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SPECIAL ISSUE

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Deinstitutionalization and psychiatric reform in Spain

Abstract The transformation of psychiatric care which has been carried out in Spain since the 1980s, under the name of "Psychiatric Reform", had produced as it most significant achievements: (i) the development of a new organizational structure for mental health care, (ii) the integration of psychiatric patients in the general health care system, (iii) the creation of an extensive community network of mental health centers, and (iv) the adoption by the general public of more positive attitudes towards mental illness and its treatment and the passing of legislative measures aimed at improving the civil rights of these patients. However, the application of the Psychiatric Reform has followed an uneven course in Spain as a whole, with marked differences between the different autonomous communities. The main deficiency has been in the development of intermediate community services and programs to rehabilitate and resettle patients in the community. With regard to deinstitutionalization, the results have also been insufficient and it is still possible to observe a strong tendency, within the system, to maintain the old mental hospitals for both long-term and short-term illness care. Finally, the analysis of the Spanish experience has revealed that (i) many of the criticisms leveled at deinstitutionalization are not aimed at its "conceptual core" but stem from its inadequate implementation, and (ii) it is wrong to equate deinstitutionalization and psychiatric reform with closure of psychiatric hospitals, without the awareness that this process is far more complex.

Key words Psychiatric Reform · Deinstitutionalization · Psychiatric care · Planing Psychiatric Services

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Introduction

The processes of transformation of psychiatric care that have been promoted during the past few decades have given the concept of deinstitutionalization great importance, and this has led to the need to assess its utility within the framework of current psychiatric care (O'Driscoll 1993). However, it should first be pointed out that the meaning of this concept has over the years varied considerably before attaining its current sense. The new approach advocates, among other things, the need to shift psychiatric care from the mental hospital to the community, making mental health units the center of specialized intervention and promoting the participation of the psychiatric patient in society (Bachrach 1978). However, under the banner of deinstitutionalization, patients have often merely been discharged from mental hospitals without the provision of the alternative health care structure required to meet their social and health needs within the community. Moreover, even in countries that have undertaken the transformation of psychiatric care by applying the precepts of "deinstitutionalization", we can find that what in simplistic terms may be considered most emblematic of deinstitutionalization – i.e., the disappearance of the mental hospital – has still to be achieved.

In this setting, the process of transforming psychiatric care initiated in Spain in the 1980s under the label "Psychiatric Reform" has taken up the most ambitious postulates of "deinstitutionalization". The main goals are to bring about changes in the health care, in the social structures, and within the community itself that will guarantee patients with mental disorders the same attention and rights as other patients, and to prevent the marginalization of psychiatric patients. However, the Spanish Psychiatric Reform has an additional characteristic that gives it a very special profile. This is because the reform coincided with the "Democratic Transition" that took place in Spain in the 1970s and 1980s. This transition involved significant changes not only in the country's socio-political and administrative organization but also in the structure of its

health services. The process of transforming psychiatric care in Spain must, therefore, be interpreted in the context of these changes.

From the conceptual standpoint, the "Spanish Psychiatric Reform" incorporated the postulates of community psychiatry together with ideas derived from previous Spanish experience of psychiatric transformation. The conceptual bases of this reform can be summarized as follows: (i) to guarantee attention to mentally ill patients within the general network of health care and specifically in primary care services; (ii) to redefine the therapeutic meaning of psychiatric hospitalization, which lost its central role in psychiatric care, and was located in general hospitals; (iii) to provide adequate community services and social support to make it possible to rehabilitate and resettle psychiatric patients in society; (iv) to bring about changes in the community to prevent the marginalization of these patients; (v) to guarantee the civil rights of persons with mental disorders. With these postulates the future of mental hospitals acquired a new dimension, their closure was not the main aim of the reform, but rather was viewed as the consequence of the changes advocated in psychiatric care (Ministerio de Sanidad y Consumo 1985; García 1998).

Material used for the present analysis

For the analysis of the "Spanish Psychiatric Reform" we have used a wide range of documents that provide precise information up to 1996. After that, we have not been able to obtain reliable data on a nationwide scale. The main documents used could be classified as: i) theoretical publications and evaluation studies on the organization of psychiatric care in Spain; ii) legislative measures, reports, protocols for the organization and management of psychiatric care and annual reports on activities within the health care services from Spain's central government and from the autonomous communities.

Psychiatric care in spain before the psychiatric reform

Until the 1980s the health system in Spain was articulated around two main axes: (i) the "Compulsory National Health Insurance", which included the health services at the national level, covered most of the population, and provided care aimed exclusively at the treatment of disease; (ii) the health services dependent on other institutions, mainly local authorities. The two systems were not coordinated in any way and responsibility for health was divided among various ministerial departments. Within the general disgregation of the health services, psychiatric care was even more disperse and fragmented. These services were provided by (i) units belonging to local authorities (mainly regional governments and occasionally city councils), which usually provided hospital care; (ii) units dependent on the Social Security system, almost always on an outpatient basis; and (iii) an additional, but limited, number of outpatient units, which belonged to different institutions and organizations, mainly of national nature (see Table 1).

Table 1 Psychiatric hospitals. distribution and beds by administrative entity (source: Statistical Data on Psychiatric Centers for 1978, INE [National Statistics Institute] 1983)

Entity	Hospitals		Beds	
	No.	%	No.	%
Central administration	8	7.0	2,765	6.7
Local administration	39	34.2	23,778	57.6
Religious orders	20	17.5	8,537	20.7
Private institutions	47	41.2	6,181	14.9
Total	114	100	41,261	100

To understand the ideological climate in the psychiatric profession in Spain at the start of the "Psychiatric Reform", it is revealing to note the results of a survey conducted by Guimon and coworkers in 1978 on a representative sample of Spanish psychiatrists. The survey found that most psychiatrists considered the so-called "medical model" out-dated and that they were convinced of the validity of psychoanalysis and of the need for psychiatrists to make an active public stand over sociopolitical problems and to embark on a course that would transform mental care (Guimon et al. 1978). These attitudes differed from those obtained by the same author in a second survey conducted after the initiation of the Psychiatric Reform, which showed that psychiatrists advocated the medical-biological model of mental illness and were far less interested in the processes of transforming society (Guimon et al. 1987). At the same time, studies of the attitudes of the general public towards mental illness revealed the existence of a mentality loaded with prejudices, a tendency to favor restrictive practices in the management of the psychiatric patient and a clear rejection of treating these patients in general hospitals and in the community, a situation which again was modified after the start of the Reform (see for example: Ozamiz et al. 1981; Consejería de Salud y Servicios Sociales de a Junta de Andalucía 1988).

The implementation of the psychiatric reform in Spain

Preliminary phase and the start of the Psychiatric Reform

After 1980, but particularly between 1982 and 1985, a number of initiatives were taken both by the central government and by the autonomous communities. They established the foundations for the subsequent development of the Psychiatric Reform. One feature that was to mark the reform became clear from the very start: it would depend both on the central and the autonomous health care institutions (Fig. 1). Thus, during this period a few autonomous communities adopted legislative measures concerning mental health. These measures were, in general,

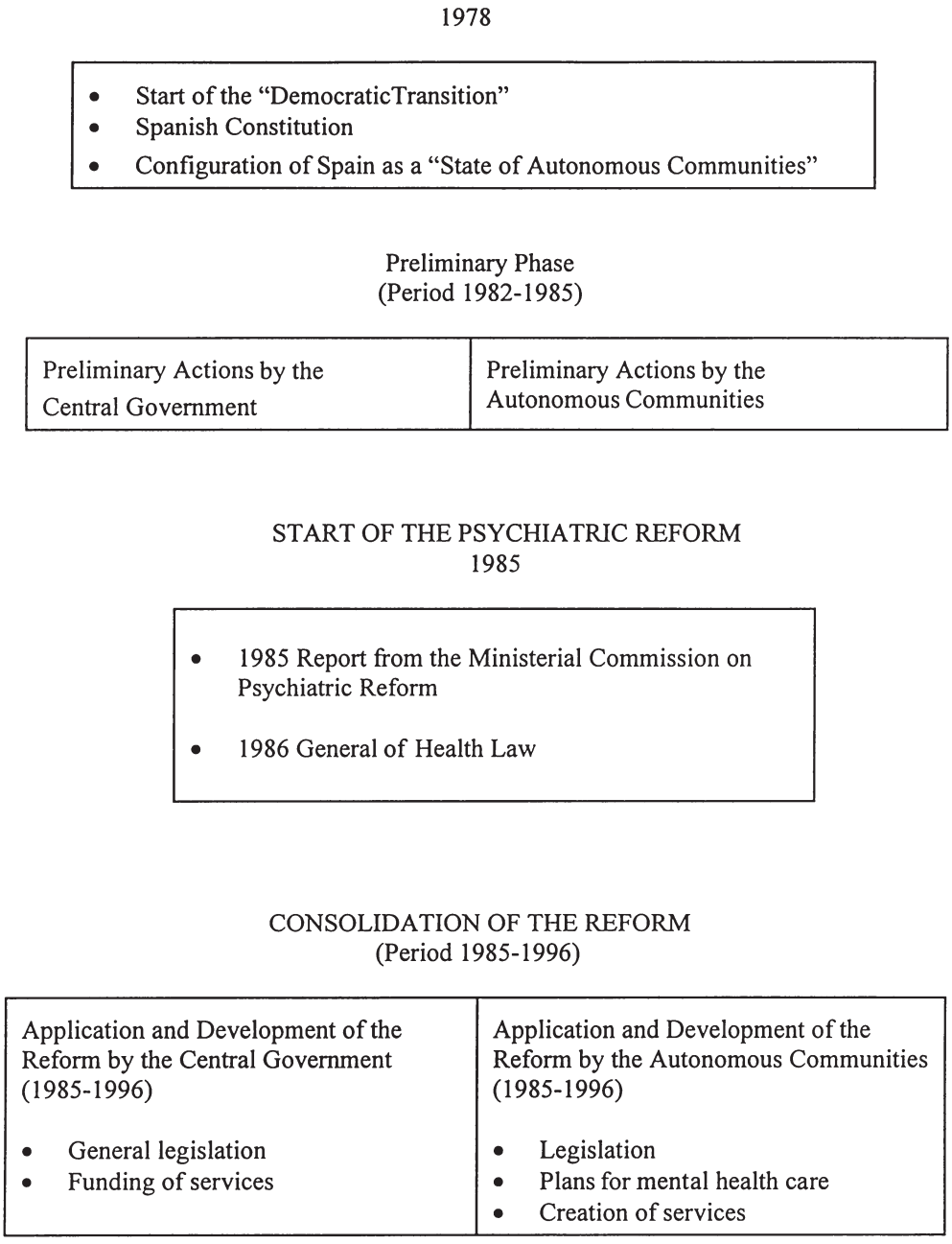

Fig. 1 The process of psychiatric reform in Spain

related to the elaboration of "Plans for Mental Health Care" and the development of organs to manage and coordinate psychiatric care. Among the legislative measures passed by the central government, during the same period, perhaps the most significant was the creation in 1983 of the Commission on Psychiatric Reform, which in April, 1985, published a report establishing the conceptual bases of the Reform (Ministerio de Sanidad y Consumo 1985). This report has become so important for the development of the processes that would transform psychiatric care in Spain that we have used it as the land-mark for the start of the Spanish Psychiatric Reform. A second legislative act that was essential for the implementation of the reform was the publication one year later, in 1986, of the "General Law of Health" in which the most important aspects of the previously mentioned report were included (Ministerio de Sanidad y Consumo 1987).

The consolidation phase of the psychiatric reform

The transfer, since the publication of the General Law of Health, of health care planing and management from the central administration to the autonomous communities has been a complex process and it has as yet not been fully achieved. Thus, there are still some communities where the health services depend on both authorities. Because of this mixed structure in which responsibilities for health care are shared by central and autonomous administrations, it is obvious that, as Fig. 1 describes, the con-

solidation of the Psychiatric Reform has been determined by measures adopted by both the central and autonomous governments.

The central government has contributed to the process of Psychiatric Reform in two basic types of action: i) actions of a normative and administrative nature aimed at promoting the progress of the reform and favoring the integration and homogenization of action at the autonomous level; ii) actions aimed at creating health services in those regions still governed by the central administration. The measures adopted by the autonomous communities have had a greater impact on the application of the reform. They have included establishing normative principles and specific structures for the planning and management of mental health, on the one hand, and creating psychiatric, services, on the other.

The impact of the reform on the organization and provision of mental health services

The new configuration of mental health services

The Spanish General Law on Health designated "Health Areas", covering between 200,000 and 250,000 inhabitants, as the basic socio-geographical structure of the health system. Accordingly, the Psychiatric Reform established that psychiatric services should be organized according to these Health Areas and provide a fully integrated mental health care. In this contest, access to psychiatric services was through primary care units, with the specialized levels of care based on mental health centers. Hospitalization, which was now considered merely one more instrument in the therapeutic process, was provided by general hospitals. Also considered of special importance was the need to complement psychiatric care by providing sufficient community services (day hospitals, day centers, units for psychosocial rehabilitation, sheltered accommodation, etc.). The plan was that all these resources should constitute a functional unit that will allow an integrated approach to the treatment and rehabilitation of patients and to the prevention of mental illness.

Changes in the hospitalization of patients with mental illness

Provision of beds in psychiatric hospitals

Although some years before the start of the Psychiatric Reform there was already a decline in the number of beds in psychiatric hospitals, this decrease was in fact of little significance. Thus, in 1978 there were still 41,261 beds in these centers, a rate of 1.14 per 1,000 inhabitants (Table 2). We can, therefore, safely say that it was the progressive application of the reform that produced the truly significant reduction both in the number of beds and in the number of psychiatric hospitals. This way, in 1995, there were only 14,989 beds in these hospitals (0.38 beds per 1,000 inhabitants). However, it should be pointed out, first, that the reduction in the number of beds varied considerably among the different autonomous communities and, secondly, that this reduction has slowed down in recent years.

Provision of psychiatric beds in general hospitals

Up to the early 1980s, the number of psychiatric beds in general hospitals had hardly changed with respect to previous years and only a few general hospitals had psychiatric units. However, after 1986, following the recommen-

Table 2 Evolution of psychiatric hospitals and psychiatric units in general hospitals, and number of psychiatric beds in the period 1973–1995 (elaborated by the authors from official sources: INE, 1983; Ministerio de Sanidad y Consumo, 1994, 1995, 1996)

Type of establishment	Year						
	1973	1978	1983	1986	1991	1994	1995
Psychiatric hospital							
No. of psych. hosp.	121	114	111	98	97	87	*
No. of beds	43,000	41,261	35,273	30,084	23,282	15,879	14,988
General hospital							
No. of psychiatric units	*	*	*	*	88	103	105
No. of beds	*	*	*	*	2,107	2,367	2,401

* No information available or the information is unreliable

Table 3 Evolution of short-stay hospitalization (elaborated by the authors from official sources: Ministerio de Sanidad y Consumo, 1994, 1995, 1996)

Year	Hospitalization of short-stay patients in general hospitals			Hospitalization of short-stay patients in psychiatric hospitals			Ratio (%) of admissions gen. hosp./ psych. hosp.
	No. of units	No. of beds	No. of admissions	No. of units	No. of beds	No. of admissions	
1990	74	1,784	–	–	–	–	–
1991	88	2,107	33,286	56	1,694	17,139	67/33
1994	103	2,367	37,439	29	1,689	16,712	70/30
1995	105	2,401	40,946	29	1,657	17,192	70/30

dations of the commission's report on Psychiatric Reform, there was a significant increase in the number of these units, which started to assume responsibility for the acute in-patient care of mental illness. In 1990, there were 74 such units with a total of 1,784 beds. The number of units continued to rise in subsequent years and in 1995 there were 105 units with 2,401 beds (see Tables 2 and 3). These short-stay beds, which represented a mean rate of 0.06 per 1,000 inhabitants, as with other psychiatric services, were unevenly distributed in the different autonomous communities.

The marked increase in the number of psychiatric beds in general hospitals did not, however, mean the end of short-stay beds in psychiatric hospitals. In 1995 there were still 29 units with short-term hospitalization in psychiatric hospitals, providing a total of 1,657 beds (Table 3). Again these beds were unevenly distributed among the different autonomous communities so that in 1995, of the 17 autonomous communities only six (representing 28% of the population of Spain) had completely eliminated short-stay units in their psychiatric hospitals.

The short-term hospitalization of psychiatric patients

The number of beds available for short-term hospitalization in Spain in 1995 totaled 4,058, a rate of 0.1 per 1,000 inhabitants, and in the same year the number of admissions for these beds was 58,138, representing a rate of 148 per 100,000 inhabitants. The bed occupancy was 79 percent.

The new distribution of short-stay psychiatric beds obviously had a significant impact on the hospitalization of mentally ill patients. Thus, admissions to general hospitals increased by 23 percent between 1991 and 1995 and, in 1995, 69 percent of all short-term admissions were to these hospitals. Nevertheless, there was still a high rate of short-term admissions to psychiatric hospitals (30% of the total for 1995), which was concentrated in 11 of the 17 autonomous communities. It should also be pointed out that hospitalization in these psychiatric units was on average longer than in general hospitals (average stay for psychiatric units in general hospitals = 17 days; average for short-stay units in psychiatric hospitals = 26 days), which indicates differences in the functioning of the two types of institutions.

Development of new forms of community care

Mental health in primary care

Extending mental health care to primary care has been one of the mainstays of the Psychiatric Reform, which established as functions of the primary care teams in the field of mental health both the identification and management of mental illness and the development of programs to prevent psychiatric disorders and to promote mental health (Ministerio de Sanidad y Consumo 1989).

In this setting, primary care has established itself in Spain as the main route of access to the specialized psychiatric level. Thus, for example in the path-way study conducted by us in Cantabria, we found that between 51% and 77% of referrals to psychiatric services came from primary care centers (Vázquez-Barquero et al. 1993), a figure which today has increased to over 80 percent of patients. Moreover, the referral rates from primary to specialized care are around 11 percent and the capacity to provide treatment is 89 percent, which shows the importance of the role played by primary care in mental illness. To counterbalance this data we have to recognize that in Spain, as in other countries, the general practitioner still only identifies around 50% of their psychiatric patients (Vázquez-Barquero et al. 1997).

Mental health centers

These centers, created following the criteria of territorial distribution and decentralization, are the facilities that have experienced the greatest growth due to the Psychiatric Reform and are, therefore, one of its most visible consequences. As a result of this growth, in 1995 there were 550 mental health centers in Spain, which overall represents a rate of one mental health center for every 71,365 inhabitants (Table 4). Their distribution by autonomous communities is, however, very uneven, so that in 1995 three communities had one mental health center for less than 50,000 inhabitants, seven had one center for between 50,000 and 70,000 inhabitants, six had one center for between 70,000 and 100,000 inhabitants, and only one community had one center for over 100,000 inhabitants. The resources of these centers also vary significantly from one autonomous community to another, but they all have a minimum basic staff consisting of a psychiatrist, a psychologist, a qualified nurse, and a person to perform administrative duties.

As can be seen in Table 4, the percentages for both first visits and all visits have increased steadily throughout the 1990s: in 1995 the figure for first visits was 9 per 1,000 inhabitants and the total number of visits was 86 per 1,000 inhabitants. There has also been a clear change in the pattern of use of mental health services, with an increase in the demand concerning minor psychiatric disorders and a greater similarity in the sociodemographic characteristics between users of these services and users of the other medical specialties. However, it is noteworthy that, as the

Table 4 Mental health centers: number and activity (Table elaborated by the authors from official sources: Ministerio de Sanidad y Consumo, 1994, 1995, 1996)

Year	No. of mental health centers	First visits per 1,000 inhabitants	Total visits per 1,000 inhabitants
1991	387	5.6	52.5
1994	519	7.4	75.0
1995	550	9.0	86.0

reports reviewed indicate, treatment on these units were mainly based on pharmacological interventions, and less on the implementation of psyco-social and community programs.

Intermediate community services

By intermediate community services, we mean community care facilities such as day centers, sheltered accommodation, rehabilitation units, etc. It should be pointed out that it has been difficult to obtain reliable information on the availability of this type of facility for the country as a whole. The only reliable data for the whole of Spain are the ones reported, in the National Mental Health Surveys, under the headings of "Day Centers" and "Day Hospitals" (Ministerio de Sanidad y Consumo 1994, 1995, 1996). These surveys reported 2,664 places in day centers in 1992 (6.8/100,000 inhabitants), increasing to 3,673 in 1995 (9.3/100,000 inhabitants). As with most health care services, the rates varied widely between autonomous communities, with some having no centers and four having 17 or more day centers.

With respect to other intermediate community services (sheltered accommodation, rehabilitation centers or centers for social integration), the figures showed enormous disparity from one autonomous community to another. Although the data available do not allow an accurate assessment for the whole of Spain, we can say that these services have been developed to a greater extent precisely in those communities which have taken deinstitutionalization and the closure of psychiatric hospitals furthest.

Changes in the provision of mental health professionals

The creation of new care facilities has been paralleled by an increase in the number of psychiatrists and, particularly, by the incorporation of new professionals into these services. Thus, the number of psychiatrists increased significantly during the Psychiatric Reform and reached 2,016 in 1994 (5.1 per 100,000 inhabitants). Again, there are marked differences between the different autonomous communities, with figures ranging from 3 to 8 psychiatrists per 100,000 inhabitants. The number of psychologists has risen even more dramatically from 1987, when they had only a token presence, to reach a rate of 2.4 per 100,000 inhabitants in 1994 and 2.6 per 100,000 in 1995. The same is true for qualified nurses; starting from very low figures they reached a figure of 2,315 in 1994 (5.9 per 100,000 inhabitants), thus, repeating the trends for other professional categories in mental health care. The changes have also affected training programs and attainment of specialist qualifications. Such is the case of certification as a Specialist in Psychiatry, which was finally regulated in 1984. During this period, a system was also created for the training and certification as a Clinical Psychologist.

Changes in communid participation in the legal system

Throughout the period of the Psychiatric Reform, the attitudes of society toward mental illness have changed significantly with a considerable decrease in the elements of discrimination and stigmatization. This has been reflected, for example, in the changes in the patterns of use of mental health services, which are now comparable to those for health care as a whole. A strong associative movement has also arisen among relatives, friends, and carers of the mentally ill. This movement has fought for improved care for the mentally ill and, even in some cases, has created social services for the resettlement and support of these people in the community. Finally, of particular interest are the modifications promoted in the Spanish legal system, both in the civil and in the penal code. These modifications have been mainly directed to equating psychiatric patients with other patients, and to introducing important improvements in the penal treatment of the mentally ill (Diez Fernandez 1998).

Discussion

We have to begin by saying that the analysis of the process of Psychiatric Reform in Spain has been made difficult by the paucity and deficiencies of the information available and by the lack of adequate systems of evaluation and follow-up of this process. Nevertheless, from the data available we can say that the period between 1982 and 1996 saw the introduction in Spain of a new model of mental health care. This model was the result of the application of new knowledge in the field of mental health care and of the implementation of changes not only in the organization of health care but also in the political and social structure of the country.

In this model the most outstanding achievements have been (i) the development of a new organizational structure for mental health care, decentralized in character and territorially based, which is aimed at improving the equity and accessibility of the health care system and at providing continuity of that care; (ii) the integration of psychiatric patients in the general health care system, which is reflected mainly through the involvement of primary care services in the management of mental illness and in new forms of hospitalization for the mentally ill in general hospitals; (iii) the creation of an extensive community network of mental health centers; and (iv) the development in the general population of more positive attitudes toward mental illness and its treatment, and the adoption of legislative measures aimed at improving the civil rights of these patients. All this has meant a new way of understanding mental illness and its management, in which the emphasis is placed on "normalizing" the care of the patient and the relationship between patient and society. This concept of "normalization" is in our opinion essential since it attempts to overcome the "special status" that previously characterized mental illness in the Spanish

health system. Through this concept it has been possible to reduce the stigmatization associated with mental illness and its treatment and significant changes have occurred in the social and medical profile of users, and also in the patterns of use made of mental health services.

Although significant achievements have been made, particularly in view of the situation before the reform and the period of time involved, it should be borne in mind that the development and application of the reform has followed an uneven course within Spain as a whole, and marked differences are evident between the autonomous communities. These differences are so patent that it is difficult to give the overall picture for such a complex process. But one thing which we could say it is that they create a situation of unfairness and inequality in mental health care in the autonomous communities.

Our analysis revealed that the most unsatisfactory part of the Psychiatric Reform in Spain involves the development of intermediate community services and of programs for the rehabilitation and resettlement of the mentally ill in society. Thus, in most autonomous communities, these services are clearly inadequate, and there appears to be no clear consensus as to which services are required for adequate community management of these disorders, nor as to what level of administration should be responsible for creating and managing them. This situation is also reflected in the lack of programs for intervention and management of mental illness in the community. These deficiencies have had a negative influence both on the deinstitutionalization of patients, resulting in the continuing existence of the psychiatric hospital, and on the incorrect use of short-stay units, which have been forced to make inappropriate admissions and to prolong the length of hospital stay. In this respect again, the differences between the autonomous communities are pronounced, and can thus be seen as the most significant indicator of the willingness of the respective administrations to implement the Psychiatric Reform.

Of particular interest is the influence that the reform has had on the deinstitutionalization of patients and, therefore, on the closure of mental hospitals. The results obtained for Spain as a whole are clearly inadequate because, although the number of beds in these hospitals has been reduced by over 60 percent in only 12 years and some hospitals have been closed, there is still a strong tendency within the system to maintain these hospitals for both long-term and short-term illness. This tendency is, as we have seen, causing the reduction of beds in psychiatric hospitals to slow down, and this deceleration cannot be attributed only to the complexity of deinstitutionalizing the remaining psychiatric patients with diseases that make them difficult to accommodate in the recently-developed community services.

The question arises, therefore, whether the continued existence of psychiatric hospitals is due to an inherent limitation in the implementation of the transformation process, or, on the other hand, whether it is a consequence of political reluctance to put it into practice. The autonomous character of the Psychiatric Reform in Spain, which is reflected in marked differences both in the political will to carry the reform through and in the results obtained in the processes of deinstitutionalization and transformation of psychiatric care, shows that when firm policies are adopted to create services and set up community programs, it is possible to deinstitutionalize most mentally ill patients. That replacing the mental hospital with other alternative forms of care depends on political decisions rather than on technical reasons is also exemplified by what has occurred with the hospitalization of patients with acute psychiatric disorders. As we have seen, despite the recommendations of the report on Psychiatric Reform and in the absence of any technical justification, hospitalization of these patients is still carried out in the old psychiatric hospitals in 11 of the 17 autonomous communities (representing 72% of the Spanish population).

It should be noted that the deinstitutionalization carried out in some autonomous communities has not resulted in certain adverse effects reported from other countries, such as increased violence and a rise in the number of homeless. The results of studies performed in this country showed that these aspects were not associated with deinstitutionalization of the mentally ill (Muñoz et al. 1995; Vega et al. 1995), and they should not, therefore, be used as arguments in favor of retaining the psychiatric hospital.

Our analysis of the situation in Spain shows that the processes of psychiatric reform basically depend on commitment to a decision and maintaining political support, which in a system like Spain's must come not only from the central administration but also from the autonomous communities. This requires combining the firm resolve to replace the psychiatric hospital, the development of alternative forms of community care, and changes in legislation and within society itself that will allow the integration of the mentally ill and the "normalization" of their status. The complexity of the process with its impact on health care, society, and culture demands a sustained effort over a long period and the consolidation of political and professional criteria that should be protected from possible political changes by achieving a basic consensus among the different political parties and health organizations in the country.

Another significant aspect of the Spanish experience is the influence that integration of mental health care within the general health system has had on the Psychiatric Reform. It must be said, however, that while this integration has generally been beneficial, especially by equating psychiatric patients with other patients and, thus, removing some of the elements of stigmatization, it has also had its negative aspects. These have arisen mainly from the difficulty that the health administrative organs tend to have in understanding certain specific aspects of mental illness and its treatment, particularly those that are furthest from the traditional medical-biological model. Since this difficulty usually has a negative effect not only on the assignation of funds for specific services and programs but also on the organization of psychiatric care itself, changes must be made in the administration of health services to

guarantee an understanding of the special needs of mental illness and its management.

Finally, in our opinion, many of the criticisms leveled at deinstitutionalization are not aimed at its "conceptual core" but stem from its inadequate implementation. We also believe that deinstitutionalization and psychiatric reform are often simplistically equated with closure of psychiatric hospitals, without taking into account, as the Spanish experience has shown, that this process is far more complex and entails action at a much deeper level not only within the health services but also through other political, administrative, and social agencies in the country. This means that the process should be evaluated globally in terms of all the changes that it has set out to achieve and not forgetting that its ultimate goal is, as we have indicated, to "normalize" the status of the mentally ill and to remove the elements of stigmatization and discrimination that still persist in our society with regard to psychiatric patients.

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