10. OUTPATIENT PSYCHIATRY AND MENTAL HEALTH CARE IN THE TWENTIETH CENTURY: INTERNATIONAL PERSPECTIVES

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This article is about the main similarities and differences between the twentieth-century history of extramural psychiatry and mental health care in the countries that are central in this volume: France, the Federal Republic of Germany, Italy, the Netherlands, the United Kingdom, and the United States. My comparative analysis not only switches back and forth between relevant general trends and specific national developments. It also has a double focus: the development of outpatient services and other facilities in society, also known as 'community care' in the Anglo-Saxon countries, and 'de-institutionalisation', the demise of the public system of mental institutions, or at least a considerable reduction of its size. First I outline the relevant developments in extramural mental health care during the first half of the twentieth century. Then I will explore the changing constellation of psychiatry and mental health care in the second half of the last century, which some scholars refer to as the third psychiatric revolution[1]: the different ways and degrees in which de-institutionalisation was implemented in the various countries and the accompanying shift towards outpatient or community care. Moreover, special notice will be taken of the tensions between ideals and realities. At the very end I shall again briefly consider the main differences and similarities between the six countries.

Histories of psychiatry largely centre on mental institutions; studies on the history of outpatient psychiatry and mental health care are still thin on the ground and therefore the data at my disposal are incomplete and fragmentary. My comparative analysis relies on some available studies in English, Dutch and German, the preceding articles in this volume, and some papers presented at the Anglo-Dutch-German Workshop on Social psychiatry and Ambulant Care in the Twentieth Century, which took place in London in 2002.[2]

Outpatient psychiatry and mental health care before de-institutionalisation

In the post-World War Two era, it was hardly a new view that it was better to keep psychiatric patients as much as possible outside mental institutions and establish alternative care facilities for them. In the nineteenth and early twentieth centuries, mental institutions were not by definition isolated, total institutions. British, Dutch, Italian, and Japanese studies show that many patients stayed in them for only a limited time-period, not so much because of their illness in itself as their disturbing behaviour. Also, their relatives played a central role in the decisions over admission and discharge, and often they or non-related households took care of patients. The walls of the mental asylum were not impregnable barriers separating the insane from society.[3]

Nor was the aim of prevention through early treatment of essentially healthy individuals, troubled by psychosomatic and mental symptoms or behavioural problems, a product of new insights. Already in the last decades of the nineteenth century, some psychiatrists extended their professional domain beyond the walls of the asylum, not only by treating psychosomatic complaints, nervous disorders, addiction, sexual deviance, 'moral insanity' and criminal psychopathology, but also by presenting themselves as

experts in the field of social hygiene in society at large. The first national psycho-hygienic movement was established in 1909 in the United States on the initiative of the ex-psychiatric patient C.W. Beers and the psychiatrist A. Meyer. After the First World War, the American National Committee for Mental Hygiene began to spread its doctrine internationally, and in 1930 it organised an international conference in Washington. Mental hygiene organisations were founded in the United Kingdom (1918), France (1920), Belgium (1924), Italy (1924), the Netherlands (1924), and Germany (1925). Besides the US, France stimulated international developments in this area: in 1922, 1927, and 1937 international conferences on mental hygiene were held in Paris. While laypersons played a major role in the American Mental Hygiene movement, in Europe psycho-hygiene was mainly promoted by professionals - psychiatrists and other doctors in particular - but also by psychologists, educational experts and social workers.[4] Various mental health services, such as pre- and aftercare facilities, outpatient clinics, and prevention-orientated counseling centres for children and adults, were also set up. These small-scale facilities mainly depended on scattered local or private initiatives, though. Centrally co-ordinated national networks of services still barely existed during the first half of the twentieth century.

The first social-psychiatric facilities, dating back to the early twentieth century, originated in Germany. The so-called *nachgehende Fürsorge*, a form of aftercare with facilities where discharged psychiatric patients could work, was aimed at reducing their chances of regression and subsequent re-admission. This project, set up by psychiatrist G. Kolb from the psychiatric institution of Erlangen, received international attention, just as H. Simon's occupational therapy in the 1920s, which in part aimed at enhancing the social rehabilitation of the mentally ill through work. In the early 1920s, there was also a pioneering initiative by the psychiatrist F. Wendeburg in Gelsenkirchen, who, independently of the mental asylum and as part of public health care, developed a form of social psychiatry that sought close collaboration with social and juridical agencies. This project comprised the monitoring of discharged patients, their aftercare, their social reintegration, as well as the registering of mental disorders among the population at large so as to be able to provide immediate care if necessary.

Apart from these forms of social psychiatry, during the Weimar Republic psychotherapeutic institutes and counseling centres for psychosocial problems emerged in some cities, especially in the fields of family, marriage, sexuality and education, staffed by psychologists, psychoanalysts, sexologists, and educational experts. They were inspired by reformist ideals and were occasionally supported by social-democratic local authorities. Psychiatrists, who in general followed a medical approach and rejected psychoanalysis, hardly played a role in these activities on the borderland of mental health and social work. In fact, social psychiatry struck out on a very different course. The protection of public order and the improvement of people's mental health at large already played an important role in pre-World War One German social psychiatry, a tradition that in the 1920s became strongly influenced by eugenics. From the start, social psychiatry was not only extramural care for psychiatric patients, but it also implied a preventive regime as a way to monitor the overall population's mental health. In this light, some psychiatrists argued in favour of a prohibition on marriage for mental patients, their sterilisation or long-term institutionalisation, and even euthanasia, so as to prevent the mentally ill from procreating. Proposals of this sort suggest there was at least some

continuity between German social psychiatry and the murder of psychiatric patients in the Third Reich, despite the fact that the Nazi regime had banned all mental hygiene associations in Germany in 1935.

The Third Reich and the Second World War signified a radical break in the development of extramural psychiatry in Germany. Until the mid-1960s, when initiatives from innovation-minded psychiatrists could count on more support, the various social-psychiatric and other outpatient services remained minimal. Psychiatrists who worked outside mental hospitals, like those in university psychiatry, were mainly geared toward medical science, neurology in particular. The social aspects of care provided to the mentally ill received little attention and extramural facilities for chronic patients, like special housing and work facilities, were scarce. Preventive and aftercare services aimed at psychiatric patients, as well as other social-psychiatric activities such as those involving admission, were co-ordinated by the *Gesundheitsämter*, local public health services that were not allowed to perform medical interventions, such as the prescription of medication. Before the mid-1970s, with the exception of university psychiatric hospitals, there were hardly any outpatient clinics for emergency psychiatric care. The largely privately established medical sector closely guarded its monopoly on treatment. By and large, private psychiatrists and neurologists dominated mental health care outside the walls of mental hospitals. They almost exclusively practised in urban centres and were medically orientated, treating psychiatric disorders and neurological complaints in tandem, a practice with roots in the late nineteenth century. This medical focus was in part stimulated by the medical insurance system, which discouraged time-consuming forms of counseling and psychotherapy. Furthermore, psychotherapy in Germany did not so much develop as part of psychiatric practice, but more in general health care, as part of psychosomatic medicine.

In Great Britain, a Mental After-Care Association was founded already in 1879, but until the 1930s, it did not provide any services to support mental patients in society. The frequently large-scale and overcrowded asylums mainly functioned as shelters, rather than as hospitals, and they were closely linked up with the poor relief tradition and the juridical procedures that were necessary for admission. Although many of the mentally ill were cared for in the community by their own families, in non-related households (in Scotland), or in other institutions and were never hospitalised or only for a short period, outside of the asylum, psychiatric treatment could only be found in private practice. By the 1910s, however, in part because of the attention given to soldiers who suffered from shellshock, this situation began to change. Some of these soldiers were treated according to new psychotherapeutic principles in the Maudsley Hospital, which opened in 1916 and offered both intramural and outpatient treatment of acute psychiatric disorders. In the 1920s, psycho-dynamic psychiatry, which undermined degeneration thinking and the therapeutic pessimism tied to it, was also applied in the Tavistock Clinic, established in 1920. Starting in the late 1920s, under the aegis of the mental hygiene movement, Child Guidance Clinics were established in some British cities. Extramural mental health care was further stimulated by courses in psychiatry offered to nurses and general practitioners, and by training facilities for psychiatric social work, the first of which started in 1929 at the London School of Economics. A major impetus for such developments was the Mental Treatment Act of 1930, which marked a first step toward the integration of psychiatry in medicine. This act not only provided for voluntary

admission in what were now called mental hospitals instead of asylums, but it also enabled the establishment of some public outpatient clinics, voluntary aftercare services, and convalescent homes. However, their scale and numbers were small and only in London a few psycho-analysts in private practice offered psychotherapy. On the eve of World War Two, there was certainly no comprehensive extramural network in place.

World War Two, like the first one, brought a number of psychiatric innovations. Army psychiatrists, for instance, who tried to address the problems of soldiers traumatised by the war's violence, applied new forms of treatment, like brief psychotherapy and group therapy. After the war these innovations challenged psychiatrists to work more with psychotherapy and to experiment with therapeutic communities. Moreover, that psychiatry became part of the National Health Service in 1946 was of the utmost importance. This collective health provision made it possible for people with more or less serious mental disorders to receive treatment outside of psychiatric hospitals. After the number of inpatients peaked in the mid-1950s, the application of anti-psychotic drugs in particular, but also Electro Convulsion Therapy, shortened the average time of hospitalisation and led to a larger turnover of patients. The new medication also enlarged the opportunities for psychotherapeutic and social-psychiatric treatment of patients, as well as for helping them outside mental hospitals in outpatient clinics, day hospitals, and general practice. Some psychiatrists and psychiatric social workers began to visit patients at home, emphasising the importance of the social environment and integration in society. In the 1950s, British psychiatry gained an international reputation with its approach aimed at breaking the barriers between mental institutions on the one hand and somatic medicine and society on the other. It was argued that psychiatry had to be integrated into general medicine as much as possible, which implied, among other things, that acute mental disorders should be treated in psychiatric wards of general hospitals. Furthermore, there was increasing interest, also at the level of government, in new ideas about what was termed 'community care', which would make patients less dependent on mental hospitals.

Even earlier than in Great Britain, the legislative conditions in France were favourable to the development of forms of outpatient psychiatry. Already in the second half of the nineteenth century, the French government permitted asylums to spend as much as a third of their budget on activities aimed at reintegrating patients in society. In practice, however, for a long time little was accomplished. Although in the 1920s, on the initiative of the psychiatrist E. Toulouse, the first outpatient facility for the treatment of psychiatric disorders was established in Paris, such facilities continued to be scarce in France until the 1950s. The centres for mental hygiene, which were set up in the 1930s under the aegis of the *Societé d'Hygiène Mentale*, were tied to *dispensaires* (outpatient clinics) for social hygiene that targeted children and, from 1937, adults as well. During the reign of the leftist *Front Populaire*, the government was positively interested in social hygiene, as well as in open wards of psychiatric hospitals and social casework, as a method for managing discharged patients.

After the Second World War, the preventive activities in general health care that were funded by local, regional, and national government, co-ordinated by the *Office Public d'Hygiène Social*, provided the framework for developing an aftercare system aimed at early discharged psychiatric patients, which helped to reduce the average length of their hospitalisation. Both psycho-tropic drugs and the increased role of psychotherapy

were instrumental factors. In the mid-1950s, the fight against alcohol addiction provided a reason to increase the number of social-hygienic *dispensaires*, of which the psychiatric counseling-centre became a mandatory unit. In medical psychiatry, however, little changed at first: around 1960, the mental hospitals still existed basically in isolation from the rest of the medical world and to the extent that general hospitals had psychiatric departments they were fairly small and operated on a policy of selective, limited admission. In the late 1950s, several psychiatrists in Paris took the initiative to organise a first form of community psychiatry that consisted of a local clinical facility and various outpatient services for treatment, care, and support. This local project would serve as a model for the reforms that were launched in the 1960s and beyond.

In Italy, some local extramural psychiatric facilities were set up in the early twentieth century, but more important was the widespread practice of various forms of family-care in several provinces. Mental asylums saw little modernisation. The 1904 Insanity Act stipulated that the mentally ill who were dangerous to themselves, other people, or the public order had to be confined in public asylums. Patients who were not considered dangerous could also be cared for in society by their families or in other facilities. Voluntary admissions were only possible in private hospitals and university clinics. The fascist regime, stressing that the insane were dangerous to society, expanded the number of public asylums so that the number of inpatients doubled during the first four decades of the twentieth century. It also introduced the provision that a person's psychiatric admission was registered by the police. Even though the Italian asylums were renamed 'hospitals' after the war, in comparison to the other countries discussed here, the quality of the care they offered was low, in part because of these institutions' overcrowding and the lack of qualified personnel. Although the government paid lip service to the desirability of outpatient facilities, in practice little changed, with the exception of local experiments that were set up from the 1960s in some cities in the North and middle of Italy. A notable example was Trieste, where the isolation of the psychiatric hospital was brought to an end and patients received much more freedom of movement. These innovations were inspired by *Psichiatria Democratica*, developed by a group of left-orientated psychiatrists, social workers, and sociologists under the direction of F. Basaglia. They turned against medical psychiatry and argued for the socialisation of care and treatment of psychiatric patients. This would allow psychiatry to cater to their needs more effectively, which in turn would improve their ability to cope with their problems on their own.

In the Netherlands, several social-psychiatric pre- and aftercare services, counseling centres for alcoholism as well as Child Guidance Clinics and other mental health facilities for children were set up during the first four decades of the twentieth century. Pre- and aftercare, organised by psychiatric hospitals, was first modelled after German examples, but in the 1930s, a Dutch version of social psychiatry emerged in the sense that its facilities developed more or less independently of mental institutions. The Child Guidance Clinics in the Netherlands, which combined a psycho-dynamic and social approach, were a copy of the American ones. Already before the Second World War, many psychiatrists were working in general hospitals and public outpatient clinics as well as in private practices. In the early 1940s, two new types of outpatient facilities emerged: the public clinic for psychotherapy and the Centre for Marriage and Family Problems. The next three decades saw a vast expansion of the various extramural services. A striking

feature of mental health care in the Netherlands was its broad orientation. It comprised not only social psychiatry in the sense of outpatient care for psychiatric patients, but also included counseling centres for problem children, marriage and family related issues, social adjustment, and alcohol addiction. This broad orientation is accounted for in part by the fairly early differentiation between institutional psychiatry and the outpatient mental health sector in the Netherlands, and the moral-didactic and, increasingly, psychosocial focus of the latter. In other European countries the institutional and public mental health sectors were more exclusively geared toward psychiatric patients, while there was also a closer link with the domain of clinical psychiatry. From the start, Dutch psychiatrists working in outpatient facilities joined forces with other, non-medical mental health workers: social-psychiatric nurses, psychiatric social workers, clergymen, psychologists, educational experts, and various specialist therapists.

In the United States the first form of outpatient psychiatry took shape at the end of the nineteenth century, when the growing professional group of neurologists in private practice, who dissociated themselves from asylum psychiatry, started to treat not only patients with neurological problems but also those with mental and psychosomatic difficulties. Several psychiatrists too began to dissociate themselves from the asylums and established their own practices. In part because of the rise of psycho-dynamic psychiatry, which downplayed the boundary between mental health and mental illness, psychiatrists focused on new categories of patients, which until then had remained outside psychiatry's scope. In the early twentieth century, this broadening of the professional domain not only occurred in private practice, but also became manifest in the social-hygienic focus of psychiatrists. Some of them stressed the need for social-economic reforms, while others emphasised the desirability of eugenic measures, as a way to counter unwanted immigration, alcohol abuse, and various forms of deviant behaviour. In the US, as in Germany, there was an overlap between the mental-hygienic aim of prevention and eugenics. From 1896, in various states, the mentally ill were not allowed to marry anymore and from 1907, as many as thirty states adopted laws that made it possible to sterilise without consent feeble minded and mental patients.

American psychiatrists, however, were divided on eugenics and many opposed compulsory measures. In the 1920s and 1930s, they became more interested in developmental psychology – in part through the influence of psychoanalysis – and began stressing the impact of education and social environment. In the mental hygiene movement, the two divergent orientations - eugenics and psycho-dynamic approaches - existed side by side; both fitted the aspirations of psychiatrists like A. Meyer to expand the psychiatric domain. The National Committee for Mental Hygiene moved away from the problems of institutional psychiatry and geared its effort towards alcoholism, juvenile crime, feeblemindedness, venereal diseases, and deviancy. It supported in particular the prevention of juvenile crime through its Child Guidance Clinics, which were established in the 1920s and later copied in several European countries. Their approach was characterised by a combination of a psycho-dynamic and psychosocial approaches.

The psychiatric expansion from intramural to extramural care and from treatment to prevention was stimulated, in the USA even more than in Great Britain, by the experiences of army psychiatrists during the Second World War. They developed new methods of treatment for soldiers who suffered stress and nervous breakdowns from their battlefield experiences. These mental afflictions, the origin of which was traced to social

environmental factors, might strike any soldier, and the forms of treatment applied near the battlefront, had a strong psychotherapeutic element and took place in groups. After the war, psychiatrists working in mental institutions lost their dominance in American psychiatry, giving way to the advocates of psychoanalytic and social-psychological approaches. At this point, it was of key importance that innovation-minded psychiatrists found support with the federal government, which, until then, had never involved itself with psychiatry because the care of mental patients in public asylums had always been a responsibility of the state governments.

The mounting influence of the American federal government in the domains of health care and social services after World War Two gave a strong impetus to outpatient psychiatry. Federal policy-making and advisory facilities for mental hygiene and public health were set up, and they developed elaborate plans and an effective lobby. The National Mental Health Act of 1946 allocated federal funds to research in the social and behavioural sciences, professional training in mental health care (for psychiatrists but also clinical psychologists, psychiatric-social workers, and mental health nurses), and experimental facilities that served as an alternative to the large-scale, socially isolated mental institutions and were aimed at treating mild mental problems, to prevent them from growing worse. In the mid-1950s, there were almost 1.300 psychiatric outpatient clinics, most of them in the states of the Northeast, the North-Midwest and in California. Moreover, in the 1950s, partly as a result of the American middle classes' openness toward psychological and psychoanalytical approaches of feelings and social behaviour, there was also a significant growth of the treatment offered by psychotherapists in private practice. These practitioners not only included psychiatrists but also other doctors, clinical psychologists, and social workers. Although there were indications that these services primarily met the needs of people with mild problems, instead of those of serious and chronic mental patients, in the 1950s the notion caught on that the need for alternatives to mental institutions was concrete and compelling. The results of treatment with new psychiatric drugs nurtured this optimism. Far-reaching proposals for a more extensive extramural psychiatric care system, including facilities for people who sought help for their psychosocial problems, fell on fertile ground during the years of the Kennedy administration.

Bold plans

In the second half of the twentieth century, the role of extramural mental health care in Western Europe and North America grew more prominent. For a large part, this development was connected with the introduction of psychopharmacological drugs, growing criticism of institutional psychiatry culminating in anti-psychiatry, the striving for reform of the care and treatment of psychiatric patients, and the expansion of mental health care from mental illness to a variety of psychosocial problems. Although new forms of treatment had been introduced in the preceding decades and the care and living conditions of the patients had improved, mental hospitals still stood in bad repute among the general public. These institutions, often dating from the nineteenth century, were isolated from the rest of society as well as from the general health care system and many of them were massive and overcrowded. In the 1950s, the largest mental hospitals in Europe - with around 4000 beds - were to be found in France. In Germany and Great Britain, the average number

was over a thousand. In the USA, state mental hospitals were even lager: some had around 10.000 beds. Only in the Netherlands did most of them not surpass a thousand beds.[5] In all countries, mental hospitals were often seen by the public at large as secluded shelters for the chronic and incurable mentally ill that belonged in a tradition of social care or poor relief, rather than to the health care system.

Reform efforts aimed at a renewal of psychiatric hospitals by reducing their size and breaching their isolation on the one hand, and an organisational shift to new or already existing alternative intramural and, especially, extramural facilities on the other. The alternatives included special institutions for demented elderly and the mentally handicapped, psychiatric wards of general hospitals, outpatient clinics, day hospitals, night shelters, halfway houses, social-psychiatric services, general practitioners, Community Mental Health Centres, counselling centres, and rehabilitation and work facilities. This re-organisation was motivated by the aspiration to separate the functions of therapeutic treatment, care, custody, and social rehabilitation. Closely connected to this was the wish to differentiate between the facilities for various categories of patients, such as chronic cases and emergency cases, or mentally handicapped and demented elderly. The alternative facilities were no longer merely conceived as complementing psychiatric hospitals but also, at least partly, as replacing them. It was strongly felt that treatment and care for psychiatric patients should be integrated into the overall health and social care-providing system, while their social integration came to be seen as also a priority. Moreover, the medical character of psychiatry increasingly became an issue of debate; in hospitals, psychiatrists and nurses were in charge, but in the outpatient sector, other professional groups, including clinical psychologists, social workers, and social-psychiatric nurses, claimed responsibilities as well. Finally, especially in the closing decades of the twentieth century, there was a growing emphasis on volunteer aid and self-help, partly because of efforts to reduce public spending on mental health care.

New ideas about the treatment and care of the mentally ill had been developed from the late 1940s and sometimes had been put into practice on a small scale, but it was only from the 1960s that they could be realised on a broader scale. Growing prosperity made it possible to increase budgets for mental health care and thus expand provision and employ rapidly increasing numbers of psychiatrists, as well as psychologists and other mental health professionals.[6] Three other new developments were of no mean importance in all of the countries discussed here: greater interference by government in a period characterised by democratisation and social emancipation, a growing attention to a variety of mental health problems that did not require hospitalisation, and acknowledgement of the rights of individual psychiatric patients. The nationally designed plans for new mental health networks were meant to bring care-providing facilities closer to the people, enlarge their accessibility, and ensure an efficient interconnection between the various psychiatric and psychosocial services for the mentally ill, as well as clients with minor complaints or behavioural difficulties. The combination of growing supply of and demand for mental health care entailed an extension of its domain.

In the first half of the twentieth century, social-psychiatric services were set up mainly for pragmatic reasons, such as cost-effectiveness and to relieve the overcrowded asylums. However, the interests of individual patients were clearly secondary to those of society. In the post-war period and especially since the 1960s, when ideals concerning better, more humane care, a greater autonomy of psychiatric patients, and discouraging

prejudices against them played a major role, psychiatry was brought up for public debate, often with strong political overtones. (Financial concerns, however, made a comeback from the mid-1970s.) In nearly all countries, the legislation on insanity, which often dated back to the nineteenth century, was amended. This reflected the shifting emphasis from legal procedures associated with maintaining law and order as well as protecting citizens against arbitrary detention to voluntary admission, patients' civil rights, and their right to receive adequate care and therapeutic treatment. This recognition became concrete in the Netherlands in 1916, 1929, and 1994, in the United Kingdom in 1930, 1959, 1983, and 1995, in several German states from the early 1950s on and from the second half of the 1970s, in France in 1968, and in Italy in 1968 and 1978.[7] However, the increased rights to self-determination of the mentally ill, in combination with de-institutionalisation, would enlarge the friction between the freedom of the individual and public safety. At the end of the century, there was a growing concern over the risk posed by those who neglected themselves or who were dangerous to themselves or other people.

Most national governments played an active part in the renewal of the mental health care system. After World War Two, Western Europe and the USA saw greater government involvement in and more collective funding of health and social care, whereby mental health became increasingly integrated into these two domains. (This is not to deny that mental health care still received less funding, compared to somatic care, in nearly all countries. Even after de-institutionalisation took off only a small portion of the health care budget ended up in the publicly organised mental health sector, while most of that budget – eighty percent on average – went to psychiatric hospitals.[8]) In the United Kingdom, for example, the establishment of the National Health Service (1946) and the National Assistance Act (1948) caused the management and funding of intramural and outpatient psychiatry to become part of a centrally co-ordinated collective health care and welfare sector.[9] In France, where the central government had administered asylum psychiatry since the nineteenth century, the extramural facilities were publicly funded as part of the public health care system and co-ordinated by the national *Office Public d'Hygiène Social*. While in the United States institutional psychiatry was traditionally a responsibility of the governments of the individual states, after World War Two, the federal administration actively involved itself in mental health and increased national funding substantially.

In the federally organised system of West Germany, the situation was rather complicated. The responsibilities and financing of both intramural and extramural care were distributed between the national government, the governments of the individual states, and local boards and voluntary organisations, but here too the federal government relied on legislation and increased funding to become a more active player in this sector. However, with the exception of the *Gesundheitsämter* for public health, the carrying out of health care was largely left to (subsidised) voluntary organisations and doctors in private practice. Although the Netherlands had a more centralised political system, until the 1970s their mental health sector had more in common with that of Germany than with that of France or the United Kingdom. Both in Germany and the Netherlands, a central principle of welfare and health care was 'subsidiarity' - a basic preference for organising provisions at the lowest organisational level possible. The Dutch government issued regulations, provided subsidies, and monitored mental health care, but left the responsibilities for actual care-providing in the hands of the (partly religiously based)

voluntary organisations and local and regional authorities, while funding tended to be scattered. Not until the late 1960s did the central government begin to play a more active role, especially by introducing uniform, collective funding regulations. The Italian government was even slower in adopting a more active stance. Only in the late 1970s did it propose nation-wide initiatives for renewing Italy's mental health sector and was psychiatry included in a national health insurance.

Decisions to reform mental health care and pursue de-institutionalisation were taken at the national level, although local experiments and voluntary initiatives sometimes served as the model. In Europe, the United Kingdom, whose psychiatric sector was internationally regarded a model in the 1950s, led the way. After a Royal Commission voiced its preference for community care, in 1959 parliament passed a new Mental Health Act, which replaced the older legislation. To bridge the gap between hospital and society and promote community care, the juridical procedures for admission and discharge were simplified and medical criteria were given priority. Two years later, the conservative Minister of Health, E. Powell, pointed to a drastic reduction of the number of beds in psychiatric hospitals. Psychiatric wards of general hospitals would take care of acute cases, while outpatient facilities should provide care to chronic psychiatric patients in society.

In the United States, under the Kennedy and Johnson administrations, inclined as they were to social reform and the expansion of the welfare state (the 'Great Society'), the government took an active stance in reforming the mental health sector, in part thanks to an effective lobby of the National Institute of Mental Health under the leadership of R.H. Felix. In the early 1960s, the mental health lobby aimed for the establishment of the Community Mental Health Centre that should serve as an alternative for mental hospitals. This easily accessible facility would offer outpatient mental health services to a broadly composed clientele, and also provide public educational programmes aiming at prevention. Throughout the country, 2.000 of these centres were deemed necessary, to be supported by the federal government in the initial phase. This plan constituted the core of the Mental Retardation and Community Mental Health Centres Construction Act of 1963. Also, the expansion of federal medical insurance and assistance programmes (Medicare and Medicaid), as well as social security benefits for the indigent, was a driving force behind the decline in the number of patients in mental hospitals. Many of the elderly patients moved to nursing homes, while others were able to live in the community and could be treated in the short-term and outpatient psychiatric clinics of general hospitals.

In France, changes in governmental policies were associated with several reform-minded hospital directors and officials of the Ministry of Public Health. In 1960, in a ministerial memo, they launched an ambitious plan aimed at both the improvement of institutional care and the building of a uniform system of extramural facilities on a regional basis, the *psychiatrie de secteur*. France was supposed to be divided into 750 geographical regions, with an average population of 70.000, in which multidisciplinary teams were granted the responsibility for running mental health care on a local basis. Social-psychiatric outpatient clinics, day centres, and work facilities, together with psychiatric hospitals, would contribute to a coherent care system based on preventive activities, early detection and intervention, curative treatment, and aftercare. For the time being, however, all of this did not get beyond the planning stage. In the mid-1960s, a group of progressive psychiatrists led by H. Ey, who favoured a social orientation of

psychiatry rather than a strictly medical one, argued for the actual implementation of the reform plans, as well as for a larger budget to enable this reform to take place.

Around 1960, bold plans were launched in the UK, the USA, and France at the level of the central government. By contrast, the reform proposals in Germany and the Netherlands were less drastic, less promoted by the government, and formulated somewhat later. After critical and reform-minded psychiatrists had organised themselves in pressure groups, like the German Society for Social psychiatry and the Mannheim-Circle, a special investigative commission of the German parliament, established in 1971 on their instigation and mainly consisting of medical and academic experts, published a report in 1975. Painting a bleak picture of Germany's large-scale, overcrowded, and isolated mental institutions, it concluded that there were not enough preventive, outpatient, and rehabilitation facilities. It called for a decrease of the size of mental hospitals, more psychiatric wards in general hospitals, a sustained effort in prevention and social reintegration, and the establishment of regional networks – *Standardversorgungsgebiete* of about 250.000 inhabitants – of integrated extramural services. Moreover, in addition to the care provided by psychiatrists in private practice, there was a need for more psychiatric outpatient clinics and multidisciplinary social-psychiatric services in public health centres.

Starting in the mid-1960s, the first plans for reorganising mental health care in the Netherlands came from the sector itself, rather than from the government. Although mental health care was increasingly funded by national health insurance schemes and the outpatient sector, psychotherapeutic facilities in particular, expanded rapidly, only in the early 1970s did the Dutch government begin to formulate policies in this area. The Ministry of Health presented a plan for a new system that would provide public inpatient as well as outpatient facilities on a regional basis to all citizens. The plan aimed at a reinforcement of the outpatient sector by forging a more coherent ensemble of all the various facilities that had developed since the 1920s, and establishing Regional Institutes for Ambulatory Mental Health Care, which were modelled on the American Community Mental Health Centres.

A striking similarity in the French, German, and Dutch government policies was the absence of sweeping plans for large-scale de-institutionalisation. They aimed at a reform of mental hospitals - reducing their size, ending their isolation, and improving care and psychiatric treatment - and an expansion of extramural services, not so much as a substitution of hospitals, but as an extension of a more or less integrated mental health care system. This rather cautious approach contrasted with developments in Italy. Although Italy had been slow to develop new policies, none of the countries discussed proposed such drastic plans. Perhaps it was precisely Italy's antiquated institutional psychiatry that led to the formulation of radically new policies in the late 1970s. It was only in 1968 that the 1904 Insanity Act was amended, certification was abolished, and voluntary admission became possible. At the same time, in the wake of the 1960s protest movement psychiatry and the mental hospital in particular became the subject of heated public debates. In 1978, the Italian government, in order to avoid psychiatry becoming the subject of a referendum for which the activist groups were lobbying, ensured that parliament passed a law that contained far-reaching provisions. This prohibited the building of new hospitals and the admission (and, from 1981 on, also readmission) of patients to public mental institutions. Furthermore, it was decided that psychiatric wards

of general hospitals could have no more than fifteen beds, that compulsory admissions were subject to restrictive rules, and that multidisciplinary extramural facilities, *Servici d'Igiene Mentale*, had to be set up to offer a broad range of services – not just medical treatment, but also counselling, social care, and public information.

Stubborn realities

The modernisation of mental health care through de-institutionalisation and the promotion of community care were frequently accompanied with high expectations and much enthusiasm, but nearly everywhere, this commitment met with financial, political, organisational, or professional obstacles. In most countries, the reform plans were developed in the 1960s and early 1970s when the economy was booming, public expenditure rose sharply, and there was a euphoric, change-minded, even revolutionary political climate. When, in the ensuing decades, plans had to be implemented, the economic tide had turned and, in many cases, the political tide as well. As a result of the economic crisis that started in 1973, there were fewer funds available and governments cut back on collective services - a policy to which especially the public facilities for mental health care fell victim. A community care policy appeared to create the possibility of cutting costs in a way that institutional care did not allow. The assumption that community care was cheaper than hospital care - in itself doubtful if hospitals were to be replaced by extensive outpatient facilities that would offer good quality substitute care - was now realised in some countries, just by shifting the emphasis from public to voluntary and informal care. Moreover, the ideals of the 1960s movement paled, confidence in the steering power of central government diminished, and the political spectrum as a whole, especially in Anglo-Saxon countries, moved toward the right: smaller government and more free market was the motto of both the Thatcher government and the Reagan administration. Their example, albeit in a more moderate form, reverberated on the European continent. The pace of reform slowed down and the distinction grew more pronounced between widely accessible public care facilities and private facilities that were only available for people of means. One of the negative results was that chronic and long-stay institutional patients in particular were sometimes neglected.

Besides changing external circumstances, organisational problems put a brake on innovation. Policies that were designed at a central level proved not always easy to implement in actual local and professional contexts. It turned out to be hard to distribute the forms of care provided by the various intramural and extramural facilities effectively, in part because both health care and welfare officials were in charge of their supervision, and in part because these facilities could have a public, voluntary, and/or commercial status. Moreover, innovation did not always agree well with the divergent interests of the therapeutic professional groups involved. Psychiatrists in particular succeeded in opposing some measures that would negatively affect their dominant position or because the prevailing medical approach threatened to be sidelined. Psychiatric hospitals did not automatically co-operate in de-institutionalisation; after all, in general, the extramural sector could only be expanded at the expense of their own funding and influence.

As the available data suggest, in the period 1950-1980, the total number of beds in psychiatric hospitals substantially declined only in Great Britain, the USA, and Italy.

Whereas in England, the USA, and the Netherlands the mental hospital population peaked in the mid-1950s, this happened in the Italy around 1960, and in France and Germany in the early 1970s.[10] In the last two countries and in the Netherlands, the subsequent decline in beds was slower and less drastic than in the first three. Until the early 1970s, in France and Germany there was still a serious increase of the number of beds in mental hospitals, to be followed by only a slight decrease, but there were still more beds in 1980 than in 1950. Moreover, the relatively small loss of beds in mental hospitals in these countries was more or less compensated for by the creation of new beds for psychiatric patients in general hospitals and for the elderly with dementia in nursing homes. The Netherlands saw a slight decrease of the number of beds in psychiatric hospitals, as well as a slight increase of provision in the psychiatric wards of general hospitals between 1950 and 1980. Around 1980, the number of psychiatric beds (in psychiatric hospitals and psychiatric wards of general hospitals) for each 1000 inhabitants varied from 1,2 in the United States, 1,5 in Italy, around 1,9 in Germany, the Netherlands, and Great Britain to 2,3 in France.[11] It should be added that fewer beds did not automatically imply more community care: many demented elderly and mentally handicapped individuals who used to be in psychiatric hospitals were increasingly housed in nursing homes and other specific institutions. In this respect, 'trans-institutionalisation' rather than de-institutionalisation would be a fitting term.[12] In this period, though, the average length of a psychiatric patient's hospital stay did go down in all the countries discussed.

To what degree was community care in fact accomplished in the various countries discussed? In Germany, it ran up against institutional obstacles: the split responsibilities between federal and state governments in particular, the funding systems in health care and social care, and the established medical interests. The implementation and funding of federal policies was largely left to the individual German states, as the central government only funded specific model experiments temporarily, and their willingness to implement changes varied substantially, depending on the political colour of their governments. The individual states generally responded rather slowly to the 1975 parliamentary report. Day- and night hospitals as well as facilities for emergency care were set up, but in general, these did not replace a large number of hospital beds. Radical de-institutionalisation was not pursued in Germany. Although between 1975 and 1981 the number of beds in psychiatric hospitals dropped by thirteen per cent, this drop was mainly caused by removing older and chronic patients to other (cheaper) living and nursing facilities.[13] Germany's states tended to spend more money on improving and reducing the size of mental hospitals than on building and expanding extramural facilities.

The latter was also complicated by the fragmented financing and management systems in mental health care. The distribution of responsibilities among federal government, state governments, private organisations, medical professional associations, health insurance companies, social security boards, and hospital organisations conflicted with the promotion of community care. Mental health care in Germany was funded by health insurance (inasmuch as medical treatment aimed at curing patients was concerned) and by collective social insurance (inasmuch as the care and rehabilitation – mainly of chronic patients – was involved). The strict distinction between medical treatment and (social) care hardly favoured the building of new services for psychiatric patients, like

special housing or work facilities that were geared toward providing social assistance to patients rather than 'curing' them. While such provisions were not eligible for funding from health insurance, the criteria for funding from social insurance frequently did not apply to the care needed by chronic psychiatric patients. As a result, not enough services were put in place to facilitate community care for these patients. Furthermore, the projected expansion of outpatient clinics in psychiatric departments of general hospitals for emergency cases did not work out as planned. Both psychiatrists in private practice and general practitioners feared competition from these clinics, and their professional organisations succeeded in restricting their spread. Before an outpatient service could be established, it had first to be demonstrated that there was a shortage of private office psychiatrists. Private practitioners even strengthened their dominant position as their number went up significantly; in the early 1980s, 45 per cent of all psychiatrists were in private practice.[14]

In part because social psychiatry and psychotherapy received little attention in the academic training of psychiatrists, German extramural psychiatry continued to have a solidly medical focus. This emphasis was also encouraged by the fact that psychiatrists in private practice were inclined to have patients hospitalised rather than refer them to social-psychiatric facilities, because of the limited options provided by the health insurance system. This meant that the public social-psychiatric services – with their emphasis on emergency care, aftercare, and social care – were basically left to service chronic psychotics, addicts with mental problems, and the mentally handicapped. When, starting in the early 1980s, the German government's policies in the area of health care and welfare became dominated by cost-control it was the public outpatient mental health sector in particular that was hurt. Many chronic patients who were not hospitalised were to a large extent dependent on family care, and had little contact with psychiatric services. In general, the reform process of the German health care system continued in the 1980s and 1990s at only a slow pace. At the end of the century, the integration of psychiatry into general hospitals was accomplished and many of the chronic and elderly patients had been moved from mental hospitals to other institutions. Psychiatrists were divided over the question whether all inpatient mental health care should be transferred to general hospitals, but in general, there was a strong reluctance against radical de-institutionalisation. The availability of community services, which have to compete with private psychiatrists, varied by federal state or region.

Funding and organising mental health care was a less complicated matter in centralised France. Each year, the Ministry of Social Affairs, which was responsible for this policy area, decided on a total budget and issued five-year plans. Around 1980, in the light of a decentralisation effort, the responsibility for the actual activities was handed over to the provinces and regional agencies for health care and welfare. The organisation of public extramural facilities was assigned to local governments, which either took charge or - the option that was chosen by most - conferred their authority to voluntary organisations and psychiatric hospitals. Patients could go to the public facilities, but also to their family doctor, and, in large cities, to the growing number of psychiatrists – and psychotherapists – in private practice. Mental health care was basically funded in three ways: health insurance companies paid for medical treatment in hospitals and treatment by psychiatrists in private practice; as part of its preventive effort, the government subsidised most of the public extramural facilities for both mental patients and alcohol

and drug addicts; finally, the provinces paid for most of the care and reintegration of chronic psychiatric patients.

Although the idea had been launched already in 1960, the *psychiatrie de secteur*, in which regional teams for outpatient care – each consisting of some fifteen members (one senior psychiatrist, four to five junior psychiatrists, seven psychiatric nurses, one social worker, and one secretary) – played a major role, did not develop until the 1970s. In addition, outpatient clinics saw strong growth, with the number of patient-visits increasing fivefold between the mid-1960s and the mid-1980s.[15] Furthermore, new extramural facilities were established: for child and adolescent psychiatry, and housing and nursing facilities for the mentally handicapped and chronic psychiatric patients. Despite these innovations, a government commission concluded in 1980 that only a minority of the regions had enough facilities and that day centres and housing facilities for chronic mental patients were especially lacking. As a result, the expansion of community care had not contributed to a reduction in the number of hospital admissions; the new services largely served another, less seriously ill clientele. Psychiatric hospitals, which fulfilled a major role in the organisation of extramural care, also proved to be an obstacle for its realisation; to ensure their continued existence, their discharge policies tended to be conservative.

The socialist government that came to power in 1981 developed plans to fund extramural facilities at the expense of hospitals, but starting in 1984, the emphasis shifted towards controlling expenditure, in which the community care for chronic patients especially suffered. It was apparent, moreover, that private practice and commercial initiatives for those of means were outperforming the public mental health system. In France, as in Germany, psychiatrists – their number rising fourfold in the 1970s – continued to play first fiddle in mental health care. Frequently, they combined a position in hospitals with extramural work, but gave priority to their intramural responsibilities; it was not uncommon for them merely to pay lip service to community care. Psychiatric nurses, who saw their number double between 1975 and 1985 and whose training in the 1970s became directly tied to the general training for nurses, continued to have a subordinate position.[16] By and large, their career opportunities remained tied to psychiatric hospitals. In France, clinical psychologists and social workers played only a minor role. As a result of this overall situation, many regional teams were not multidisciplinary but consisted mainly of psychiatrists and nurses, which carried the risk that the outpatient sector merely became a copy of the hospital model. In the 1980s, innovation-minded mental health workers began to doubt the feasibility of the once ambitious reform plans. However, compared to Germany, Italy, and the Anglo-Saxon countries, where extramural services were often patchy, in France, with its strongly centralised health policy, a uniform mental health framework was realised on a national scale. In the early 1990s, more than 800 sector teams were in operation, each covering areas with around 70.000 people and providing care for psychiatric patients in hospitals as well as in outpatient clinics and day and rehabilitation centres.

If large-scale de-institutionalisation did not happen in France and Germany, nor did it take place in the Netherlands.[17] Certainly, the medical model and the powerful position of psychiatrists were increasingly questioned, but the medical-psychiatric establishment averted polarisation or a radical break by adopting a co-operative and accommodating stance and by integrating new practices into the existing institutional

framework. Experiments with new psychotherapeutic and social-psychiatric forms of treatment, like the therapeutic community, were supported, and the democratisation of internal professional relations made it possible that nurses and patients could voice their views. In the 1980s and 1990s, the isolation and large size of psychiatric hospitals was broken down and outpatient clinics and halfway facilities, like sheltered housing, were expanded. Increasingly, psychiatric patients lived and worked outside treatment facilities, so as to raise their sense of self-responsibility. The number of long-term admissions, although still significant, dropped because of this process, for which policy-makers introduced the term 'socialisation' (*vermaatschappelijking*) rather than 'de-institutionalisation'. That no priority was given in the Netherlands to more radical forms of de-institutionalisation became clear in the early 1980s, when plans to build new psychiatric hospitals, aimed at downscaling, substituting old institutions, and a more even regional spread were pursued, despite protests. In fact, some new psychiatric hospitals were built.[18]

Changes were implemented in the Netherlands on the basis of gradual, well-prepared, and extensive deliberations with those involved and with respect for the structures that were in place. Thus, it took more than ten years before, at the government's initiative, most of the existing outpatient facilities were combined into about sixty Regional Institutes for Ambulatory Mental Health Care in the early 1980s, each covering catchment areas of between 150.000 and 300.000 residents. Continuing the tradition of some of the older extramural facilities, in these new institutes psychiatrists constituted a minority among other mental health professions, while various forms of psychotherapy and counselling set the tone. They were not so much geared towards (chronic) psychiatric patients as toward clients suffering from minor mental complaints and psychosocial problems. Fuelled by a generous budgetary system, compared to that in other countries, they developed into the main providers of outpatient mental health care and, despite the crisis of the welfare state in the 1980s, they and other extramural and halfway facilities saw further expansion in subsequent years.

In actually achieving de-institutionalisation, the United Kingdom, Italy, and the US clearly distinguish themselves from France, Germany, and the Netherlands. The first three countries saw a drastic reduction of beds in psychiatric institutions, but at the same time, their organisation of alternative community care facilities did not live up to their intentions and were not up to the standards of those in France and the Netherlands. The United Kingdom was the first country in Europe that put de-institutionalisation on the agenda. From the late 1950s, pragmatic concerns constituted a major incentive. De-institutionalisation was inspired by optimism about the new pharmaceutical options for treating mental illness, rather than by a decided preference for a social-psychiatric approach. Although the British government again and again stressed the importance of community care, it did not actively pursue policies in this area. The responsibility for the organisation of it was largely left to local authorities in the field of health care and welfare, which had insufficient funding to compensate for the reduced number of psychiatric beds by aftercare services, day centres, special housing, work, and reintegration facilities. In the 1970s, the de-institutionalisation effort became increasingly mixed up with efforts to control expenditure, a trend that under the Thatcher government grew even stronger. Moreover, a gap continued to exist between psychiatry and social care, and this hardly contributed to the development of extramural care for chronic

psychiatric patients. Psychiatrists and nurses mainly looked to the medical world because it meant more professional status; as a result, they basically operated independently of social work and other social services. Great Britain developed a combined form of community care: a social-psychiatric service by community mental health teams of psychiatric departments of general hospitals, and basic care, provided by general practitioners in collaboration with social workers and community psychiatric nurses. Compared to Germany, France, the Netherlands, and the USA, Great Britain had only few psychiatrists and psychotherapists in private practice, most psychiatrists being employed by the National Health Service. Moreover, the number of clinical psychologists in British mental health was fairly small until the 1970s.

In the mid-1970s, the British government launched plans for a regionally organised and multidisciplinary mental health care system, whereby the proposed size of each region varied from 60.000 to 250.000 inhabitants. However, the policies of the Thatcher government, aimed at the primacy of the free market and the downsizing of the welfare state, conflicted with this plan. While the number of psychiatric beds continued to decrease – of the 130 hospitals in 1960 only 41 were left in the early 1990s[19] – the public community care services were facing serious cutbacks, while market forces were introduced into mental health care. Voluntary initiatives, commercial facilities, and volunteer aid had to take over public tasks in part, without there being much co-ordination between them. The overburdened community mental health teams increasingly concentrated on acute mental patients who were considered dangerous to themselves or others and who made up a large part of the so-called 'revolving door' group. Consequently, more and more chronic psychiatric patients ended up in commercial boarding-houses and nursing homes, or became dependent upon their relatives. In 1985, a parliamentary commission referred to the United States and Italy, where radical de-institutionalisation had produced a situation in which psychiatric patients were entirely left to their own devices and ended up on the streets - a development that could also be witnessed in Britain. Chronic mental patients, it seemed, were discharged from mental hospitals without there being sufficient alternative forms of care available.

In 1979, a year after de-institutionalisation was formally enacted in Italy, the accessibility of (mental) health care facilities was enlarged by the introduction of national health insurance. These two measures, in theory at least, offered a favourable condition for the development of the public *Servici d'Igiene Mentale*, the Italian version of the Community Mental Health Centre that was meant to replace the psychiatric hospital as the basic mental health facility. These centres, staffed by psychiatrists, nurses, psychologists, and social workers, had to provide accessible and flexible psychiatric care and be fully integrated into society. It was only when hospitalisation could not be avoided that small psychiatric wards of general hospitals had to bring relief. Around 1980, the Italian experiments with community care received much international attention, and were frequently seen as a model. This positive response, however, was mainly prompted by some more or less successful local projects in regions and towns in North and central Italy, including Trieste, the home base of Basaglia. In the rest of Italy, notably the southern part, community care remained basically a pipe-dream and mental hospitals remained dominant. The Italian government, even more than its British counterpart, did not set out a tough policy, hardly allocated funds, and left the actual organisation of care facilities in the hands of local initiative. This caused the remaining patients in the public

psychiatric hospitals – around forty were still in operation at the end of the century – to be neglected, while in many regions, there were hardly any alternative forms of care available, in part because local authorities ignored or even resisted the mental health law of 1978. The outpatient clinics, more often than not the only extramural facilities, were overburdened with acute patients, so that psychiatrists and nurses were driven back on methods of coercion and pharmacological treatment. They could not prevent many chronic patients from being left to their own devices. Halfway houses and sheltered accommodation were in short supply, whereas relatives were not always able or willing to take care of them. In addition to the often poorly organised and under-funded public facilities, in large urban areas there were also private hospitals, university clinics, and private psychiatrists and psychotherapists, but in general, they only treated patients with acute disorders or less serious mental problems from the middle and upper classes. Not surprisingly, de-institutionalisation stagnated and became controversial in Italy, not only among members of the professions involved, but also with the general public.

The trend towards de-institutionalisation developed in the United States more drastically than in any other country. Since the mid-1960s, the number of patients and their average stay in American public mental institutions quite rapidly declined. Between 1970 and 1990, the number of beds decreased from more than 410.000 to around 120.000.[20] Alternative residential accommodation (halfway houses, group homes and nursing homes for elderly chronic patients and other people with long-term psychiatric disorders) and psychiatric departments of general hospitals (for emergency cases) took over some care or treatment, but in the 1970s, more and more of the mentally ill ended up in society for shorter or longer periods of time. The Community Mental Health Centres, set up after 1965, were supposed largely to replace intramural care for mental patients by offering a broad supply of outpatient services. Yet, in the course of the 1970s, it became apparent that they failed to do so. First, too few facilities were in fact established: the 754 centres that were put in place by 1980 lagged far behind the total of 2.000 that had been planned in the early 1960s.[21] In part because of the war in Vietnam and the economic crisis of the 1970s, there were not enough financial means, while in the 1980s the Reagan administration even discontinued the federal involvement and financing of the extramural mental health care sector. Second, most Community Mental Health Centres were not geared to providing social care and the rehabilitation of chronic psychiatric patients; rather, they catered to the needs of another clientele with less severe problems, who were offered psychotherapy; thus they overlapped the substantial private psychotherapeutic sector. The social-psychiatric care for the first group suffered, also because psychiatrists, influenced by biological psychiatry, increasingly retreated from outpatient facilities, with psychotherapy-minded psychologists taking their place. Given these circumstances, de-institutionalisation could hardly have been successful. Although many older discharged mental patients, who previously were hospitalised for long periods, managed to cope with their problems because of the support of family and neighbours or some other form of community care, the limitations of the extramural care system became visible once more and more individuals with psychiatric disorders (who were often young and who might also be addicted to alcohol or drugs) joined the growing army of homeless people in the metropolitan areas of the United States.

Conclusion

In the last three decades of the twentieth century, there was clearly a general trend away from reliance on long-term hospitalisation towards a more varied and more extramural pattern of care and treatment. However, between countries and regions, considerable variations in policy and implementation as well as timing can be found. My comparative account suggests that in terms of de-institutionalisation, France, Germany and the Netherlands lagged behind the United Kingdom, Italy, and the United States, but also that the gap between reform plans and their implementation was smaller in the first three countries than in the last three. Whereas in France, Germany, and the Netherlands de-institutionalisation was pursued in a more gradual and moderate form, at the same time, France and the Netherlands especially succeeded in building and maintaining a network of alternative outpatient facilities and community services on a national scale. In the Netherlands the public outpatient sector was well established already from the 1940s - earlier than in other countries - and it also showed a great degree of continuity. The French *psychiatry de secteur* and the Dutch outpatient sector, as well as the policy of 'socialising' mental health care were rather successful compared to the fragmented and understaffed situation in Germany, Great Britain, Italy, and the USA, which were sometimes lacking community care facilities. In France and the Netherlands, more money was spent on health care and social provision than in the other countries.[22] The Dutch welfare state and the French centralised health funding system guaranteed that public mental health care facilities were available and accessible to all citizens and that they functioned fairly well. However, the end of the twentieth century saw a growing differentiation between the public mental health sector and private practices, which had occurred earlier on in other countries. In Germany and the United States in particular, private practice had held a prominent place in extramural psychiatry for a longer time.

In another way, the United States and the Netherlands stood apart from France, Germany, Great Britain and Italy. Whereas in the other countries the expansion of public community care facilities was concomitant with de-institutionalisation and they focussed on psychiatric patients, in both the United States and in the Netherlands, the development of extramural public mental health care was only partly linked to what happened in institutional psychiatry. In both countries, the emphasis on prevention and a multidisciplinary approach in outpatient services during the second half of the twentieth century ultimately resulted in the wide expansion of the mental health domain, as well as a strong psychological orientation. The psychologising approach and the prestige of psychotherapy in both countries contributed to the situation where many mental health workers in public extramural care focused their attention on psychosocial problems, rather than on psychiatric disorders. In the 1970s and 1980s, there was a clear parallel in this respect between the development of the American Community Mental Health Centres and the various Dutch counselling centres, psychotherapeutic institutes, and, later, the Regional Institutes for Ambulatory Mental Health Care.

What was a unique Dutch development was that from the late 1960s, psychotherapy developed as a separate, interdisciplinary profession and that it was practised not only by private therapists but also in public mental health institutes. This ensured broad accessibility of this treatment. The major role of psychotherapists – psychologists among them in particular – in Dutch mental health since the 1960s sets the Netherlands apart from other European countries, where psychotherapy largely remained

limited to more or less elitist private practices or, as in Germany, was part of psychosomatic medicine. In this respect and probably also in the more general psychologisation of society, developments in the Netherlands were more similar to those in the USA than to those in its neighbouring countries. However, since the last decade of the twentieth century, these differences have decreased. With the return of a stricter biomedical and pharmaceutical approach, many Dutch psychotherapists have withdrawn into private practice. As in other European countries, public mental health care in the Netherlands focussed more and more on medical treatment, as well as on the social rehabilitation of psychiatric patients.

At the beginning of the twenty-first century, some convergence may be taking place between the six countries. Apart from the dominant biomedical and pharmaceutical approach, it is more and more recognised in all countries that de-institutionalisation has its limits. Community care partly depends on a great deal of social tolerance for mentally ill patients, if their behaviour is disturbing or risky, but it is questionable whether people in modern society are able to meet this ideal. De-institutionalisation and community care have clearly not improved the quality of life of all psychiatric patients; for some of them, who are not able to cope with life in society, these may have resulted in a deterioration of their living-conditions. The emphasis has often been more on treatment of acute patients and clients with minor mental problems than on social support and rehabilitation of the chronic sufferers. Some categories of the mentally ill still need and perhaps prefer the overall protection and care of a mental hospital in order to lead reasonably secure and untroubled lives. Also, there is a growing anxiety over the mentally disturbed who are (possibly) violent or who cause public nuisance. In the countries where de-institutionalisation has been carried through extensively - the United States, Great Britain, and Italy - there is evidence of increasing use of hospital beds and some movement towards re-institutionalisation.

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[*] I am indebted to Hugh Freeman, Marijke Gijswijt-Hofstra, Gerald Grob, Patrizia Guarnieri, and Joost Vijselaar for their comments on earlier drafts of this article, and to Ton Brouwers and Hugh Freeman for correcting the English.

[1] See R. Castel, F. Castel and A. Lovell, *The Psychiatric Society* (New York: Columbia University Press, 1982). They refer to the emergence of psychiatric asylums since the early nineteenth century and the rise of dynamic psychiatry since 1900 as the first and second psychiatric revolution, respectively. The third revolution marks the diffusion of mental health care facilities and a psychological approach of problems in society.

[2] Comparative overviews are provided by S.P. Mangen, 'Psychiatric Policies: Developments and Constraints', in S.P. Mangen (ed.), *Mental Health Care in the European Community* (London, Sydney, Dover (NH): Croom Helm, 1985), 1-33; H.L. Freeman, T. Fryers and J.H. Henderson, *Mental health services in Europe: 10 years on* (Copenhagen: World Health Organization, Regional Office for Europe Copenhagen, 1985); S. Goodwin, *Comparative Mental Health Policy. From Institutional to Community Care* (London, Thousand Oaks, New Delhi: Sage, 1997).

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[3] Bartlett and Wright (eds), *op. cit.* (note 2) and the articles by Vijselaar, Guarnieri and Suzuki in this volume.
[4] On international developments in the field of psycho-hygiene, psychiatry and mental health care and the growing impact of the United States and Britain see: M. Thomson, 'Mental hygiene as an International Movement', in P. Weindling (ed), *International Health Organisations and Movements, 1918-1939* (Cambridge: Cambridge University Press, 1995), 283-304; M. Thomson, 'Before Anti-Psychiatry: "Mental Health" in Wartime Britain' in Gijswijt-Hofstra and Porter (eds), *op. cit.* (note 2), 43-59; K. Angel, E. Jones and M. Neve, *European Psychiatry on the Eve of War: Aubrey Lewis, the Maudsley Hospital, and the Rockefeller Foundation in the 1930s* (London: The Wellcome Trust Centre for the History of Medicine at UCL, 2003); H. Pols, 'Preventing Mental Disorder, Fostering Mental Health, and Diagnosing Society: Mental Hygiene in the United States', unpublished paper for the Workshop *Cultures of Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, Amsterdam, 18-20 September 2003.
[5] Goodwin, *op. cit.* (note 2), 9.
[6] Freeman et al., *op. cit.* (note 2), 60-65.

[7] Mangen, *op. cit.* (note 2), 28.
[8] *Ibidem*, 9-12.
[9] This, however, hardly ensured generous funding. In fact, the portion of the national income that was spent on health care in Britain – six per cent – was lower than in the other EU member states. Mangen and Rao, *op. cit.* (note 2), 236.
[10] Goodwin, *op. cit.* (note 2), 105. The information on the Netherlands has been provided by Marijke Gijswijt-Hofstra on the basis of publications by the Dutch Central Bureau of Statistics.
[11] The data on the various European countries are derived from the World Health Organisation statistics as listed in Mangen, *op. cit.* (note 2), 21-22 and in Goodwin, *op. cit.* (note 2), 50-51, and the data on the US are based on Grob, *op. cit.* (note 2), 291 and C.A. Taube and S.A. Barrett, (eds), *Mental Health, United States 1985* (Washington, D.C.: Government Printing Office, 1985), 30. Taking the substantial decrease in psychiatric bed space in Britain over the past decades into consideration, these figures suggest that, at least until the mid-1950s, this country must have had more beds in mental hospitals than France, Germany, and the Netherlands, and probably also than the United States and Italy.
[12] See Grob in this volume.
[13] Mangen, 'Germany: The psychiatric enquete and its aftermath', in *op. cit.* (note 2), 96.
[14] *Ibid.*, 108.
[15] Mangen and Castel, *op. cit.*, (note 2), 136.
[16] *Ibid.*, 134.
[17] However, recent information on France reveals that between 1989 and 2000 40 per cent of the beds in psychiatric hospitals were closed. NRC-Handelsblad, 20 December 2004. See also: Dominique Provost and Andrée Bauer, 'Trends and Developments in Public Psychiatry in France since 1975', *Acta Psychiatrica Scandinavica*, 104 (Suppl. 410) (2001), 63-68: 65.
[18] H. van de Beek, *Tussen zorgen en behandelen. Ontwikkelingen in de sociaal-psychiatrische hulpverlening* (Utrecht: Nederlands centrum Geestelijke volksgezondheid, 1991), 4.
[19] Busfield, *op. cit.* (note 2), 22.
[20] Grob, *op. cit.* (note 2), 291; Goodwin, *op. cit.* (note 2), 12.
[21] *Ibid.*, 262.
[22] Mangen, *op. cit.*, (note 2), 10.