Irish Journal of Psychological Medicine (2015), **32**, 347–352.
doi:10.1017/ipm.2015.20

HISTORICAL

Psychiatric deinstitutionalisation in Ireland 1960–2013

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Objective. This paper reviews the decline in numbers in inpatient psychiatric care in Ireland over the past half century.

Method. The relevant policy publications advocating de-institutilisation have been examined. Change has been monitored through successive census reports of the Medico-social Research Board and the Health Research Board.

Findings. Ireland has moved from having the highest hospitalisation rate of any western country to a position of equality with other comparable countries in the quantum of inpatient care provided. In the public sector virtually no patients remain in 19th century mental hospitals with acute care being provided in general hospital units. Numbers have also decreased in the private sector but to a lesser degree and acute private care is still delivered in stand-alone psychiatric hospitals.

Received 23 February 2015; Revised 16 March 2015; Accepted 2 April 2015; First published online 7 July 2015

Key words: Ireland, psychiatry deinstitutilisation, 1963–2013.

Introduction

Throughout the Western world, in Europe and North America, the 19th century and the first half of the 20th saw a massive rise in mental hospital building based on the belief that the appropriate setting for the care and treatment of the mentally ill was in an institutional setting. One of the greatest changes in medical service delivery over the past 70 years has been the change in policy which has lead to provision of care for the mentally ill in community settings rather than in mental hospitals

Ireland was no outlier in this development. By 1900 the 26 counties of what was later to become the Republic could boast 20 district and auxiliary lunatic asylums. A further mental hospital at Ardee, Co Louth opened in 1933. These together with 13 private establishments, accommodated close to 21 000 patients.

However with the coming of the second half of the 20th century a re-appraisal of the relevance of these institutions brought uncertainty to their purpose and function. Publications such as that of Erving Goffman's Asylum (1961) in the United States and Michel Foucault's Histoire de la Folie (1961) in France were influential in questioning opinions and attitudes to a philosophy and practice that was at least a century and a half old. The underlying motivations for such questionings were not unitary, rather a mix of ideological, humanitarian and economic (asylums were expensive to run).

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In the United States President Kennedy, who had a sister who experienced mental health problems, introduced in 1963 the Community Mental Health Act aimed at providing mental health centres as alternatives to state mental hospitals at federal cost. The result was that over the following 17 years numbers in federal mental hospitals in the US fell from over 500 000 to 130 000 (Fuller Torrey, 2013). Fuller Torrey in the same publication has been highly critical of the rapidity of this change without the necessary community alternatives being put in place. In fact only half of the mental health centres envisioned by the 1963 legislation were ever built and none were fully funded.

In the United Kingdom, Health Minister Enoch Powell in the 1950s was determined that mental hospitals should close and that all inpatient care for mental illness should be given in general hospitals although he was criticised by Kathleen Jones (1960) for not providing adequate resources to bring this about. By 1954 the number of psychiatric beds in England and Wales had reached its peak of 152 000. Plans were in hand to provide more beds but these were deferred due to financial stringencies. However in 1961 Tooth and Brooke reported that 'the tide had turned' as seen by the fact that by 1959 bed numbers had fallen by 8000. They predicted further progressive decreases and attributed the change to three factors: more effective treatment, the provision of outpatient and other community facilities and the rehabilitation of long-stay patients.

In France a realisation that very limited community services resulted in patients being over dependent on hospitalisation led to the policy of 'psychiatrie de secteur'.

This geographical sectorisation made access to facilities such as day hospitals readily available in proximate community settings thus decreased the numbers in hospitals (Paumelle, 1964).

In Italy socio-political influences as transmitted through pioneers such as Franco Basaglia (1968) who, by establishing 'psychiatrica democratica', gave juridical force (Law 180 of 1976) to legislation ordaining that no one could any longer be admitted to a psychiatric hospital. It further decreed that all extant hospitals should close with those remaining on site being regarded as ospiti or guests.

In Ireland the numbers psychiatrically hospitalised reached an apogee in 1959. By 1961, 730 beds per 100 000 population were provided for mental illness and this ratio was regarded by the Commission of Inquiry on Mental Illness (1966) as 'the highest in the world'. It was this observation, together with the sentiment that the quality of inpatient care left much to be desired, that led to the setting up of the Inquiry Commission in 1961. The Commission stated that 'At any given time, about one in every seventy of our people above the age of 24 years is in a mental hospital'. The Commission went on sharply to criticise the conditions obtaining in these mental hospitals. It added 'In the Commission's view, a pattern of services confined to the traditional type of mental hospital would leave unfilled the need to diagnose and treat as widely as possible incipient mental illness, to provide in whole or in part treatment in the home or in surroundings akin to the patient's normal mode of living, to provide adequate community services, and in particular it would leave unabridged the gap between psychiatry and general medicine'.

It added that 40% of all hospital beds in the country were in mental hospitals while about one quarter of all non capital health expenditure was spent on the day-to-day running of these hospitals, leaving aside the cost of maintaining their fabric. Thus the drivers for deinstitutilisation in Ireland were scientific – better and more effective treatment in a community setting – as well as humanitarian and economic.

Because of lack of data to examine why such a high rate of psychiatric hospitalisation existed the Commission recommended that information on inpatient usage be established. Accordingly a data system was established by the Department of Health beginning with a census of all residents in psychiatric inpatient care on 31 March 1963. For each resident a form was completed that would continue throughout the patient's hospital stay up to discharge or death, when that occurred, and would be reactivated when re-admitted. Additionally a similar form was to be initiated on each admission subsequent to the census and would be similarly followed through, including being used when admission of the same patient occurred to a different hospital or unit. The development of this system was to record the process of deinstitutionalisation recommended by the Commission and to assist service planning.

With the establishment of the Medico-social Research Board (MSRB) these forms were transferred from the Department to the MSRB for analysis and publication. This resulted in the 1963 Psychiatric Census (Walsh, 1971). In 1971, the MSRB set up the National Psychiatric Inpatient Reporting System beginning with a census of hospital and units in 1971 (MSRB, 1972) covering admissions, discharges and deaths thereafter which in fact it had been monitoring from 1965 with Departmental returns and later on its own initiative up till 1971. Further censuses followed in 1981, 1991, 2001, 2006, 2010 and 2013 with these latter appearing under the aegis of the Health Research Board into which the MRSB had morphed.

The Commission of Inquiry had optimistically predicted that, if its recommendations were implemented, the numbers hospitalised would have fallen to 8000 by 1984 and the number of long-stay beds would reduce to 5000. The reality was that in 1984 numbers stood at 12 000 and the long stay at 9000. Why was this so?

The Commission to some extent had itself to blame in that it had not set out any implementation plan to reach its suggested goals. Nor had it, in any detail, addressed the issue of financing the measures it recommended such as the provision of community-based staff and structures. It may have assumed that staff would readily transfer from institution to community, that existing community structures already in place for other medical and social purposes could be readily adapted to psychiatric care and that general hospital psychiatric units would somehow appear.

Obstacles to progression to community care and the rundown of inpatient numbers were two-fold, economic and social. In a country suffering economically, with high unemployment and mass emigration, any arrangement that offered employment and economic security was to be prized. The asylums, built up over decades of the 19th century, provided just that to generations of Irish men and women. In 1951 there were just short of 4000 nursing staff in the public psychiatric hospitals which number was to reach 6000 later in the century. The economic value to an Irish town of an asylum was patent. For example the town of Ballinasloe had a 1951 population of 5596 of whom over 2000 were patients in the mental hospital and with just short of 500 employed in the hospital as nurses, tradesmen and employees on the 600 acre hospital farm. So over the decades a culture and tradition of dependency on the asylum grew.

The incentive and politics of maintaining the institution at its original level of occupancy were overwhelming as

https://doi.org/10.1017/ipm.2015.20 Published online by Cambridge University Press

evidenced at local council meetings. The employee component together with its well-organised union support resisted change. This conservatism was understandable because of the perception of possible job losses as well as anxiety and fear of role change from institutional settings to a community function for which many were professionally unequipped and untrained.

Planning for the future

Because of the slow pace of moving to community care the then Minister for Health, Eileen Desmond, in 1981 set up a Study Group, 'to assess the existing services and to draw up planning guidelines for future development of the service with due regard to cost implications'.

The Group, called Planning for the Future (PFF), reported that 'At present the psychiatric hospital is the focal point of the psychiatric service in most parts of the country. Large numbers of patients reside permanently in these hospitals. Many of them have lived there for years in conditions which in many cases are less than adequate because of overcrowding and capital underfunding. In addition staff and public attitudes have tended to concentrate effort on hospital care as a result of which community facilities are relatively underdeveloped. The hospitals were designed to isolate the mentally ill from society and this isolation still persists. The psychiatric service which we favour will require many changes' (Department of Health, 1984).

The report then went on to present these changes. In truth much of the report reiterated the recommendations of the Commission of Inquiry Report. Ominously the Report warned 'We appreciate that our recommendations require some financial investment. We are also acutely aware of the financial difficulties arising from the current recession and that this will discourage or prevent any development in the immediate future. We would point out, however, that the main financial consequence of our recommendations will be a diversion of current expenditure from institutional to community services rather than an increase in total expenditure. We would also point out that if our recommendations are not implemented, the capital requirement, in order to maintain the existing structure, will be much greater'.

Unlike the Inquiry commission, Chapter 15 of PFF was devoted to 'Cost Implications'. In summary this estimated that on the basis of 0.5 beds per 1000 population to be provided in general hospital, adding to the 700 already existing, a further 1000 would be required at an estimated cost of £34 000 per bed, nationally £34 million. In addition long-stay patients would require 1700 places nationally at a cost of £12 000–£15 000 per place. Calculations of the projected cost of community based facilities were then provided. In total the report estimated that the fulfilment of its recommendations in moving care to the community would amount to a capital requirement of £50 million in all, although over what time line was unspecified, whereas the estimated cost of refurbishing the existing hospitals to an acceptable standard would cost £150 million. No increase in revenue expenditure, running at £145 million in 1984, was envisaged.

In 1984 the proportion of non-capital health expenditure on mental health services lay at 13%, down from almost 25% in 1959. This proportion was to decline progressively until by the end of 2013 it stood at 5%.

To accelerate the rundown of beds Minister for Health Barry Desmond in 1987 decided that with immediate effect two psychiatric hospitals, St Dympna's, Carlow and St Patrick's, Castlerea should close and he dispatched Departmental officials and the Inspector of Mental Hospitals to work with local officials to that purpose. Despite this initiative, neither hospital closed and it was several years into the future before they ceased functioning as psychiatric establishments. In the case of Castlrea a change of use to a prison rather than abolition was the outcome and the final closure of St Dympnas, Carlow, to patient care was as recent as 2014.

The report of the Inspector of Mental Hospitals for 1995 commented on 'the reduction of numbers resident in mental hospitals and units, the increasing provision of community-based services and the location of acute patient inpatient admission facilities in general hospitals' and concluded 'The decline in patient numbers was due to two main causes. These were mortality among the elderly long-stay population and a decrease in the number of patients passing into long term care' (Department of Health and Children, 1996). A further factor in the decrease in inpatient numbers was the device of 'dedesignation'. This involved the taking off the hospital register of some patients no longer deemed to require specialised psychiatric care while still needing residential care in an appropriate setting. Such patients were moved to special units often in the same hospital campus. In the 1995 Inspector's Report 407 elderly and 247 intellectually handicapped patients were recorded as having been dedesignated but were still catered for on the original hospital campus.

The consequence of all this was that whereas at the end of 1990 there were 7807 patients resident in the public sector facilities by 1995 these had fallen to 5327 while patients in the private hospitals numbered 503, down from 736 in 1992.

By 2001 numbers had fallen to 4321 and this census included 1104 patients in 86 high support community residences staffed mostly by nurses on a 24-hour basis (Health Research Board, 2001). These patients had all

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almost come from long-stay inpatient care and were complemented by a further 2000 in less intensively staffed smaller community residences.

A Vision for Change (VFC)

Reporting in 2006 the latest formal policy document on mental health services, VFC recommended that 'A plan to bring about the closure of all mental hospitals should be drawn up and implemented. The resources release by these closures should be protected for re-investment in the mental health service'. VFC also recommended that 'Substantial extra funding is required to finance the new mental health policy'. It further advocated that 'a programme of capital and non capital expenditure in mental health services adjusted in line with inflation should be implemented in a phased way over the next seven to ten years' (Department of Health and Children, 2006).

By 2006 when VFC appeared some psychiatric hospitals had already closed or been converted to alternative uses – a hotel in Sligo, apartments in Cork and educational facilities in Castlebar. Unfortunately the aspiration to sell the remaining hospitals and their lands was not taken during the inflationary period of the Celtic Tiger with the result that they became unsellable and the emerging revenue aimed for the service never materialised.

Ten years later numbers were down to 2812. This 2010 Irish hospitalisation rate of 66 per 100 000 of population compared with rates of 60 in England and Wales, 63 in Northern Ireland and 77 in Scotland (Heath Research Board, 2010). Clearly Ireland had progressed a long way from 1963 when the rate of hospitalisation was two and a half times the rate of England and Wales.

By 2013 numbers were down again, to 2401 a rate of 52 per 100 000 (Health Research Board, 2013).

Figure 1 illustrates Irish deinstitutionalisation over 50 years.

Of the 2401 patients, 574 were in independent/ private hospitals and, collectively, another 261 in St Josephs Intellectually Disabled Service in St Ita's, Portrane, the Central Mental Hospital and Carraig Mor Unit in Cork. The number of acute beds in the public service in 2013 was 995 (Health Service Executive, 2013) of which 718 were in general hospital units and 277 in psychiatric hospitals with the remaining 571 beds in psychiatric hospitals providing continuing care/rehabilitation. This however excludes some acute patients who may have been in the 24 bedded Phoenix Care Centre for intensive care and rehabilitation which opened in mid 2013.

By end of 2014, with the exception of one 19th century public psychiatric hospital containing a small number of rehabilitation/ continuing care patients, one public catchment service with beds in an independent/ private psychiatric hospital, the Central Mental Hospital and the specialised St Joseph's Unit for intellectually disabled no patients remained in 19th century psychiatric hospitals. St Brigid's, Ardee remained open but was built less than 100 years ago and is scheduled for proximate closure. Small numbers of patients, acute admission patients and some continuing care

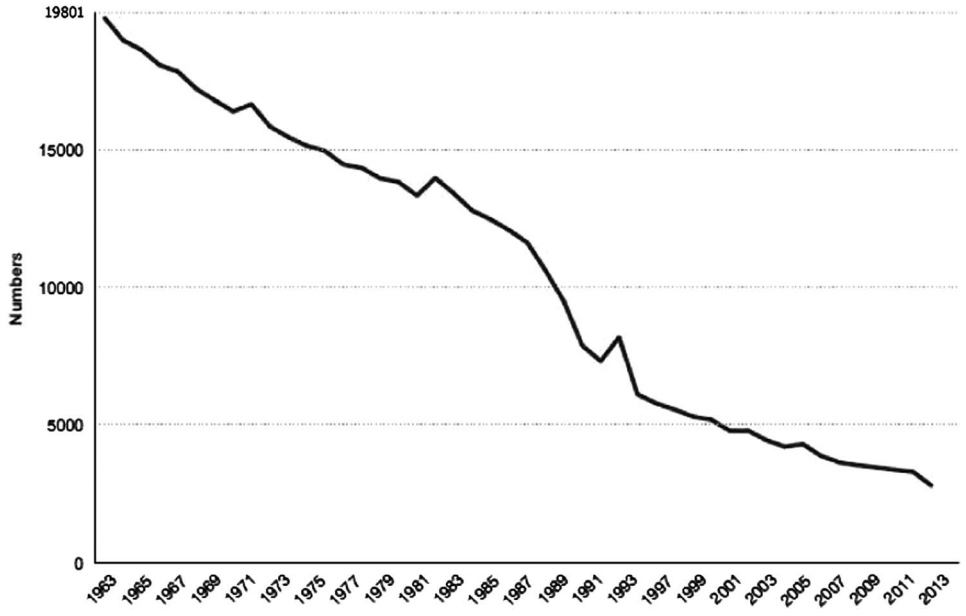

Fig. 1. Irish Psychiatric Units and Hospitals Census 1963–2013 Numbers. Source: Irish Psychiatric Units and Hospitals Census 2013. Health Research Board.

https://doi.org/10.1017/ipm.2015.20 Published online by Cambridge University Press

patients, in Sligo and Mullingar, remain in 19th century campuses but not in the original buildings.

VFC had recommended 50 beds per 300 000 population in the public sector. On a 2013 population basis (4 593 100) VFC criteria would ordain 762 public beds whereas HSE through its performance indicator scheme reported 955 acute beds in that year indicating an oversupply of 233 despite, because of uneven geographic disposition, some local under provision and including a small private component. In addition there were an estimated 420 beds in acute usage in the independent/ private sector. With an estimated combined independent/private and recommended public acute bed total of 1182 beds, the ratio emerging nationally would be 26 acute beds per 100 000 whereas with existing public bed numbers the national total is 1415, a ratio of 31 per 100 000. In 2013, despite some recession-related decrement, just under half the Irish population was covered by private medical insurance. As it stands the recommended public and existing private acute provision per head of denominator population may be considered 'right' taking into account the greater deprivation characteristics of the public sector clientele adversely affecting morbidity and outcome and the differing diagnostic characteristics and longer lengths of stay before discharge in the independent/private sector.

Nonetheless while deinstitutionalisation as a policy and moral imperative appears to have been largely accomplished, through falling admission rates since 1986, decreased lengths of stay, mortality among long-stay elderly, a marked decrease in persons becoming long stay and increased community provision, a number of anomalies remain. In the public sector there is a moderate over provision of acute beds and a corresponding deficit of community alternatives whereas in the independent/private sector acute care is provided in standalone psychiatric hospitals.

Despite the overall bed decline there are concerns that provision for children and adolescents are inadequate and that accommodation in intensive care units has not yet attained recommended levels.

The prisons

There have been some concerns in England that a bed decline of 60% from 1988 to 2008 has coincided with an increase in compulsory admission of 80% (Weich *et al.* 2014). No such influence has so far emerged in Ireland. However criticism has linked the growth of the prison population in Ireland to the closure of psychiatric beds. The prison population has increased almost ten-fold since 1950. There are now almost 4000 persons in prisons with a further ~750 on various forms of release. There are 15 000 committals annually. Critics complain that many prisoners have serious mental illness, are misplaced and should be in inpatient psychiatric care.

There have been prevalence surveys of psychiatric illness in Irish prison populations, most notably in Mountjoy Prison. A major survey in 2003 covering interviews with 1582 prisoners used standardised diagnostic methods (Linehan *et al.* 2005). Addictions were, by far, the commonest diagnoses, most of whom would not require inpatient care. Psychosis rates among men were 3.9% among committals, 7.6% among remands and 2.7% among sentenced males and among women prisoners 5.4% The researchers commented that these rates were higher than 'comparable samples from abroad' and estimated that most of these should be diverted to psychiatric services, presumably the great majority to public services. Translating these percentages into hard incidence and prevalence numbers is not easy and it is difficult to apportion numbers between those requiring short time acute care and those in need of more intensive rehabilitation and continuing care in appropriate facilities.

The homeless mentally ill

The scale and nature of the problem of the unaccommodated mentally ill is hard to determine and therefore the extent and type of accommodation to be provided for acute, rehabilitatory and continuing care required to deal with the matter remains obscure.

In care abroad

Finally there is a small number of persons with psychiatric illness mostly of an enduring nature being cared for in specialised inpatient settings in the United Kingdom but unlikely to be relevant to acute bed requirement.

Conclusion

Psychiatric deinstitutionalisation in Ireland has been a major policy objective since the early 1960s particularly in view of the preponderant dependence on undifferentiated mental hospital delivery of psychiatric services at that time. This objective has been shared with most psychiatric services in the western world. In Ireland the process was initiated later and progressed more slowly than elsewhere. It was largely accomplished in the public sector some 50 years later. And, whereas the slow pace of its progress was in some respects advantageous, satisfactory levels of alternatives to inpatient care such as community based services and appropriate social housing have only been partially achieved. There are concerns that existing bed provision for adults in some catchment areas and for children and adolescents

https://doi.org/10.1017/ipm.2015.20 Published online by Cambridge University Press

may be deficient. Acute inpatient care in the public sector has transferred from the traditional mental hospital to the acute general hospital. And although numbers have fallen in the independent (private sector), acute inpatient care remains a psychiatric hospital provision rather than in general hospitals. Finally there are concerns that existing bed provision falls short in the case of mentally ill prisoners and the homeless with major psychiatric problems.

Competing interests

The author appeared as a personal witness before the Commission of Inquiry on Mental Illness, was a member of the groups Planning for the Future and a Vision for Change and was Inspector of Mental Hospitals 1987–2003.

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