, the number of inpatient episodes of mental hospitals decreased from 818,832 in 1955 to 459,374 in 1985. Also, from 1969 to 1982, the average days for inpatient treatment declined from 421 days to 143 days (Rochefort 1997). These reductions in the various indicators of state mental hospitals have provided us a meaningful insight to understand the effect of deinstitutionalization trend as a single most important issue in mental healthcare service provision. After enacting the introduction of the national community-based mental health policy in 1963, the state guaranteed a financial support to federals during first three years in order to construct a network for community-based mental healthcare centers in the whole state. Under the administration of the National Institute of Mental Health (NIMH), the structure of this network for local service and community was based on the principle of the catchment area; this catchment area pointed out space which had no fewer than 75,000 people and no more than 200,000 people (Beigel, Levenson 1972). Its area included smaller mental healthcare facilities as well as a group of mental healthcare professionals and, there was a federal support for costs of staffing in these facilities. In time, the first draft of J. F. Kennedy's administration was expanded and prospered in other cases; for example, there were opened various supportive day treatment facilities under the law of the Alcoholic and Narcotic Addiction Rehabilitation in 1968. On the other hand, there are variations in the trend of deinstitutionalization with taking into account no uniformity in federal states; the rate of decreasing in inpatient was stated as 4.2% and 11.3% for 1955-1960 and 1960-1965, respectively. In the time period of 1970-75 and 1975-80, this number reached to 42.7% and 31.7% (Rochefort 1997). In this regard, there are two essential breakpoint of deinstitutionalization trend; one of them was the "benign" phase (1956-1965) and the "radical" phase (1966-1975) constituted the second era. Especially, within the radical one, the state mechanism appealed to the idea of "closing of the front door" because of economic hardship and, while the closure of state mental hospitals was quickened, the amount of federal support to community mental healthcare services was reduced in different ways from the mid-1970s (Rochefort 1997).

Today, with the depopulation of state mental hospitals and the introduction of community-based mental healthcare centers as a heart of deinstitutionalization trend, the service provision of medical treatment and care for chronically mentally ill has been transferred to non-traditional institutions, gradually. In the United States, there has been established so many private mental hospitals, new psychiatric wards among general hospitals and special psychiatric units in place of former mental hospitals and clinics from the 1970s. Apart from short-term hospitals, community-based centers, board-and-care homes, and halfway houses for chronically mentally ill persons, the nursing homes have served as a significant facility in provision of treatment and care for many elderly patients with severe mental illness including dementia and Alzheimer (Rochefort 1997).

### **III. DEINSTITUTIONALIZATION IN THE UNITED KINGDOM: THE ROLE OF COMMUNITY-CARE MODELS**

For the United Kingdom's context, the transition from hospital-based to community-based service provision resembled to the process in the United States. In the period from 1930s to the mid-1950s, there were two reasons for this transition in the mental healthcare service provision; first of all, the number of first admissions to mental hospitals had increased because of the changing nature of understanding of mental illness in public opinion. There were advancements in the medical treatment of mental illnesses and the branch of psychiatry had approached with the general medical science. Mental health hospitals began to be perceived as a place for curing of mental disorders in the public eyes. Secondly, the changing nature of rural family because of internal migration, wars and industrialization caused to need for professional treatment and care outside families. In this point, mental health hospitals served as a suitable place for meeting basic needs of patients with mental disorders during this first period (Bennett, Morris 1983). After the completion of the first transition, there was a growing tendency towards involuntary admissions for long-termed treatments and poor conditions in mental hospitals and the Mental Health Act of 1959 was introduced in order to answer the problem of involuntary admissions as well as poor standards of living conditions (EU 2015). With taking into account the effect of new medical drugs, the new approach to community-based treatment psychiatric disorders and the importance of families and society on treatment process, the service provision for mental illnesses had moved to outside asylums, gradually since the government policy of 1971. As government policy papers, in the "Hospital Services for the Mentally Ill (1971), and Better Services for the Mentally Ill (1975)" was focused on relocating of mental healthcare services in local level with establishing more qualified and sufficient healthcare teams (Department of Health 1971; 1975). Besides, the service provision for mentally ill has based on the principle of shared-working in between the local authority and the National Health Service. Organized by these policy papers, the assigned position of social services of local authorities has been expanded and these social services began to provide residential places for individuals with mental disorders alongside daycare and social work. It is seen that the role of local authorities in deinstitutionalization of mental healthcare provision is more important than the United States and Italy. Alongside these papers on community-based mental health service provision, the problem of housing for people with mental disorders was handled with the National Health Service and Community Care Act in 1990. As a way of deinstitutionalization, the specialized- supported housing and hospital hostel was constructed by health and social services, voluntary organizations as well as housing associations. On the other hand, there has increased the role of private service provision which have provided to housing and care for long-termed mentally ill (Killaspy 2006). These patients have been known as the 'new long stays' in these 'virtual asylums' and their medical treatment have been maintained by private institutions like in the Italian case. On the other hand, this term of virtual asylums has triggered to debate that whether or not this process is a form of- institutionalization' trend for the United Kingdom's case (Curtis et al. 2009; Priebe et al. 2005; Thornicroft et al. 2013).

As a distinctive feature of the British mental healthcare system, the term of community mental health nursing (CMHN) is based on the principle of working within a multidisciplinary team and working in the local settings rather than mental health hospitals. A community mental health nurse must maintain his/her work-flow with collaborating psychiatrists, psychologists, general physicians in the primary healthcare level, social workers and paid or non-paid nursing staff as well as patients' families. At the end of 1980, the term of community mental health teams (CMHTs) has been begun to use in order to state a partnership in between psychiatrists, psychologists, and community mental health nurses, basically. Before that, the service provision for mentally ill in the community-level was

maintained under the strict control of psychiatrist by the nurses. According to Hannigan, the initial point for this concept can be dated in the years of 1954 and 1957 with the works of two nurses from Surrey and four nurses from Devon (Hannigan 1999). During nearly 10 years, the field of duty for nurses remained as visiting to patients' houses and families, however, the need for community mental health nursing increased with the changing of authorities of local services in the 1970. Despite the fact that the concept of community mental health team has been used in most the countries for providing mental healthcare services, the role of community mental health nursing developed earlier in the United Kingdom. From this time to onwards, both the number and power of community mental health nursing has increased and this concept became one of the cornerstone within the Britain mental healthcare service provision. Apart from the Italian case, there was no complete closure of mental health hospitals in the United Kingdom; the size of mental hospitals has decreased gradually, and the community mental healthcare centers has established as a transitional institution in between mental health hospitals and patients. In order to decline the number of admission to mental hospitals and the length of hospitalization of patients, case management, early intervention teams and assertive outreach community treatment (ACT) have been organized as a way of deinstitutionalization and as a part of community-based care models. Three of them are based on the principle of home-based care programmes and they have aimed to reduce inpatient bed use and long-termed medical treatment in hospitals.

#### **IV. ITALY; A HUMANISTIC APPROACH TO PSYCHIATRY WITH THE “BASAGLIA’S” LAW**

In the year of 1978, there had been launched a psychiatric reform (Law-180) which is called “Basaglia’s law” in Italy. Franco Basaglia was known as a radical psychiatrist alongside as a leader in the community-based mental healthcare movement under the association of *Psichiatria Democratica* in Italy. During his working life, Basaglia conducted director positions within two asylums in Gorizia and Trieste and he managed to carry out deinstitutionalisation of Trieste’s asylum during the 1970s against several difficulties. Before the deinstitutionalisation movement in Italy, the mental healthcare system was also based on large and isolated asylums and state-funded mental hospitals like the other parts of the world. The concept of medical treatment for mental disorders was related with long-termed inpatient care. In this regard, the transformation of mental healthcare system in Italy can be summarized in three periods; increasing in the number of residents, beds and admissions as well as the mean length of stay (from the mid-1950s to the mid-1960s), a little decreasing in the number of beds and residents, but not in the number of admissions (from the mid-1960s to the mid-1970s) and lastly, a sharp decline in the number of beds, residents alongside the mean length of stay in mental hospitals with the deinstitutionalization revolution (from the mid-1970s to nowadays) (Barbato 1998). This transformation had been quickened by the help of reformist ideas of Franco Basaglia. He defended his own thoughts over the condition of mental hospitals with these following sentences; “An enormous shell filled with bodies that cannot experience themselves and who sit there, waiting for someone to seize them and make them live as they see fit, that is as schizophrenics, manic-depressives, hysterics, finally transformed into things.” (Hughes, Lovell 1987). His reformist ideas about the need for new mental healthcare system have influenced over the introduction of Law – 180 and this law was based on four points; the total closure of Mental Hospitals (MHs), the introduction of General Hospital Psychiatric Units (GPUs), the increasing in procedures for compulsory admissions and the establishment of Community Mental Health Centres (CMHCs) in specified local areas, respectively (Girolamo et al. 2007).

After the Law-180 was enacted, all of the Mental Hospitals in Italy were closed and the total number of long-termed individuals with chronically mental disorders has been restricted

around 2.000 individuals. Apart from them, most of the elders and patients with acute psychiatric illness have been moved to community-based and smaller residential facilities like nursing homes, day-hospitals and day-care centers as well as acute inpatient facilities. There are three processes within Basaglia's reform and the meetings of "assemblies" in coordinating with psychiatrists, nurses and patients constitute the first one. In this case, the mission of assemblies was a provision of a free space for patients in order to explain their thoughts about many issues. Besides, the assemblies' method has been used by local communities and family members of patients as a way of deinstitutionalization. Basaglia as a medical doctor was aware of the importance of a qualified mental healthcare workforce for sustainability of service provision and there has been a new form of mental health worker as a second way of deinstitutionalization in his reform policy. As a main actor of community-based mental healthcare unit, the mental health worker team has composed of psychiatrist, psychiatric nurses and social workers; this mental healthcare team does not work not only in the mental healthcare centers or residents, but also work with the ex-patient and their family side by side. As a third way, together with the complete closure of mental hospitals and the establishment of community-based alternatives, Basaglia and his colleagues aimed to prepare the ex-patients for the adaptation of daily-life practices through community-based rehabilitation (EU 2015). These changes in service provision for patients with mental disorders have been performed with the organization of mental health services in the national level by the introduction of Law-833. Under the 21 regional governments, Departments of Mental Health (DMH) are responsible in administrating mental healthcare centers for both inpatient and outpatient care within their regions and the number of these departments are 211 for the whole country. By dividing each region into several local health units, the state would like to manage and coordinate these community-based centers in the topic of regulation, funding and provision. With taking into account inequalities within the Italian healthcare service provision due to mostly geographical and administrative reasons, the coordination of community-oriented models in mental healthcare service provision has been evaluated as successful for many parts of Italy. As a similarity with the United States and England, the transformation of the Italian mental healthcare system happened earlier than other European countries. The rate of reductions in admissions, beds and residents has resembled to the rate of the United States and England (Manderscheid et al. 2000; Glover et al. 2004). From the early 1970s to 1981, the number of inpatients in both public and private mental hospitals declined from around 75,000 residents to 38,000 (EU 2015). Today, the provision of mental healthcare services in Italy has been conducted in two main categories as inpatient and outpatient care. General Hospital Psychiatric Units, University Clinics, 24-h Community Mental Health Centres, Other Public Facilities, Private Psychiatric In-patient Facilities, and Non-Hospital Residential Facilities have composed the inpatient side. On the other hand, Community Mental Health Centres, Outpatient Facilities, Day-Hospitals and Day Centres have constituted the outpatient one. Today, the radical shifting of the Italian deinstitutionalization movement can be clearly seen in the number of psychiatric beds in Italy (0.26 per 10,000 population) (EU 2015). This number constitutes currently one of the low levels of psychiatric beds among the OECD countries, after Turkey and Mexico (OECD 2014). Besides, as the latest reform in the deinstitutionalization of mental healthcare services, the Law 81/2014 was launched to the complete closure of the six forensic psychiatric hospitals in Italy. After that reform, smaller community-based facilities for offenders with mental illness (Residenze per la Esecuzione Della Misura di Sicurezza, REMS) substituted the old-fashion forensic psychiatric hospitals (Casacchia et al. 2015).



## **V. DISCUSSION AND CONCLUSION**

Throughout 19th and early 20th century, mental health services have continued to evolve in three stages: the rise of asylums, the decline of these asylums and hospital-based mental health institutions and lastly, the reform of mental health services (Thorncroft, Tansella 1999; 2002; 2004). In these three periods, the center of gravity of mental health services has gradually changed from hospitals to community-based services and mental health hospitals served as the core institution of care for patients with severe mental illness (SMI) as well as homeless and needy populations. However, over the last three decades, provision of mental health services has transformed from the institutional-based services to the community-based services as a result of deinstitutionalization movement in the policy of mental health. The term of deinstitutionalization in mental health policy can be defined as that the closing down and downsizing of large psychiatric hospitals and the introduction of smaller mental health care centers in the community. In time, the mission of psychiatric hospitals had been transferred to these local centers which are entitled to the provision of mental health services i.e. prevention, diagnosis, and treatment services, respectively. The scope of psychiatric hospitals has been restricted in most of the Western countries including Germany, Italy, and Norway and other developed countries e.g. the United States, Canada, New Zealand and the United Kingdom since the 1950s.

“What are different ways of deinstitutionalization in mental healthcare provision?” is the main question in this research paper. The term of deinstitutionalization has been used in order to define “displacement” in mental healthcare services from residential-based to community-based service provision for chronically mentally ill. Under the light of provided background, by taking into account the Community Mental Health Act of 1963, it is accepted that deinstitutionalization movement began in the United States. This act was related to changing the financial resources for community-based mental health centers (CMHC) rather than large mental health hospitals and isolated asylums. After that, the United States’ mental healthcare service provision transformed towards community-based outpatient care with establishing of mental healthcare centers, nursing homes, residential facilities, mental healthcare teams, board and care homes as well as half-way houses. As additional mental healthcare services, intermediate community services (ICS), specialized outpatients / ambulatory clinics, assertive outreach community treatment (ACT) and early intervention teams are organized to provide medical therapy inside a patient house or community.

Over the last three decades, the provision of mental health services in the United Kingdom has also changed from hospital-based to community-based with decreasing number of admissions, patients, and beds in the mental health hospitals. Nevertheless, this transition does not include a total closure of mental hospitals, rather than, it is based on establishing new psychiatric wards within general hospitals, specialized-supported housing and hospital hostels for individuals with mental disorders. Like in the United States, the Britain mental healthcare service has some supportive organizations and some of them are community mental health nursing, community mental health care team for the districts and early intervention teams. The way of the United States and the United Kingdom can be evaluated the first one.

On the other hand, the Italian mental healthcare policy evolved from hospital-based inpatient care to community-based mental healthcare centers and residential facilities with a total closure of mental hospitals. As a second way of deinstitutionalization, Italy adopted a completely community-based mental healthcare system in place of hospital-based care, apart from the UK and the US. In the following years, this sharp transformation has caused to emerge inadequacy of psychiatric beds for patients who need to a long-termed inpatient care

alongside insufficiency of forensic beds for convicted mentally ill. In the Italian case, nursing homes, community-based residential facilities, acute inpatient care facilities, day-hospitals, and centers have been established to provide inpatient care to people with mental illnesses.

Consequently, the way of the United States and United Kingdom can be evaluated the first way of deinstitutionalization in the mental health policy; it has foreseen the provision of supported housing, the availability of forensic beds, and the limited number of involuntary admissions. As the second and more strong way of deinstitutionalization, the Italian mental health policy was transformed from hospital-based care to community-based one with a total closure of mental hospitals after Law 180 that was enacted in 1978. As a straighter dissolution policy in deinstitutionalization, Italy adopted a completely community-based mental health care system in place of hospital-based care, apart from the United Kingdom and the United States. Each specified geographical area, there were established community-based mental health care facilities with mental health workforce. Nursing homes, community-based residential facilities, acute inpatient care facilities, day-hospitals, and centers have been established to provide inpatient care to people with mental illnesses. As a similarity with the United States and England, the transformation of the Italian mental healthcare system happened earlier than other European countries.

In the following years, this sharp transformation of the Italian mental health system has caused the inadequacy of psychiatric beds for patients who need to a long-termed inpatient care alongside insufficiency of forensic beds for convicted mentally ill. The Italian case offers us that changes in the provision of mental health care services from hospitals to community care services can be implemented as rapidly and consistently. (Thornicroft, Bebbington 1989) On the other hand, the first way of deinstitutionalization in the United States and United Kingdom has caused a complicated debate in the literature; because it is termed as re-institutionalization or trans-institutionalization. (Fakhoury, Priebe 2007) It can be seen that deinstitutionalization of mental health care services has different alternatives. In recent times, there has been an ongoing debate in the literature between those who are supporters of the provision of mental health treatment and care in hospital-based settings and those who prefer to provide solely community-based mental health services. This change in mental health service provision arrangements has been experienced with different ways in countries and these two ways of deinstitutionalization are related to a country's socio-economic background and culture as well as a country's capabilities.

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