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SPECIAL ISSUE

Povl Munk-Jørgensen

Prologue

In this special issue of the European Archives of Psychiatry and Clinical Neuroscience the question: *Has deinstitutionalization gone too far?* is considered by means of examples from Austria, Denmark, England, Germany, Luxemburg, Spain, and Switzerland.

Through the last quarter of the 20th century deinstitutionalization has been on the top of the agenda in the western part of the world. The examples given show how broadly both the concept of deinstitutionalization can be used and how large the differences can be between even geographically and culturally closely related countries of Europe.

The discussion of a few more or less available beds has during the years become more varied. However, one is certain. Deinstitutionalization only by closing down psychiatric beds, today, would be regarded as near the line of the unethical, just as our current problems can hardly be solved by a mere reestablishment of the psychiatric beds. The examples described from Austria, Switzerland, Luxemburg, and Germany point out the danger of making transinstitutionalization instead of deinstitutionalization and consequently suggest, a bit provocatively, that more beds should be closed down. Though, it should be emphasized that this is not an invitation to politicians and managers to make budgetary improvements due to a closing down but to establish the units, institutions, sheltered workplaces, housing, and other services that form true deinstitutionalized and decentralized psychiatry. When using the term *deinstitutionalization*, one normally refers to the long-term care of the socially disabled mental patients and to a lesser degree the short-term treatment of acute mental disorders.

The question of accessibility of sufficient resources is supported by the English example which points out that different local areas should be provided with the necessary hospital beds and other services needed such as the necessary and sufficiently educated staff, self-evident but not always political understood and implemented. The English contribution also includes the discussion about costs. A well-functioning decentralized psychiatry is, if sufficiently established, at many occasions cheaper than institutionalized psychiatry, especially as to expenses for first ever contact patients.

It is, however, emphasized that no decentralized psychiatric functions without a sufficient number of available psychiatric beds. It is necessary to keep in mind that the severe mental diseases are diseases of the brain, neuropsychiatric diseases, that cannot be cured and certainly not be prevented by a deinstitutionalized psychiatric effort not even with an offer of optimal social conditions. Mental diseases demand examination, treatment, and research in a medical-based psychiatry.

The development in psychiatry and especially in the organization of psychiatry during the last 30 years has had strong political factors. This has most clearly found expression in the Spanish example in which the process of deinstitutionalization is described as an integrated part of the general political changes in Spain. The principle of decentralization which has not only taken place in psychiatry is emphasized by the authors of the Spanish example who point out the heterogenity alongside a decentralization also of the political regulation of the psychiatry. Furthermore, this example clearly shows what must not be forgotten in our concern about the negative factors by decentralization, namely the necessity of the changes that were behind the process of deinstitutionalization and the enthusiasm the development has caused.

The Danish example shows that it is necessary to monitor the process of changes by a careful, nation-wide, and personidentifiable registration of the activities and their implications (Munk-Jørgensen and Mortensen 1997). In Denmark a list of negative indicators has been documented as, for instance, increasing suicide ratio among psychiatric patients, an increased number of criminal mentally ill, as well as increasing use of coercion in the

P. Munk-Jørgensen (✉)
Department of Psychiatric Demography,
Institute for Basic Psychiatric Research,
Psychiatric Hospital in Aarhus, DK-8240 Risskov, Denmark
Tel.: +45-8617-7777, ext. 2810, Fax: +45-8617-7455,
e-mail: pmj@psykiatri.aaa.dk

psychiatric departments, all problems that cannot be neglected and that probably are present in other countries where the principles of deinstitutionalization are followed – also if these countries are currently unable to monitor the process. Such data are seldom popular among the enthusiastic politicians, managers, and professionals who have devoted themselves to decentralization of the psychiatry; however, one must not neglect these problems if one wants to be able to face the basic ethical humanistic principles.

The English example predicts an ongoing decentralization of psychiatry towards primary care. This shows that no organization model is final. The process is continuous and the psychiatrists and not least politicians, organizers, and managers must be prepared for constant (cronical) changes.

Let us finally stress that the closing of psychiatric hospitals, reduction of beds, and discharge of chronically ill patients can only be regarded as recommendable steps of action if there are alternatives in community care of a higher or at least equal standard.

Improvements for the majority of mentally ill must be welcomed. However, if these improvements are at the expense of deteriorated conditions for some of the psychiatric patients, maybe even fatal for a few, Norman Sartorius's statement in a recent editorial in Acta Psychiatrica Scandinavica (Sartorius 1998) might become an embarrassing political current interest, "... in many of the so-called developed countries there are parts (or population groups) that in all respect resemble the countries of the developing world".

Politicians, managers, and professionals must support development in psychiatric care in such a way that it does not become vulgarized so that our successors will remember the present era in psychiatry as the *socialpsychiatric hiatus* in the same way as Edward Shorter (1997) coined the period around the Second World War as the psychoanalytic hiatus.

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