

Is Deinstitutionalization a 'Failed Experiment'? The Ethics of Re-institutionalization

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Introduction

For the last 40 years British Columbia has pursued a general policy of deinstitutionalizing patients from its one large psychiatric hospital, Riverview Hospital (RVH), to a variety of alternative, community-based living and care-giving arrangements. This policy has not unfolded in a systematic, linear fashion, but rather it has been punctuated by interruptions and delays as policy makers and mental health care managers have tried to balance public fears and misperceptions that mental illnesses are linked to violence and the growth in homelessness, with the need to provide shelter and treatment to people with mental illnesses while maintaining their civil liberties.

Currently, the province is in the midst of implementing a major plan to close RVH, replacing it with various other facilities and services, and establishing a full spectrum of care across the province in a newly-decentralized health care system. Ironically, this process is being challenged even as it enters its final phases. As evidence is beginning to emerge about the successes of deinstitutionalization in the province (Lesage, Groden, Ohana, Goldner, 2006) and the processes related to downsizing RVH (Morrow, Pederson, Jamer, Battersby, Josewski & Smith, 2009), the political tide has changed due to pressures related to the visibility of homelessness, addictions and poverty in downtown Vancouver, and the link between these social problems and psychiatric deinstitutionalization in the public and popular imagination. The result has been increased

calls for re-institutionalization, particularly from some key community leaders. Using BC as an illustration, this paper reflects upon some of the current ethical issues arising from calls for the re-institutionalization of people with chronic and persistent mental health challenges.

Calls for re-institutionalization reflect the historic tension between providing support and imposing control on people with mental health challenges, as well as public understandings of the nature of mental illnesses, their treatment and their impact upon the community. Further, in the current neo-liberal context of mental health reform and welfare state restructuring, re-institutionalization is attractive to policy makers and community leaders seeking to make homelessness and poverty in urban centres less visible. Indeed, because neo-liberalism justifies policies and programs that emphasize individual responsibility and bio-medical explanations of mental illnesses over social and systemic analyses, it contributes to a climate of opinion in which calls for re-institutionalization are not easily contested.

As health care providers and researchers we must be wary of policy directions that could result in greater restrictions on people who use mental health services as opposed to providing them with better supports to live full and rewarding lives. Specifically, we can contribute to public policy discussions by providing evidence on the impact of various responses to people with mental illnesses and remain cognizant of the tensions between support and control that

arise in providing care. In this paper, we will challenge the ethics of the call for re-institutionalization and policy making that is reactive and not supported by evidence. It is our contention that the rights of persons with mental illnesses to the most life-enhancing supports are potentially undermined by the development of new facilities and initiatives that enforce treatment and constrain individual freedom in the name of community safety.

The Current Situation: De, Re or Trans Institutionalization?

Psychiatric deinstitutionalization began in Canada in the 1950s with a shift of care from public mental hospitals to community mental health services (Shera, et al., 2002; Moran, 2000, Lesage, 2000). Deinstitutionalization was, and continues to be, driven by a number of interconnected forces including developments in psychopharmacology, new psychosocial rehabilitation practices, studies of the negative impact of institutional life, concerns about the civil rights of people with mental illnesses and cost-containment (Lesage, 2000). Some of the early assessments of psychiatric deinstitutionalization produced in the 1960s, 1970s and 1980s reported on the negative aspects of the process, particularly the deterioration of people leaving institutions (Krupinski, 1995). Critics argued that governments had failed to fund adequate community supports for people with mental illnesses trying to reintegrate into communities (Dear & Wolch, 1987; Rose, 1979). Deinstitutionalization also made people with mental illness more visible as the closing of large hospitals made the sources of a person's care less visible.

In some instances, deinstitutionalization has meant the shift of beds from large psychiatric institutions to the back wards of hospitals and/or the application of institutional treatment models characterized by paternalism and coercion in community settings; that is, one could argue that the institution has not disappeared but rather changed location. Trans-institutionalization has been further observed in research that documents the criminalization of people with mental illnesses after leaving institutional psychiatric care (Fazel and Danesh, 2002), such that people with mental health problems are institutionalized in corrections facilities rather than treated in hospitals or other health care facilities.

In BC, proposals to phase out RVH have been made periodically since the late 1960s, coinciding with welfare state restructuring and deinstitutionalization trends in other Canadian, North American and European cities (Skull, 1994; Rose, 1979; Quinn, 1996). The majority of beds at RVH were closed between the years of 1956-1976. RVH had reached its peak bed capacity in 1956 with 4,036 beds; these had been reduced by more than half by 1976.

British Columbia is an interesting case for studying mental health care because it is undergoing a final phase of deinstitutionalization in a particular historical context. The current phase of deinstitutionalization began with the 1998 *BC Mental Health Plan* (BC Ministry of Health 1998). The *Plan* called for regional self-sufficiency for mental health services through the devolution of tertiary resources from RVH to regional health authorities (BC Ministry of Health, 1998). The creation of regional health authorities began in 1996 and, though it too has undergone successive organizational forms, continues to be the formal organizing mechanism

for health care in the province. The "Riverview Redevelopment Project" began in 2000 and focuses on relocating RVH's remaining occupants to cities and towns throughout BC and distributing resources for the care of people with chronic mental illnesses more widely than previously. The province has developed 396 replacement beds and currently approximately 245 people remain at RVH, although some health authorities have completed the process such that there are no remaining patients from that authority at RVH. Bearing this phase of deinstitutionalization in mind, it is perhaps appropriate to describe the current situation of most people in BC with serious mental illnesses as one of trans-institutionalization as all people leaving RVH are transferred, at least initially, to other (often smaller, more pleasing) facilities that are nevertheless still characterized by institutional routines and treatments.

While the vast majority of people with mental illnesses are not institutionalized, 10-20% are in hospitals or supervised settings, and people with severe and persistent forms of mental illness typically require comprehensive forms of treatment and support. Currently, a substantial proportion of the mental health care budget is directed toward people suffering from serious mental illnesses rather than the large number of people with less serious problems. Moreover, despite medical management, some people with mental illnesses continue to express socially marginal behaviour, raising questions in the public mind about the effectiveness of current housing arrangements and medical care.

Among the political responses to the visibility of mental illness in BC has been the opening of a new 100 bed facility for people with mental health and addictions and the establishing of Vancouver's Downtown Community Court (British Columbia, 2008; CBC, 2006 & 2008). While those working in mental health have welcomed such new resources and approaches, they could impede people's recovery if these facilities simply mimic the traditional care provided in institutional settings and if no additional, comprehensive supports are provided. What is needed is a continuum of care which recognizes that housing and other social welfare supports are key to managing and recovering from mental health (and substance use) problems.

Historical accounts of institutionalization and deinstitutionalization typically describe these processes as linear and progressive yet the evidence from BC is that the processes are cyclical rather than continuous, with various phases of deinstitutionalization occurring over the past 40 years. Psychiatric hospitals serve both manifest and latent functions (Lesage, 2000; Henderson & Thornicroft, 1997; Moran, 2000). Manifest functions of psychiatric hospitals include, for example, the provision of treatment for both short to intermediate stay patients, custody for long-term patients, the desire to protect people who are vulnerable, respite for family caregivers and secure provision for involuntary and assaultive patients. Latent functions, in contrast, may include job security for professional staff, segregation from society of people who are understood as 'deviant' or dangerous (Henderson & Thornicroft, 1997) and political solutions to problems with the visibility of people who are mentally ill and homeless.

How society cares for people with mental illness reflects its social and economic tensions and highlights that care occurs, not only in a medical, but also a political context. Thus, there have consistently been ebbs and flows regarding society's tolerance for deinstitution-

alization and the visibility of people with mental illnesses. Calls to re-institutionalize people are rarely based on research evidence and instead garner support through editorials and sensationalized media reports of people with mental illnesses as violence and unpredictable (Krupinski, 1995, *The Province*, 2006). Commentators point to the numbers of people in prison or erroneously to the numbers of people on the street with mental illnesses. Missing from the public dialogue is a discussion about what is known about how best to meet the comprehensive needs of people with mental illnesses, needs which include housing, income security, access to meaningful activities and other social rights.

Re-institutionalization and the Ideology of Neoliberalism

The Riverview Redevelopment process in BC has occurred in a context of dramatic health and social welfare restructuring. Starting in the mid-1990s, the health care system has undergone successive waves of decentralization and restructuring—including regionalization. In 2001, a newly-elected BC Liberal government initiated the rapid amalgamation of what were then 52 health authorities into five geographic and one provincial health authority (plus the Nisga'a Health Board). This restructuring introduced new fiscal pressures and changes to the mechanisms designed to involve mental health care recipients in decision making. Simultaneously, changes to social welfare supports and disability pensions, the divestment of federal funding from housing and a general retrenchment of social welfare services has resulted in increased poverty and homelessness, most visible in Vancouver's downtown eastside (Klein, Pulkingham, Parusel, Plancke, Smith, Sookraj, Vu, Wallace & Worton, 2008; Morrow, Frischmuth & Johnson, 2006). The trend increasingly in this context is to expand the definition of mental illnesses to encompass people who are poor and homeless. This feeds directly into the uncritically accepted idea that deinstitutionalization, in and of itself, has increased homelessness (Mossman, 1997).

Additionally, the hosting the 2010 Winter Olympic and Paralympics Games in Vancouver has created a political climate in which the visibility of people dealing with homelessness, addictions and mental illnesses is currently in the public consciousness. A fixed election schedule for the provincial legislature, introduced in 2001 with the next scheduled for May 2009, also means that politicians are keenly aware of the need to be addressing the problems of the visibly distressed in the province's largest city.

Neoliberalism as a dominant public discourse and state modality favours reduced government (Kingfisher, 2002; Peck and Tickell 2002) and reduced social expenditures on social assistance and public programs (Raman 2008). Further, neoliberalism fosters a belief in economic individualism and a reduced role for the state in economic regulation and social support. Neoliberalism emphasizes individual responsibility to address social problems and, as such, supports individualistic models for understanding mental health and illness (Galvin 2002). As Ramon (2008) has observed in the UK, the mental health system in Canada, functions as a hybrid of liberalism, neoliberalism and social democracy. In the UK context, Ramon argues that "this co-existence leads to tensions, contradictions and to swinging from one direction

to another depending on specific constellations of interests and power operating at a given time." (p.118). In BC these swings are evident in the dramatic shift from a social democratic approach to mental health under an NDP government (with a focus on citizen engagement, protecting rights, advocacy and community based supports) and the BC Liberal regime where cost-cutting and cost efficiencies have been paramount in the organization and delivery of health care services (Morrow, et al., 2006).

Although Canada has avoided the dominant conservative paradigm of the United States in which the state's duty to impose law and order can be an explicit and decisive factor in political debate, an implicit desire for policies that promote order and security may drive mental health care planning decisions that push for a lower bar to force inpatient care on individuals with mental illness. When this is overtly seen as a medical intervention for someone who is ill – a benevolent act by the state to provide care to someone who does not know better – it may feel more acceptable than the unspoken social control that may underlie this.

Medical Versus Social Explanations of Mental Illness

Prior to the 19th century, attempts to understand or explain mental illnesses involved either magical or religious explanations such as demon possession or biophysical explanations. Moral treatment models in the 19th century recognized the role of environmental influences on hereditary influences and thus focused on manipulation of environmental factors as part of treatment (Colp, 2004).

Although initially working from a biophysical model that invoked structural and functional (physiologic) forces, Freud precipitated an explosion in interest in psychological explanations of illness that became the dominant paradigm in psychiatry. Even though psychiatric practice continues to emphasize the role of the biopsychosocial formulation in understanding people with mental illnesses, the reaction to psychoanalytic thought has further driven the dominance of biomedical paradigms that are reductionist in their de-emphasis of the psychological and sociological contributors to illnesses. Indeed, the period in which deinstitutionalization occurred parallels the shift to a biomedical paradigm to the point that "neuroscience can justifiably be considered the biomedical foundation of psychiatry" (Hyman and Cole, 1996, pg. 3).

The resultant increasing focus on mental illness as an 'illness' with neurobiological causes and underpinnings has also had beneficial results. It has helped promote the development of new treatments, it has helped reduce the stigma that may arise as a result of magical or religiously determined theories of mental illness and it has encouraged investment in research, treatment and care. Indeed, concern about stigma and its impact on people with mental illness has been increasingly addressed through public education campaigns that equate mental illness with any other illness of the body.

At the same time, by defining mental illness as an 'illness', a set of expectations has been created that may be unrealistic even for those illnesses that best fit the biomedical model of causation. Implied within this model is that there is a specific biological cause that

in turn requires a specific treatment to produce a cure. Applying this overly simplistic explanation to mental illnesses does allow optimism about treatment, but also encourages an interventionist approach that does not easily handle an individual's refusal of treatment for example. Traditional models of public health including the use of imposed treatment are easier to justify within this linear model. Ethically a conflict can be established between the right to choose versus the right to be well. The biomedical model has also fostered expectations of the 'good patient'. Indeed, Parson's (1951) construct of the "sick role" is premised on an acute model of illness in which the patient submits to medical intervention, separates themselves from the mainstream social order temporarily, and is expected to try to get well. Chronic illness generally, including mental illness, does not fit well within this model nor with its expectations of the patient.

In the minds of many people, the focus of medical treatment, especially for those who are severely ill, is the hospital. Under this model, the more ill the person, the more likely they are to need and benefit from the hospital. Hospitals provide a reassuring presence that is both highly visible and extremely tangible, and may for many epitomize care. It is hard then to understand that there are illnesses that may worsen in hospital, or may be severe and yet not require hospital care, as is often the case with mental illnesses. Although we are now increasingly recognizing that in fact hospitals can be dangerous places because they are reservoirs of infection (e.g., for MRSA or *c. difficile*), they often play an important role in assuring us that care is there when we need it. Thus, when confronted with the sometimes unusual behaviour of a person with a mental illness, the immediate assumption made is that the individual concerned must need care in a hospital, and that their presence outside of the hospital is evidence of some kind of failure of delivery of health services. The behaviour in fact may be a result of many things and may have nothing to do with that person's relative recovery or functionality (Mossman, 1997). The individual may in fact be involved in extensive community care, but their presence in public is often interpreted as a failure of the "hospital", which traditionally in many places in mental health care was the institution.

At the same time, as we have expanded our awareness of neurobiological contributions to many forms of mental illnesses, we have expanded the definitions of mental illness, often moving along continua of normal behaviour or experience. Social phobia has received increasing attention as medications such as the serotonin specific re-uptake inhibitors (SSRIs) have been shown to reduce symptoms to the point that the separation between this illness and the trait of shyness has become blurred. Similarly, as we have learned more about people's responses to trauma we have developed an expanded list of psychiatric conditions to describe this reaction, from 'Post Traumatic Stress Disorder' to 'Acute Stress Disorder' to 'Adjustment Disorder with Anxiety or Depressed Mood'. It becomes harder and harder to know what is illness and what is a normative response (Morrow, 2008). The blurring of the boundaries between what is an 'illness' and what is a normative response has consequences both for a treatment system that now assumes responsibility for care for a broader spectrum of problems, and also for individuals for whom a trait or characteristic that may not be particularly disabling or distressing, gets labelled as an illness, with resultant pressures to accept treatment.

One of the places in which these tensions play out in the BC context is in efforts to address the visible distress on the streets of Vancouver's downtown, where there is the highest concentration of poverty, homelessness, addictions and mental illnesses at the same time that the social welfare state has been dramatically diminished and the province is positioning itself to address the barrage of local and international media attention leading up to and during the 2010 Olympics and Paralympics that will shine a spotlight on visible social problems, as described earlier. In this context, advocates are hopeful that the increased attention might help all levels of government cooperate to address the complexities of service and support needs. Certainly, the very visible distress on the streets of Vancouver puts pressure on politicians at all levels to address the situation. In this context it is easier to understand mental health and addictions as strictly medical issues with individualized bio-medical solutions, rather than the complex, multi-faceted problems that they are.

The growth in homelessness in much of the western world that has occurred over the 1980s and 1990s (Neito, Gittelman & Abad, 2008) has often been blamed on the de-institutionalization of individuals with severe mental illnesses, even though the bulk of the deinstitutionalization predated that era (e.g., the majority of RVH's beds were closed between 1956-1976). Although the link between homelessness and mental illnesses would appear to be supported by studies that state that the majority of people who are homeless have an increased lifetime chance of being diagnosed with mental illness, in fact estimates of prevalence of severe mental illnesses such as schizophrenia have been shown to be in the range of 11-17% (Bonin, Fournier & Blais, 2007). Given that people with schizophrenia are often living in poverty as a result of lack of affordable housing and disability benefits well below the poverty line (Cohen, 1993), and that poverty is a major factor in homelessness, it is not surprising that there is an elevated rate of schizophrenia in this population. At the same time, Toro, Bellavia, Daeschler, Owens, Wall, Passero and Thomas, (1995) showed no increase in the diagnosis of schizophrenia in a homeless sample compared to a sample of never-homeless poor. Clearly the growth in the visibly homeless that we have witnessed in Canada cannot be explained by the proportion of individuals with schizophrenia who would previously have been institutionalized. At the same time, by providing a diagnosis for the majority of people who are homeless, and ignoring causality (i.e., the impact of homelessness on mental illness and stress), society is provided with a relatively simple explanation and solution for the complex problem of homelessness. By this logic, improving treatment and availability of treatment for mental illnesses, and targeting that treatment to those who are homeless and mentally ill, will solve the problem of homelessness. The definition of the problem as medical allows society to respond in a paternalistic way by imposing treatment, a more acceptable response than imposing social controls on people who are not defined as ill.

The problem is not whether or not one uses a biomedical model to understand mental illnesses, as the use of such a model is often quite valuable, whether it be to reduce stigma or improve treatment. The issue becomes the assumptions that are often triggered by such a model that can include a switch to paternalism and imposed care, a re-definition of a complex social problem (homelessness) as a medical problem with medical solutions, and the reactive use of traditional medical models of care such as

hospitalization, even when they may not be appropriate.

Support Versus Control

A persistent tension between the provision of support and the imposition of social and medical control permeates policy making and care-giving with respect to mental illnesses. Issues of support and therapeutic intervention on the one hand, and control of people with mental illness on the other, have been intertwined since the earliest days of the asylum movement. During the development of the asylums in the 19th century, the actual physical locations chosen for the facilities were often those which would allow the removal of people with mental illness to supposedly more healthful environments outside of urban centres (Fakhoury & Priebe, 2007). While often offering those with mental health challenges quiet surroundings, these locations served the secondary purpose (or latent function) of removing people who were deemed undesirable from more general society (Leff, 2004). Similarly, while the asylum offered support with respect to shelter and sustenance, the actual daily life of the asylum was dictated by administrators and medical staff, not those receiving care.

Although cycles in institutionalization have occurred for centuries, the current cycle, which began in the late 1950s in most western countries was characterized by a shift in the direction of autonomy for people with mental illness, as opposed to prior cycles in which primary motivations were benevolence and paternalism in conflict with desires to control or remove “undesirables” (Fakhoury and Priebe, 2007). The psychiatric survivor movement, in conjunction with allies in various mental health professions, harshly criticized traditional psychiatric care and especially forced treatment, ushering in a new era where the rights of people with mental illnesses to determine their care and access other social rights (e.g., housing and income) became paramount (e.g., Barnes & Bowl, 2001; Chamberlin, 1978; Morrow, 2007). However, these rights are still precarious in the face of a system that continues to support biomedical approaches over social and systemic ones. Critiques of deinstitutionalization (Krupinski, 1995) and the lack of government support for community based mental health supports, has unfortunately kept the door open for arguments, couched in the language of care, that certain kinds of forced treatment should be supported. The question to be addressed though is to what degree this desire for care disguises a desire to better control people who may be, by their appearance or actions, disruptive in society?

Discussion

The tensions we have described within mental health policy and care are not unique to Canada. A recent report from the World Health Organization that surveyed mental health services in 42 countries in Europe states:

Many countries are reducing the numbers of beds and are moving towards closing mental hospitals to replace such institutional forms of care with community-based mental health services. Strategies are therefore especially important to communicate the underlying change in values. Community-based services place great emphasis on people's

autonomy and providing care that is based on the needs of the individuals and sensitive to their life experiences and culture. Strategies have to reflect this. Further, introducing community-based services considerably changes the rights, duties and protection of individuals, families, staff and the community. High activity in policy-making and legislation can therefore be predicted in the WHO European Region (WHO 2008, p. 11).

As clinicians and researchers, we have a role to play in addressing the issues of social inclusion and exclusion that arise for people with mental illnesses and work to ensure that actions are taken beyond the boundaries of traditional health care to provide the care and support people with mental health challenges are entitled to receive. Anti-stigma campaigns, currently in vogue as strategies for fostering social inclusion, will not be sufficient in themselves to address the persistent tension between support and control that underlies mental health care. Strategies that ensure the representation of service users in the development of programs, facilities, and policies with respect to mental health care—and which foster interaction between those diagnosed as mentally ill with those not so diagnosed—could contribute to greater social understanding of the experience of mental illness and ensure that services are acceptable to users. In discussions of re-institutionalization in BC, the voices of those with mental health challenges have been largely absent to date.

Similarly, the expanded understanding of the brain that has arisen as a result of a focus on biomedical causation models in mental illness needs to be balanced by continued attention to broader determinants of mental health and wellness. Biomedical domination of services and supports must be resisted and governments must be held to commitments to provide funding for housing and other social supports that will increase the economic and social security of people with mental illnesses. Finally, the importance of gathering evidence on what supports and services work best for people with mental illness cannot be over-stated. Recent opportunities to study supported housing approaches for people with mental illness, being offered through funding from the Mental Health Commission of Canada for a series of demonstration projects in Canadian cities (including Vancouver)ⁱⁱⁱ, is one such opportunity.

Large public events such as the approaching 2010 Olympic and Paralympics Games in Vancouver have resulted in a greater attention to social issues in the province, as awareness grows of the international scrutiny these games will bring. If this scrutiny results in a sophisticated analysis based on evidence of the many issues involved in such challenges as homelessness, involving an inclusive approach to problem analysis and solution development, the games can catalyze social change. If, however, the approach focuses on an agenda that seeks rapid and simplistic solutions imposed from the top, be it by government or by health care authorities, the result may be an expensive and ultimately ineffective set of solutions that increasingly challenge the autonomy of people with mental illnesses in the province.

1 In 2006 BC's Premier Gordon Campbell in a speech to the union of municipalities said, "We're going to listen to what we've heard from you, and you know what you've told me - de-institutionalization is a failed experiment."

1 Recent civic elections in Vancouver (November, 2008) saw the Vision Party, who had reducing homelessness as one of their key platforms, sweep to power.

1 The Mental Health Commission of Canada has allocated \$110 million to support homelessness demonstration projects focused on people with mental illness in Vancouver, Toronto, Montreal and Moncton. 85% of the funding will go to housing and 15% to research on its effectiveness.

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Competing Interests :

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