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SCIENTIFIC CONTRIBUTION

Theoretical accounts on deinstitutionalization and the reform of mental health services: a critical review

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Abstract This article offers a comprehensive critical review of the most popular theoretical accounts on the recent processes of deinstitutionalization and reform of mental health services and their possible underlying factors, focusing in the sharp contrast between the straightforward ideas and models maintained by mainstream psychiatry and the different interpretations delivered by authors coming from the social sciences or applying conceptual tools stemming from diverse social theories. Since all these appraisals tend to illuminate only some aspects of the process while obscuring others, or do not fit at all with some important points of the actual changes, it is concluded that the quest for an adequate explanation is far from having been completed. Finally, some methodological and conceptual strategies for a renewed theoretical understanding of these significant transformations are also briefly discussed, including a comprehensive empirical evaluation of the facts, the consideration of the shifting social values and needs involved in mental health care provision and the historical analysis of deinstitutionalization policies within the framework of the broader social and cultural trends of the decades following World War II.

Keywords Mental health services · Contemporary health care · Deinstitutionalization · Psychiatric reform · Community psychiatry · Social sciences

Introduction

In connection with other vast and profound social and cultural transformations in the Western world, contemporary psychiatry has undergone major changes over the last fifty years which concern not only the development of certain research areas, new therapies, care settings or renewed legal frames, but its whole internal and institutional organization. As a result of these changes, we now encounter a psychiatric landscape of high complexity and diversity which reflects the new demands posed on psychiatry by our modern societies and the way these deal with mental derangement.[1]

An outstanding part of these developments may be seen as the consequence of the ambitious institutional projects aimed at transforming the face of psychiatry launched in the decades following World War II, processes which are worldwide known as psychiatric reforms. Promoted by the WHO, and beginning in the mid 1950s in England and the USA, and a bit later in Continental Europe and Scandinavia, an international consensus arose about the need for a thorough change in psychiatric care and new policy strategies for mental health. Above all, the main declared goal of the reforms was to overcome the old asylum-based system of care and establish new community-oriented therapeutic approaches.[2] As in many countries this meant and implied a move away from the traditional institution of the mental hospital and resulted in a considerable discharge of patients, the term deinstitutionalization was also coined to refer to one central aspect of the reforms, and it has been used to some extent in a (problematic) synonymous way.[3]

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[1] See for a broad overview Freeman (1999) or Kringlen (2003).

[2] For a paradigmatic summary of the official WHO guidelines for the reforms see Freeman et al. (1985).

[3] Recently, some authors have rejected the word deinstitutionalization to describe this dehospitalization as inappropriate, because "it wrongly suggests that many settings were patients ended up were not institutional" (Geller 2000, p. 42). For a conceptual analysis of the term and other related issues see Bachrach (1976).

In most cases, the then flourishing social and community psychiatry provided the programmatic and ideological framework for the reform initiatives. Although interest in the social aspects of mental illness and alternatives to institutional care are as old as psychiatry itself (Rosen 1959; Bartlett and Wright 1999), it was only in the postwar period when, on the background of a pervasive crisis of the asylum as a social and therapeutic institution, they began to exert a remarkable influence and became a prevailing trend in psychiatric theory and practice. The focus on the social and environmental dimension of mental health stimulated by the lessons of war psychiatry and the then—at least in the USA—dominant position of psychoanalysis converged with the assumption that psychiatric patients should not be confined in the large, undifferentiated and isolated mental hospitals, but had to be actively treated and supported 'in' the community.[4] Coupled with a strong emphasis on prevention and rehabilitation and a declared concern for the social integration of the mentally ill, 'community care'—so ambiguous the term might be—became as from the mid 1950s the goal for psychiatry. In a sort of expanding chain reaction, within two decades all major Western countries were affected by a similar process of upheaval in their mental health systems: crisis of the old model, discussion of alternatives—often on the background of a growing social and media interest—, and political involvement with new legislation or national guidelines including variable funding for new models of service development (Bennet 1991; Forster 1997; Goodwin 1997).

Celebrated as a "major revolution" or as the outbreak of a "new psychiatric paradigm" by many of their advocates, the actual implementation of the reform projects did not surely live up to the original expectations. Changing the primary locus of care from the traditional institutional settings to community-based services proved soon to be more complicated than it was previously assumed, and gave rise to new problems and some important and not sufficiently foreseen side-effects, particularly among the most severe and chronic patients (Barham 1997). Owing to these developments and other social, economic and political constraints, by the mid 1980s the reform movements had lost in most of the countries their initial impetus and seemed to stagnate. Operationalized diagnosis, neuroscientific approaches and the psychopharmacological boom gradually displaced social psychiatric and psychoanalytic concepts and interests, while psychiatry was forced to face new tasks due to a growing demand on psychotherapeutic advice and treatment (Shorter 1997; Kringlen 2003). However, many of the tendencies of structural change in the care systems initiated in the previous decades continued, or even began to be implemented in some countries. Therefore, recent reports on the situation of mental health care around the globe still speak of the reforms as "ongoing processes" (Becker and Vazquez-Barquero 2001, p. 13).

Notwithstanding all their pitfalls and limitations, the reforms have contributed to a deep transformation in the field of mental health that raises important questions concerning its very nature and long-term implications on the background of psychiatry's history. Consequently, and given the great interest that a big part of the public opinion and some social and academic sectors have shown while following all these transformations in the patterns of mental health care, it is understandable that the discussion around their actual nature and their final causes has given place to a storm of essays and studies. All these works have been written not only by psychiatrists, but also by sociologists, historians and other professionals interested in the development of social and health care policies during the second half of the 20th century. In fact, and already from the beginning of these reform programs, many explanatory models from various points of view, descriptive levels and theoretical frames were outlined in order to explain the significant transformation which was being experienced by the care strategies for mentally ill persons.

The present article intends precisely to offer a critical review of the most outstanding theoretical accounts or explanatory models concerning this recent mutation experienced by the general patterns of mental health care. As it will be shown, all these models point to some aspects of the process of transformation of mental health care which are certainly relevant and must be taken into account, but they are not free at all from important shortcomings or inadequacies that seem logical when considering the multiple dimensions and interdependences of such a complex process of social, cultural and institutional change as this one. For this reason, it will finally be necessary to ask if, taking into account the outstanding relevance of the clarification of this significant turn in the care strategies for a broader understanding of contemporary psychiatric practice, the quest for an appropriate explanatory model for this process may be taken as concluded. Instead, I shall advance some methodological and conceptual strategies that should inspire an alternative and more complete assessment of the facts.

The changing paradigm: theoretical accounts and interpretations

The big divergences between these explanatory models can be clearly seen in Table 1, where their main

[4] For an historical account on the development of social and community psychiatric thought and practices in England and the Netherlands during the postwar period see the volume by Gijswijt-Hofstra and Porter (1998); for the USA the best account remains Grob (1991); for Germany see Schmiedebach and Priebe (2004); and for Italy see Mollica (1985).

Table 1 Current theoretical accounts for the reform of mental health services

	From	To	Means	Explanation
The Conventional Psychiatric Account	Institutional care (Asylums, Mental Hospitals)	Community care (PDGH, outpatient clinics, day hospitals, rehabilitation services)	Professional and government policy (lobbies and alliances)	• Introduction of modern psychopharmacology • Acceptance of institutional critique
Critical Perspectives (Antipsychiatry)	Segregative involuntary treatment of deviant behavior in the asylum	Involuntary treatment ("therapeutic chain") of deviant behavior in the pathological community	Institutionalized power	• Pacification of psychosis • Modern anti-liberal tendencies (therapeutic state) • Masking of constraint
Professionalization	Dominance of the asylum (Professional dominance in the asylum)	Increased institutional settings, clients and forms of intervention	Professional policy (assurance of professional interests)	• Image problems • Marginal place in medical care (handicap for more resources) • Rivalry with new professions
Decarceration	Big asylums (segregative social control)	Run down of services (neglect and ghettoization)	Government policy (capital administration and mass loyalty)	• Increased costs of segregative control • Fiscal crisis of the state
Rehabilitation	Custodial care in asylums for mental patients excluded from the production process	(a) New therapeutic services and programs for rehabilitable patients (b) Custodial care (transinstitutionalization) for the not rehabilitable	Political economy (capital interests)	• The big demand of working force after WW II needed the rehabilitation of patients capable of working • Transinstitutionalization: cheaper costs of nursing and boarding homes
Psychiatrization	Asylums as part of institutional (outer) control	Modern psychiatry as part of a broader "psycho-complex" (self-control)	Discourses and technologies for social order	• Scientification • Improvement and subtilization of technologies
Medicalization	Uncompleted medicalization	(a) Increased medicalization (acute disorders, medical institutions and technologies, voluntariness) (b) Demedicalization (c) Psychotherapization	Professional and government policy	• Professional interests • Political convenience of medicalization • Interests of the pharmaceutical industry

statements concerning the starting point of the reforms, the final result of the actions, the means or actors implied in their implementation and the final factors bearing the greatest causal responsibility are summarized. Although the present review grants priority to the analysis of those models of a more sociological inspiration and scope, it is worth considering first what has been, with some minor variants, the most widespread argument among professionals of psychiatry and policy makers in order to account for the driving forces that set in motion deinstitutionalization and the other reforms in mental health services. As we will see, this view contrasts sharply with those perspectives emerging from the radical criticism of the psychiatric institution that became very popular just in the decades when the process was initiated. Given the fact that these critical sectors launched various hypotheses in order to explain what was happening to psychiatric care, these will be also reviewed next.

The conventional psychiatric account

The introduction of modern psychopharmacology around the mid 1950s,[5] together with the explicit acceptance of the generalized critique on the controversial institution of the asylum which started being spread during the same period,[6] have been doubtlessly the most frequently underlined factors in order to explain the genesis and dawn of the psychiatric reform processes. According to this interpretation—formulated for example in Jones (1993)—, what made finally possible the progressive replacement of the

[5] As successive milestones in the antimaniac, antipsychotic and antidepressant therapeutics, there must be mentioned, respectively, the introduction of lithium in 1949, that of chlorpromazine in 1951 and that of imipramine in 1957. See Healy (2002).

[6] Some of the most outstanding and influential works on this topic were Stanton and Schwarz (1954), Belknap (1956), Cumming and Cumming (1957), Caudill (1958), Barton (1959), Goffman (1961), Wing and Brown (1970) and Basaglia (1968).

traditional asylum-based model of care by different community-based services was the fortunate confluence of the progressive and humanitarian trend characteristic of the 'golden' postwar decades and the availability of selective drugs in order to treat efficiently a big part of mental disorders or, at least, to mitigate their most disruptive manifestations.[7]

These two arguments stand, generally, together with the conviction that a singular alliance between politicians and professionals, owing either to the favorable attitude of the former towards what had become an urgent social demand or to the political influence actively pursued by the latter, was decisive in most cases for the implementation of the reforms and must be therefore considered as their main actor and driving force. In this sense, it is worth pointing out that many historical studies about the development of contemporary psychiatry assume to such an extent this perspective that their contents focus often exclusively on the vicissitudes and circumstances that allowed the creation of these alliances (for example Grob 1991).

Despite its great popularity and circulation, this explanation happens to be highly questionable when carefully examining the two main arguments upon which it is based. In the first place, and even though psychotropic drugs have certainly provoked a substantial transformation in the therapeutic praxis—partly thanks to having favored the application of all kinds of psychotherapeutic techniques and contributed to calm down the atmosphere in psychiatric wards—, it is difficult to attribute to them the start of deinstitutionalization and the process of reorganization in mental health care because of a very simple reason. As many different epidemiological studies have repeatedly shown, the reduction of inmate population and the increase in the number of patients discharged from mental hospitals had already begun in many countries *before* the generalized introduction of neuroleptic drugs.[8] Data from the US, for instance, showed that whereas the absolute number of mental hospital residents peaked in 1955—one year after the introduction of drug treatment—, the rate of hospital use—i.e. the proportion of the general population treated in mental hospitals—peaked in 1945 and never climbed as high again (Warner 1994, p. 82). The application of drugs, therefore, could consolidate later this trend, but there is no evidence suggesting that it played a major causal role in its start. Furthermore, it must be reminded that other population groups who do not usually take psychotropic drugs—as is the case of the inmates of orphanages, reformatories or prisons—, have also experienced deinstitutionalization programs which are quite similar to those implemented in the field of psychiatry (Scull 1984).

On the other hand, it is also questionable to include the intense wave of institutional critique which accompanied the beginning of the reforms among their actual causes. The institution of the mental hospital was indeed receiving important critiques directed at each of its constitutive elements—the legal frame, the institutional apparatus, the theoretical code and the therapeutic technologies—at least from the end of the 19th century,[9] but these repeated assaults did not provoke any substantial modification. It is true that, particularly during the decade of the 1920s, some countries carried out some attempts to compensate the preeminence of the asylums with the creation of outpatient facilities and the development of various programs for prevention and rehabilitation,[10] but the general pattern of mental health care was clearly dominated by the long-term incarceration in the 19th-century asylums until the arrival of the reform processes following World War II. Thus, it seems quite obvious that, so radical as it could be, the institutional critique had not been influential enough to force deep reforms in the field of psychiatry unless other factors of a more structural nature had appeared and finally led, after nearly a century of disputes, to the beginning of the end of the asylum order.

Curiously, and despite the big number of authors who have repeatedly pointed out to these and other serious inconsistencies, the conventional account still enjoys a strikingly high reputation not only among politicians and mental health professionals, but also among some of the most popular and widely read contemporary historians of medicine. As late as in 1997, for example, the Canadian E. Shorter could emphatically state that "what initiated the massive discharge of psychiatric patients to the 'community' [...] was the introduction of antipsychotic drugs in 1954", concluding that "in a strict sense, therefore, deinstitutionalization was a consequence of the second biological psychiatry" (Shorter 1997, pp. 279–280). For this reason, one should wonder whether the reasons for the remarkable tempting character of this interpretative model do not lie in its function as a successful mythical tale in the

[7] For a paradigmatic formulation of this account see for example Jones (1993).

[8] One of the best-known studies on this missing correlation, which was quickly translated into other languages, was already published in the 1960s by the Norwegian epidemiologist Ødegard (1964).

[9] There exists a remarkable historiographic consensus in dating the beginning of the generalized crisis of the mental asylum around 1860. See Scull (1984), pp. 104ff. for the Anglo-American sphere, and Castel (1976), pp. 282ff. for the French one. In the case of Germany, it was also during the first half of the decade of the 1860s when the well-known confrontation between W. Griesinger and some relevant representatives of the traditional asylum psychiatry took place. See Sammet (2000).

[10] For the case of Weimar's Germany, see Siemen (1987); for the USA of the beginning of the 20th century, Grob (1985); for Spain during the Second Republic, Huertas (1998); and for French developments in that period, Campos (2001).

sense of modern social anthropology, i.e. as a sort of "sacred tale about past events which is used to justify social action in the present" (Mossman 1997, p. 71). Apparently, it gathers the most favorable conditions to play this role, since it is a tale conferring to mental health professionals an important share of protagonism and granting to psychopharmacology—both the most relevant network of interests and the touchstone of current therapeutic practice—the privileged position in the contemporary development of psychiatry.

Critical perspectives and antipsychiatry

In opposition to this conventional point of view, some of the most outstanding authors of the so-called antipsychiatry and other critics of institutional psychiatry have provided different alternative accounts on these processes of mental health care reform. Despite the notable difficulties when trying to define positively the meaning of the term 'antipsychiatry' and the great heterogeneity in the perspectives of the diverse authors and approaches (Kisker 1979; Tantam 1991), it is possible to identify some common points or elements concerning their assessments of the reforms.

Schematically, this critical or antipsychiatric point of view can be summarized as follows: psychiatric reforms must be seen as a mere attempt to replace the segregative involuntary treatment of deviant behavior in big prison-like asylums by new forms of involuntary treatment ('therapeutic chain') of deviant behavior in the same 'pathological' community that generates or does not tolerate it. In other words, this would be a process in which an open violence such as the incarceration in asylums is replaced by more subtle strategies of intervention whose coercive character is more concealed. Consequently, the move towards the community does not change substantially neither the subordination of psychiatric intervention to the political requirements of controlling certain behaviors which are socially problematic, nor the helplessness of patients against the influence and intervention of mental health professionals in their lives.[11]

Many of the most outstanding protagonists of these antipsychiatric circles were indeed from the beginning very critical with the reform programs, because they considered them as mere attempts to recontextualize the psychiatric institution without changing its essential structure. Some of them, as is the case of F. Basaglia in Italy, ended up by playing an important role in the subsequent configuration of mental health services in their respective countries, but this fact did not prevent them from maintaining very watchful positions regarding the ideology of the new community psychiatry (Basaglia 1968). On the other hand, R.D. Laing, the most conspicuous representative of English antipsychiatry, was prone to think that the new care strategies were precisely addressed to extend and optimize even more the social-hygienic duties of the old asylum psychiatry (Laing 1960). And, departing from quite different assumptions, this has also been the point of view defended by the well-known Hungarian-born North American psychiatrist T. Szasz. For him, the whole process of deinstitutionalization has only represented a further step in the constitution of psychiatry as an "inquisitorial device" which reflects the deep antiliberal tendencies of the modern States (Szasz 1970).

Although this is not the place to assess the basic assumptions of the antipsychiatric positions, it is obvious that this pattern of interpretation is not free at all from serious inconsistencies and is unsatisfactory in many aspects. In the first place, one must admit that, in the majority of the cases, the intention of these authors has been more critical than explanatory, so that their reflection about the actual causes of the reform processes has been, in general terms, quite limited. Likewise, it can be said that their insistence on stressing all the continuities beyond the possible discontinuities has prevented them from realizing the significance and scope of some of the transformations that have finally taken place during the last decades. This is, for instance, the case of the notable expansion in the voluntary demand for psychiatric services, of the decentralization and diversification of resources or of the implications of the widespread use of drugs (Castel et al. 1982). Nonetheless, the problem of a big part of antipsychiatric accounts lies foremost on their tendency to analyze psychiatric practice almost exclusively in terms of a power relationship between professionals and patients, i.e. focusing excessively on the internal dynamics of the psychotherapeutic relationship. Curiously enough, in doing so they end up by neglecting almost as much as the conventional account the possible influence of other wider social, cultural, economic or political factors in the organization and patterns of use of mental health services (Ralph 1983).

Reforms and professional interests (professionalization)

According to this perspective, which has not been systematically formulated by any author, but enjoys a remarkable

[11] A paradigmatic formulation of this interpretation could be, for instance, the following one: "The chains are gone, the beatings are less frequent and more selective, the locked doors have been opened in many institutions, and the interior decorations have been improved. However, mental hospitals are still used primarily to confine disruptive members of the lower classes. The chains are chemical and legal, the beatings are psychological, and the locks have been replaced by members of the mental health team who guard the open doors" (Leifer 1969, pp. 98–99).

circulation,[12] the institutional mutation experienced by psychiatry during the last decades should be seen as a clear example of a successful strategy of expansion, adaptation and consolidation of the interests and even of the social power and relevance of a particular professional group. Psychiatrists, therefore, would have been the main actors and promoters of this mutation, and their main objective would have been the increase of both their social prestige and their spheres of intervention. Over a century, asylums had represented the epicenter of their praxis and their power, but the isolation, the progressive deterioration and the scarce reputation of them as therapeutic spaces ended up by convincing psychiatrists of the fact that they were a big risk for the future of the profession. Encouraged then by a group of professionals increasingly aware of their image problems, of their marginality among other health services and of their rivalry with other emerging professions—foremost psychological-trained psychotherapists—, the reform processes pursued and have had as their main outcome a substantial growth in the quantity and variety of institutional settings, clients and forms of intervention.

As it happens to other models, this interpretation is doubtlessly enlightening in some aspects, but it is not exempt from various problems and limitations. In the first place, it can be said that, like the antipsychiatric approach, this perspective tends to grant an excessive power to psychiatrists, overestimating thus their influence and their ability to materialize their interests by themselves. Moreover, it is quite troublesome to determine these interests in an unitary and unanimous way, since the history of psychiatry gives plenty of examples showing us the coexistence of highly divergent positions within the profession concerning the best policy and the basic goals of mental health care institutions. In some countries like the Federal Republic of Germany, for instance, the beginning of the reforms proceeded with many difficulties due mostly to the existing division among professionals concerning their main priorities and targets.[13] The German case shows, more precisely, that many psychiatrists, even if they were interested in expanding and differentiating the networks of care settings and facilities, were not prone to give up the sphere of activity of the old asylums, because these still represented for them the context that could best guarantee their clinical pre-eminence and their privileged status in the provision of care.

In general terms, psychiatrists have grown in number and presence and have probably improved their image and social prestige as a consequence of the reform processes developed during the last decades. But, while it is true that different professional societies and lobbies have played here an important role in some countries, it seems wholly excessive to confer them the ultimate responsibility for all these transformations. Against this interpretative pattern, it is finally worth adding that the mere extension of the spheres of activity cannot be understood *per se* as the compulsory goal of all professional collectives. As the Dutch sociologist of medicine A. De Swaan has underlined, professions tend rather to watch carefully that their members stay within the scientifically recognized or traditionally established frames and ways of intervention in order to keep their internal cohesion and their reputation (De Swaan 1989).

Reforms and political economy I (decarceration)

The most popular account among a series of influential interpretations based on classical arguments coming from Marxist political economy –such as costs administration, fiscal pressures or the vicissitudes of the labor market– is doubtlessly the one suggested by the British sociologist and historian of psychiatry A. Scull, whose book *Decarceration* was released in 1977 and provoked quickly a sharp controversy around the problems of deinstitutionalization as it was being carried out particularly in the USA and England.[14]

For Scull, and in opposition to what was being contended by the official rhetoric, the kernel of the reforms should not be seen in the displacement of the locus of psychiatric intervention to the community, but on the mere rejection of the asylums, i.e. of an "institutionally based system of segregative control" (Scull 1984, p. 64). Considering the successive waves of discharges from mental hospitals and the rapid decrease in the asylums' population from the mid 1950s on, Scull stated that the great majority of these 'decarcerated' patients had been actually left to their fate:

[12] See for instance their critical analysis in overview works such as those by Goodwin (1997), pp. 33–36, and Forster (2000), p. 41. Among the historical studies that assume directly or indirectly this perspective, it is worth mentioning the already quoted monograph by Grob (1991) on postwar North American psychiatry.

[13] In this case, the divisions reflected largely the interests of various influential subgroups within the psychiatric profession, such as the directors of mental health hospitals and university clinics, the neuropsychiatrists in private practice and the young professionals who pioneered social and community psychiatry. Until the definitive outline of the recommendations of the parliamentary commission (Enquête) in 1975, each of these groups made very divergent reform proposals. See Schmiedebach and Priebe (2004).

[14] As a sample of this controversy, see the critiques made to Scull by Jones (1982) and his corresponding reply in Scull (1983). Along those years, many Anglo-Saxon journals such as the *Millbank Memorial Fund Quarterly*, the *New Directions for Mental Health Services* or the *International Journal of Mental Health* dedicated special issues to the development of deinstitutionalization. A second edition of *Decarceration* was released in 1984—it is the one quoted here—, and the author included then an interesting epilogue where he reviewed and replied to all the received critiques (Scull 1984, pp. 161–198).

> "For many [...] ex-inmates the alternative to the institution has been to be herded into newly emerging 'deviant ghettoes', sewers of human misery [...]. Many become lost in the interstices of social life, and turn into drifting inhabitants of those traditional resorts of the down and out" (Scull 1984, p. 153).

Seen from this perspective, the first thing that can be said about this approach is that its description of the process seems to lead to an unique explanation, i.e. that the actual reasons for the implementation of the reforms had a financial character. In his analysis, Scull specified these reasons in two interrelated arguments. On the one hand, the new disability insurances and the social benefits introduced by the postwar Welfare States would have for the first time facilitated to former asylum inmates the subsistence outside the institutions (the so-called 'outdoor relief'), so that, according to Scull, "segregative modes of social control became, in relative terms, far more costly and difficult to justify" (Scull 1984, p. 135). On the other hand, the notable increase of public expenditure derived from the general tendency to socialize production costs which was being then experienced by Western States would have provoked an urgent fiscal crisis that led governments to choose the less expensive alternative for the care of dependant people.[15]

The radicalism of this perspective and the problems that deinstitutionalization programs were facing in many countries happened to be decisive in the great circulation and influence of Scull's works at the beginning of the 1980s. Anyhow, and despite his commendable attempt to link the emergence of the reforms with wider socioeconomic processes, his theses reflected a quite biased view of the post-asylum psychiatry, and are questionable in some important aspects. Firstly, his description of the whole process of transformation in psychiatric care is extremely partial, forgetting the notable development of both alternative resources to asylums and new settings for other clients that have taken place in numerous countries and regions. The reason for that partiality could lie on the nearly exclusive consideration by Scull of the case of the USA, but also there, a remarkable number of community mental health facilities have been created with public funds (Mechanic and Rochefort 1990). Secondly, Scull's theses do not fit with the actual facts of recent economic history, because the fiscal crisis he refers to is a phenomenon which began to be observed in most Western countries from the mid 1970s on, and not during the decades when the psychiatric reform programs were planned and introduced, i.e. in the 1950s and 1960s (Van der Wee 1986). For this reason, the fiscal crisis of the States can hardly have had a direct causal role in the genesis of the reforms, but, on the contrary, it seems to have had a big part of the responsibility for the stagnation and deficiencies of the reform processes during the subsequent decades, caused precisely by the higher costs of the new resources if compared with the traditional mental hospital (Breemer Ter Stege and Gittelman 1987). Last but not least, another argument against this account concerns the improbable relevance conferred by Scull to the social aid programs of the Welfare State and to the new possibilities of an 'outdoor relief' as driving forces for deinstitutionalization. If this had been the case, those countries, such as the Federal Republic of Germany, that first introduced these benefits would also have been the forerunners in initiating the reforms in psychiatric care, an assumption which is overtly false (Warner 1994, p. 92).

Reforms and political economy II (rehabilitation)

An account also based in Marxist political economy, but far more informed and perhaps also more consistent than Scull's, has recently been proposed by the North American psychiatrist and anthropologist R. Warner in the frame of an outstanding study on the prognosis of schizophrenia along the last century (Warner 1994). From Warner's point of view, the key element in the great transformation experienced by psychiatric care during the last decades has not only been the goal of saving costs, but, foremost, the development of the labor market and the evolution of the demand for working force since the end of World War II.

Up to that moment, asylums had accumulated a big number of people excluded from the production process and to whom society only offered a strictly custodial and segregative care. But the great demand for working force in the immediate years after the war, especially in the United Kingdom and in other North European countries, would have led to a double program for transforming psychiatric institutions aimed at including in the labor market all those patients able to be rehabilitated and capable of working.[16] Consequently, various strategies for rehabilitation and treatment in the community such as the 'therapeutic communities' developed by Maxwell Jones and others in England (Millard 1996), together with a policy of short-term hospitalizations and a notable liberalization in the management of psychiatric wards (Clarke 1993), spread in those

[15] Some years later, Scull summarized his interpretation as follows: "Given the reluctance to fund rehabilitation appropriate to the needs of the severely disabled, and the disincentives associated with income maintenance programs, one might conclude [...] that society has decided to 'pay off' the mentally ill rather than rehabilitate them—and to do so at near subsistence levels" (Scull 1985, p. 551).

[16] It is interesting to note here that this correlation between labor shortage and psychiatric rehabilitation has been also proposed for the case of countries belonging to the old socialist bloc as the German Democratic Republic. See Schmiedebach et al. (2002).

countries during this period. In the case of the most severely ill patients or those who were unemployable, the lack of credibility and the high costs of the asylum model would have led, as Scull thought, to their transfer to a problematic series of parallel or auxiliary institutions, or to provide them with pensions or benefits for their rough subsistence in the community.[17]

Nonetheless, this interpretation of the reforms as a process exclusively dependant on the ups and downs of the labor market or aiming at rehabilitating and optimizing the working force is the result of a partial assessment of the available data. Indeed, the existence, assumed by Warner, of an inverse correlation between unemployment rates and the decrease in the number of psychiatric beds is highly questionable considering the evolution of these indicators in many countries (Goodwin 1997, pp. 57–59). Taking again as an example the case of the Federal Republic of Germany, this statement happens to be clearly false: whereas the average rate of unemployment in this country between 1960 and 1970 was one of the lowest in the world—less than 1% (Van der Wee 1986, p. 81)—, the bed space in mental hospitals did not stop increasing during the same period, rising from 1.4 beds per 1,000 inhabitants in 1961 to 1.6 in 1973 (Kunze 1977, p. 83).

The poststructuralist view (psychiatrization)

From this perspective, which was originally formulated in an influential book by the French sociologist and historian of psychiatry R. Castel and his coworkers at the beginning of the 1980s (Castel et al. 1982), the transformation experienced by psychiatry has to be placed in the context of a substantial modification in the technologies aimed at shaping conformity and social order. Accordingly, whereas the traditional asylum was an emphatic expression of forms of discipline and discourses based on objectification, regulation, surveillance and classification (Foucault 1972, 2003), the progression of modernity has provoked a remarkable internalization of behavioral control and the spreading of a pervasive ideology of self-enhancement and manipulation. Consequently, psychiatry has been forced to move from a pattern of "reparation of illness" towards a scheme centered on the "reinforcement of normality" (Castel et al. 1982, p. 331).

As spaces for segregation and coercive (outer) social control of overtly deviant behavior, asylums were widely inappropriate to cope alone with such new demands, and they have been finally complemented with a broad and complex network of practices and institutions aimed at promoting individuals' mental health. In a social and cultural context where the concepts of psychiatry and psychology have penetrated nearly all spheres of daily life, the new institutions are now not only in charge of a limited number of ill people, but they also offer orientation to the general population in order to solve multiple problems in the most diverse areas and stages of life. In a well-known formulation, Castel and his co-workers summarized all their account under the heading of the emergence of an "advanced psychiatric society" (Castel et al. 1982, p. 344). The reorganization of psychiatric institutions initiated by the reforms would be thus, above all, the expression of a process of 'psychiatrization' or 'psychologization' that corresponds to a late stage in the development of the culture of subjectivity and of the strategies for keeping social conformity imposed by modernity, more based on self than foreign or merely repressive control.

Again, it does not seem that this interpretation is able to capture some essential aspects of deinstitutionalization and other related reforms. So, for instance, Castel and coworkers underlined that the contemporary expansion of psychiatry had quietly coexisted with the maintenance of older forms of internment (for example in Castel et al. 1982, p. 332). Consequently, the crucial fact that many people with serious mental illness now find themselves living in community settings when previously they might have been institutionalized does not seem to be easily explained within this account. The expansion of psychiatry towards new clients and tasks has been surely one of the major processes of the last decades, but many new services and facilities (PDGH, residential homes, day hospitals, domiciliary services and others) have been expressly created in order to replace older functions of the asylums (Thornicroft and Bebbington 1989). This process has certainly had important gaps and shortcomings, and old-fashioned practices do continue to exist, but it is also a central phenomenon which has to be accounted for.

A new level of medicalization

Taking into account the undeniable process of 'clinification' that, being or not a declared intention of the different

[17] Warner summarizes this dual interpretation of the process as follows: "Labor dynamics, then, may explain many features of the deinstitutionalization movement. Before the introduction of the antipsychotic drugs, the post war full employment in northern Europe required the rehabilitation of the marginally employable mentally ill, stimulating the development of more therapeutic styles of hospital care and a policy of early discharge. The move to milieu therapy and community treatment was delayed in the United States, where full employment did not generally develop. The introduction of disability pension schemes made possible the discharge of patients in the absence of employment opportunities, and the advent of antipsychotic drugs allowed the control of symptoms in patients placed in inadequate and stressful settings. These changes, particularly in the United States, led to a different style of community management—the transfer of patients to low-cost placements, often without genuine attempts at making patients productive, valued and integrated members of society" (Warner 1994, p. 95).

reform programs, has ended up by experiencing psychiatric practice in the last decades (Novella 2002), some authors have placed right here the starting point of their theoretical understanding of the actual changes. So, for instance, the Austrian sociologist R. Forster, who has proposed an interpretation based on the concept of 'medicalization' with the twofold objective of integrating and differentiating the empirical findings on the reforms and of identifying those elements of the process that might suggest a wider theoretical perspective (Forster 1997, 2000).

Forster considers that a detailed analysis of the consequences of the restructuring of psychiatric services reveals the differentiation of at least three subsystems of care for persons with mental disorders. In the first place, a system of an eminently medical character for the treatment of acute episodes or severe disorders which, in general terms, is relatively well integrated into the framework of the basic sociosanitary coverage of the general population. In second place, a subsidiary subsystem dedicated to the care and supervision of the daily needs of chronically ill and disabled persons that is nowadays only partially controlled by conventional psychiatry. And, lastly, a psychotherapeutic sector dealing with milder disorders or stressful life events, which is usually not covered by the basic schemes of social and sanitary insurance. In his opinion, this differentiation must be understood as the result of a major shift in the form and level of medicalization experienced by psychiatry:

> "In the core areas of psychiatry, medicalization has increased and there has been an approach to typical patterns of general health care. At the same time, there has been a partial demedicalization in those areas where psychiatry was too unsuccessful or its image was in danger (chronicity, disability, constraint). In the case of milder psychological disturbances and psychotherapeutic interventions, psychiatry could not reach a monopoly. The essence of deinstitutionalization has to be considered as an intensified, better integrated and legitimized medicalization" (Forster 2000, p. 42).

Although this description seems to be quite accurate when considering the actual developments in many countries, the proposed list of causal factors that are responsible for the process happens to be, nevertheless, a bit heterogeneous and arbitrary. In Forster's opinion, the intensification in the level of medicalization of psychiatry shaped by the reforms would have been the result of a particular confluence of professional interests, political convenience and economic interests of the pharmaceutical industry. If, as it has been shown, each of these factors is unable to account for the reform programs set in motion, or is even inadequate, it is very unlikely that their mere addition implies a specific synergy determining the deep dynamics of the whole process.[18]

But there are also two other main reasons for questioning this interpretation. Firstly, the assumption that the old mental hospitals were not medicalized enough or were places subject to an incomplete medicalization, cannot be taken at face value considering the theoretical and practical evolution of psychiatry during a big part of the asylum age. Indeed, once the reeducational efforts imposed by the moral therapeutics of the foundational period were abandoned, the medium of the asylum favored for decades some of the most overtly medicalist theoretical views along the history of the discipline, while their inmates were submitted in a generalized way to all kinds of somatic treatments.[19] Secondly, confirming that the pattern of psychiatric intervention has approached to a great extent that of the rest of medicine does not seem to imply per se any theoretical profit if this pattern of intervention is not itself defined in more concrete terms.

Concluding remarks

Logically, this critical review of the main explanatory models which have tried to account for or to find a certain logic in the important transformations experienced by

[18] Similar conclusions may also be valid for different mixed models that have enjoyed some diffusion, as it is the case of the account proposed by the English sociologist J. Busfield, who assumes a dual description of the process—creation of new services for mild or acute patients and transinstitutionalization for the most severe or chronic patients—that reminds the one by Warner, while her list of 'underlying factors' responsible for the bloom of the reforms combines arguments which are close to those of the critical accounts, to the economicist positions of Scull or to the medicalization hypothesis (Busfield 1986, pp. 342–346). Nevertheless, Busfield adds to this list another element that has not been mentioned here, but whose importance in the initial rhythm of the reform processes in some countries should not be neglected, i.e. the notable therapeutic optimism that pervaded psychiatry during the decades of the 1940s and 1950s: "This optimism, heightened though not initiated by the introduction of psychotropic drugs, stemmed from a number of sources: from the therapeutic developments of the period; from the increasing numbers of voluntary patients and those with less severe complaints using the mental hospitals; from the administrative reorganization of the services; and from the general climate of optimism of the period associated with post-war recovery and economic growth" (Busfield 1986, p. 344).

[19] On this chapter of the history of psychiatry see, for instance, the excellent monograph by J. Braslow on the administration of somatic therapies in North American asylum psychiatry during the first half of the 20th century (Braslow 1997). An outstanding analysis of the process of medicalization experienced by French asylum psychiatry in the 19th century was offered by Lantéri-Laura (1972). For an overview of the "first biological psychiatry" developed in the traditional mental hospitals, see Shorter (1997), pp. 69–112.

psychiatric care during the last half century, cannot intend to cover all the numerous arguments and hypotheses suggested year after year in the most diverse publications, but it is nonetheless a complete inventory of the most relevant and widespread perspectives.

As we have seen, and despite the undeniable interest and heuristic value of the reviewed interpretations, they are not free at all from important shortcomings or inadequacies, so that they tend to fall both into localism—their conclusions seem to be valid only for some regions or countries—or partiality—they consider only some aspects of the process while neglecting others—. Consequently, it is necessary to advance some methodological and conceptual strategies which should guide an alternative and more complete assessment of the facts as well as the outline of new theoretical approaches on this significant shift in contemporary mental health care. Although these strategies refer to different academic areas and fields of research such as health care analysis, philosophy of medical practice, social history or even historical sociology, they have to be seen as necessary and closely related steps in the multidisciplinary task of providing more suitable accounts of deinstitutionalization and the reform of mental health services.

First of all, any attempt to offer a general explanatory model of these processes should be based on a comprehensive and careful description of the actual changes in order to avoid one-sidedness or oversimplifications. Furthermore, and as the intended explanation should avoid to be misled by regional or national variations, this description should proceed from a comparative international perspective, looking for those tendencies in the changing patterns of mental health care which appear to have a cross-national character or what phenomenologists would call their eidetic traits. In this sense, it may be said that a preliminary analysis of available data and comparative reports suggests that the recent transformations have represented almost everywhere the transition from a pattern of care based on less differentiated long-term interventions in large and isolated asylums to an extended and more differentiated—according to age, diagnoses, therapeutic techniques, chronicity or additional social problems—model centered on short-term interventions in small and—if possible—community-near institutions (Goodwin 1997). Thus, it is not merely the run down of older facilities or the creation of new services what an accurate explanation should account for, but all relevant areas and dimensions of this paradigmatic shift, including its different implications for policy makers, professionals and users or the emergence of new institutional devices, therapeutic cultures, funding schemes and legislation (Novella 2007).

Secondly, it seems quite difficult to reach an adequate understanding of the recent processes of deinstitutionalization and reform of psychiatric services without considering not only the role of some factors such as professional interests, political convenience or costs administration, but also the crucial issue of the emerging social values and needs which may have inspired this changing pattern in mental health practice. At the beginning of the 19th century, psychiatry made its generalized appearance as a social and historical actor and founded itself as a medical discipline through a set of legal, theoretical and practical operations centered on the key institution of the asylum. Paradoxical as it may seem from today's perspective, the birth of the asylum was also accompanied by a clear reformist spirit of nearly utopical traits and a broad consensus about the essential role of isolating the patient from the community in the work of recovery (Schrenk 1967). The asylum was then widely perceived as the symbol of an enlightened and progressive civilization that no longer ignored or maltreated its dependent mentally ill citizens (Scull 1989). One hundred and fifty years later, it was exactly the very institution of the asylum and the practice of segregation that turned out to be in the discourse of many mental health professionals and policy makers the most important obstacles for the therapeutic commitments of psychiatry. The paradigmatic statement by two prominent researchers of the 1950s that "the worst home is better than the best mental hospital" (Cumming and Cumming 1957, p. 310) reflects this major opinion shift, since it did not suggest a concern for the material or human conditions of the asylums, but a radical questioning of their therapeutic value. From this point of view, it seems therefore that the "drive towards the community" and the subsequent reforms have been rooted in a broad consensus about certain social values and needs of a distinctive quality which any accurate analysis has to account for. If, as some voices recently claim, the reflection on the conceptual principles and values which inform the practice of mental health care represents one of the major tasks and challenges for the current philosophy of psychiatry (Baca 2004), an appropriate understanding of this programmatic shift from asylum to community should be seen as a first and inescapable step.

Finally, it seems also essential to place in a consistent way the emergence and consolidation of these new values and needs and the whole process of deinstitutionalization and reform in the field of mental health care within the context of the extraordinary changes experienced by Western societies during the same period. As is known, the official beginning of these reform programs took place in most Western countries between the decades of the 1950s and 1970s, when diverse legislative initiatives settled the bases for what society expected from the future system of

psychiatric care.[20] Significantly, a global approach to these three key decades (1950–1980) reveals that they were a time of radical breaks in the economic, social and cultural order or, to put it in other words, a period where some of the most significant aspects and consequences of the contemporary social and cultural order which is commonly described as modernity spread more rapidly and with more universality.[21] Consequently, it does not seem probable to find a satisfactory explanation of the psychiatric reform processes lacking a solid historical and sociological analysis of this period, i.e. without a reflection on the requirements imposed to the new devices of mental health care by a social and cultural order which became then in many decisive aspects completely different from that of the beginnings of the asylum age.

So then, and although we are dealing with processes which started more than five decades ago, the quest for accurate explanatory models seems far from having been completed. And, in this case, it seems especially true that, as A. Scull wrote, "sensitivity to questions of evidence and inference must be combined with theoretical sophistication and vision, and understanding the particular necessarily depends on an ability to place one's findings within a broadly comparative frame of reference" (Scull 1989, p. 5).

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[20] The most emblematic landmarks of this official beginning of the psychiatric reform projects were the passing of the Mental Health Act of 1959 in the United Kingdom, the signing by J.F. Kennedy of the Community Mental Health Centres Act of 1963 in the USA, the delivery at the end of 1975 of the report of the Enquête-commission in the Federal Republic of Germany, and the passing in 1978 of the Law 180 for the case of Italy. See for example Forster (1997), pp. 36–62, for a synthesis of these and other relevant events in each of these countries.

[21] Historical approaches to the postwar decades which emphasize the radicality and deepness of the economic, social and cultural transformations experienced during the period are offered in the known volumes by Hobsbawm (1994) and Judt (2005). It is certainly noteworthy that, in the course of a general work on the history of the 20th century as Hobsbawm's one, the case of the community psychiatric reform programs is explicitly related to the consequences of social and cultural modernization (Hobsbawm 1994, p. 338).

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