Comparing National Cultures of Psychiatry and Mental Health Care in the Twentieth Century (Centre for the History of Science, Technology and Medicine, University of Manchester, 18 November 2008)

Two weeks ago my colleague Marijke Gijswijt-Hofstra and I presented our work on the history of psychiatry and mental health care in the Netherlands from 1870 until 2005: ***The Disordered Mind and other Discomforts***. This book is the final result and synthesis of a research project that started 10 years ago. A dozen scholars participated in it, doing research on patients' files in Dutch mental hospitals; the history of the psychiatric profession; of academic psychiatry, of 'anti-psychiatry'; of psychiatric nursing; the public mental health movement, and the financing of mental health care and some other subjects. The overall aim of this project was to write a **contextual history** about ideas, institutions and practices of psychiatry and mental health care as well as their socio-political and cultural settings. Before addressing the issue of international comparison, let me sketch **the outlines of our book**.

A basic theme in our book is the development of a (largely subsidised) **market for mental health care**. It implies an interplay between the development of care provisions and society's response to mental disorders and psychological problems, including the growing demand for mental health care. On **the supply-side** we see an enormous expansion and differentiation of the psychiatric and mental health domain. While in the nineteenth century psychiatry's reach was mainly restricted to the mental asylum, in the course of the twentieth, psychiatrists and other mental health professionals began to be active at universities, in general hospitals, in social psychiatry, in various out-patient counselling centres, in provisions for alcohol and drug addicts, in forensic medicine, in the army, in education, and in private practices. The Dutch outpatient mental health care network, which has emerged since the 1930s and 1940s, in particular is extensive in comparison to mental health systems in most other Western countries. Psychiatry, originally only a medical specialty, became an integral part of a broad interdisciplinary care sector, in which the boundaries of what counts as a mental disorder have increasingly been extended. Consequently, entirely **new groups of patients and clients** were constantly drawn into the mental health domain. The Dutch population tended to make use of its services frequently and in ever larger numbers, in both absolute and relative terms. In **1900** the number of people who received psychiatric care and treatment did not exceed **0.2 (zero-point-two) percent** of the general population and at least 80 percent of those mental patients were hospitalised. Around **2000**, the number of clients and patients in amounted to a little under **five percent** of the population; now the majority of them, 80 percent, were treated in outpatient facilities.

We argue that to a large extent the **growing supply of professional care created its own demand**, rather than the other way around. This was even more true of the outpatient sector than of institutional and social (pre- and aftercare) psychiatry, that focused on the core group of severely mentally ill individuals [of which the relative size has probably remained fairly stable over time in the population at large]. The establishment and spread of the various facilities were mainly triggered by **a dynamic on the supply side**: the initiatives of socially concerned individuals and groups; various professional aspirations; the rivalry among the religious-ideological pillars; the role of local, provincial and later also national governments; and last but not least, funding opportunities and surprisingly, also **cutbacks on funding**. The development of social psychiatric pre- and aftercare for example, and also of psycho-hygienic facilities, was advanced by cuts on institutional budgets, triggering the need for alternative and

supposedly cheaper provisions. (Often this policy was an example of being penny-wise and pound-foolish, since new provisions also cost money, all the more because they often showed an irresistible tendency to attract new patients and clients and thus expand the mental health market.)

Apart from the dynamic on the expanding supply of mental health care, we also argue that social and cultural factors, in particular the way **people gave *meaning* to personal disorders and problems**, had greater influence on the consumption of care than a rising incidence in society of mental problems in themselves. There are indications that no correlation exists between the incidence of mental suffering in a population and the degree to which its members make use of care-providing facilities. The crucial factor is **the changing and expanding *definition* of behavioural, mental, social and existential problems**.[1] Deviant behaviours and diffuse personal problems are of all times, but their specific interpretation as mental health complaints has been strongly determined by the availability of specialised services, their treatment options, and professional discourses. These rendered a host of tacitly experienced problems visible and offered a concrete context for talking about them. The processes of **medicalisation and psychologisation as well as proto-professionalisation** left their mark on Dutch society and the self-image of human beings.

We relate the development of the mental health market and changing theories and practices in psychiatry to more **general economic, social, political and cultural developments as well as specific characteristics of Dutch society and culture**. For example: increased prosperity and the development of a service-economy; the particular system of confessional traditions and their closely associated social and political organisations (the so-called 'pillarization'); the rise of the welfare state; secularisation and other processes of modernisation; democratisation of Dutch public and private life, the changing power and dependency relationships among individuals, and the development of democratic citizenship, emancipation and individualisation; the typical tendency in Dutch social and political affairs to consensus-building, compromise and accommodation requiring a high degree of self-control, subtle social regulation and psychological insight from individuals; and the prominent socio-political role of experts, because their supposedly objective professional stance, neutralises social conflicts over sensitive issues.

Another important issue in our book concerns **the foreign influences on Dutch psychiatry and mental health care and the comparison of Dutch developments to those in other countries**. Understanding the way in which they resembled and differed from those in other countries, helped us to sharpen our historical analysis and understanding, especially concerning the question in which ways Dutch psychiatry and mental health care were special from an international perspective. Let me summarise some of these features:

As far as the nineteenth-century-**construction of new therapeutic mental asylums** in the countryside and **the introduction of moral therapy** were concerned, the Netherlands lagged behind England, Germany and France. Although the Netherlands was among the first countries to introduce an **insanity law** emphasising that the insane were to be treated and cured, and imposing state supervision on asylums, the Dutch government hardly incited the provincial governments to build public asylums, as the law required. Until the late nineteenth

[1] By psychiatric cultures we understand ‘distinct worlds of meaning’ with respect to how mental illness and mental problems were/are defined, named, interpreted, and treated or prevented.

and early twentieth century, when many new asylums *were* constructed in the countryside, most asylums were old and small, and they were situated in towns. The new asylums, seldom counting more than 800-900 beds[2], were generally also of a rather **small scale**, certainly if compared to the large British, French, and American mental institutions. Many of Dutch ones were built according to the pavilion or cottage system, and this might offer an explanation for the very prominent and exceptional role of the so-called **active therapy** (*aktivere Therapie*) - a didactic form of occupational therapy - between the 1920s until the 1960s. Dutch mental institutions also distinguished themselves by the relatively early opening up of wards for **'voluntary', uncertified admissions** in the early twentieth century and the relatively late and cautious introduction, at the end of the last century, of 'socialisation', as the Dutch variant of **de-institutionalisation** was called.

As far as **theoretical and therapeutic approaches** were concerned, Dutch psychiatry and mental health care were rather eclectic and pragmatic. The current idea of a strong antagonism of and alternation between a medical-biological approach and psychological as well as social methods has to be put in perspective. Apart from biomedical models many psychiatrists, university professors in particular, had an open mind towards psychoanalysis as well as social, phenomenological, and anthropological psychiatry. (Psychiatric chairs, by the way, were established at Dutch universities from the 1890s.) In contrast with pre-war Germany, the United States, and some Nordic countries, **eugenics** never really caught on in Dutch psychiatry. Compared to other countries, the influence of biomedical psychiatry in general remained somewhat limited, at least until the 1990s, when there was a shift in Dutch psychiatry to a stricter biomedical and pharmaceutical approach. A more general preference for moral, didactic, social and psychological approaches can also be found in Dutch outpatient mental health care.

Closely connected to this versatility was a large degree of **professional diversity**. From early on, Dutch psychiatrists, especially those in outpatient facilities, joined forces with other mental health workers: psychiatric nurses, social workers, clergymen, psychologists, educational experts, and from the 1950s on, various specialist therapists. What was more or less exceptional internationally was the development, from the mid-1960s, of **psychotherapy** as a separate, interdisciplinary profession, not only practised by psychiatrists and private therapists but also by psychologists and social workers in public mental health institutes. This ensured broad accessibility of psychotherapy and a psychotherapeutic boom in the 1970s and 1980s. The Netherlands belonged to the countries with the highest number of psychotherapists in proportion to the size of the population. In other European countries psychotherapy largely remained limited to more or less elitist private practices of psychiatrists or, as in Germany, was part of psychosomatic medicine. The major role of psychotherapists in Dutch outpatient mental health care, especially since the 1960s, probably sets the Netherlands apart from other European countries, where psychotherapy largely remained limited to the more or less elitist private practice of psychiatrists.

With respect to Dutch **outpatient mental health care in general**, a network of (public) facilities was established already from the 1930s and 1940s, and it showed, as far as I know, a stronger degree of **continuity** and a **broader orientation** than anywhere else. It not only offered pre- and aftercare for psychiatric patients and the mentally handicapped, but also

[2] The Santpoort institution near Amsterdam that in the early 1930s hospitalized almost 1500 patients was by far the largest institution in the Netherlands ever.

included specialised counselling centres for problem children, for marriage- and family and other personal problems, for psychotherapy, and for alcohol and drug addiction. In the early 1980s most of these facilities merged into Regional Institutes for Ambulatory Mental Health Care, the Dutch counterpart of the American Community Mental Health Centres - however, the Dutch institutes were more lasting and played a much more central role in de mental health care system than the American ones.

Outpatient mental health care, which emerged under the wings of the psycho-hygienic movement aiming at prevention, and which was partly organised on a religious basis, was not just medical psychiatry and psychotherapy, to a large extent it was **also (moral) education, pastoral care, counselling, and social work**. Moral-didactic and psychosocial approaches rather than medical treatment gained the upper hand in this sector, which differentiated itself from institutional and clinical psychiatry. In other European countries, public mental health was more geared toward social-psychiatric facilities for the mentally ill, while there was also a closer link with clinical psychiatry. Whereas in many other countries the expansion of public community care was a consequence of de-institutionalisation and they focussed on psychiatric patients, in the Netherlands the development of the outpatient sector was only partly linked to what happened in institutional psychiatry. Many mental health workers in the outpatient sector focused their attention on psychosocial problems, rather than on psychiatric disorders. On the other hand, when, from the 1980s onwards, in the Netherlands de-institutionalisation began to be implemented in a moderate way, an extensive and multifaceted network of outpatient facilities was already in place in contrast to other countries which pursued de-institutionalisation earlier on and more radically, like Britain, the United States, and Italy. The most recent development in the Netherlands is the integration and mergers of mental hospitals with half-way and outpatient facilities, which now focus more on psychiatric patients than before.

Compared to other countries, the psycho-hygienic movement and the mental health sector successfully established themselves in the Netherlands. This can be attributed to **the broad resonance that the concept of mental health found** in Dutch society. Precisely because of its vagueness and flexibility and as a positively contested concept, it fulfilled a major strategic function in linking various social domains and appealing to various groups. Mental health applied to both the individual and society, which established a connection between the personal and public sphere. The notion of health care evoked associations with medicine and hygiene, while 'mental' – **in Dutch *geestelijk*, which also means 'spiritual'** – referred to psychic features as well as religious, moral, cultural and values. Thus an explicit connection was established with the strong charitable tradition in the Netherlands and the bourgeois civilisation offensive, which in the form of a moral-didactic ethos was adopted by both Christian groups and socialists.

The ideal of mental health also tied in with the need to articulate **public morals** and a certain utopian message, the belief in the perfectibility of society. Against this background psychiatrists and psycho-hygienists played a prominent role in the advancement of **psychological definitions of citizenship**. Expressing views about the position of individuals in modern society and their possibilities for self-development, they connected mental health to ideals of democratic citizenship and civic virtue. The focus was on the internalisation of certain normative mental health standards and thus finding a balance between self-control and social responsibility on the one hand and self-development, self-reliance, and self-expression on the other. Adapting their views on self-development to the continuously changing socio-

political circumstances, mental health experts played a prominent public role as moral guides who prepared people for modern life by enhancing the required mental attitude and psychological abilities. Especially between the 1950s and 1980s they functioned as major agents of **social-cultural renewal** by articulating new values and offering a clear alternative for the religiously inspired morality of dos and don'ts. They put controversial and sensitive issues on the social agenda and stood up for sexual reform, the self-determination of patients, the public recognition of war victims and other traumatised victims, as well as a de-penalisation of euthanasia, abortion, contraception, and drugs - all those issues that make the Netherlands so famous or infamous.

Next to public, government-sponsored initiatives, **voluntary, religiously inspired initiatives** played a prominent role, not only in the building and administration of mental institutions, but also in the development of outpatient mental health care - which, by the way, was also the case in Belgian and German institutional psychiatry.[3] As in other social sectors, there has always been a delicate balance in Dutch mental health care between voluntary organisation and administration on the one hand, and public financing and government supervision on the other. Otherwise, **the role of the government** remained rather passive, at least until around 1970, when it began to formulate and implement its own policies and organise rather generous collective funding in the context of the welfare state.

Psychiatric nursing appears to have some specific Dutch features. Together with Britain and Ireland, the Netherlands is one of the few countries where it developed apart from general nursing in somatic medicine and where there has been a separate training system for psychiatric nurses from the late nineteenth century until the late twentieth century. Partly under the influence of protestant ideas on psychiatric care, in the Dutch training system psychological, didactic, and social approaches were allotted an increasingly important place, whereas in other countries nursing was much more orientated toward medical care. This might explain the involvement of so many men in this profession.

To conclude my overview of the characteristics of Dutch psychiatry and mental health care, I would like to point out that they have been **open towards various foreign examples**. Before the Second World War, social psychiatry, active therapy, psychoanalysis and other forms of psychotherapy, phenomenological and anthropological approaches, and experimental and clinical psychology were adopted from Germany, Austria, and, to a lesser extent, France. Whereas these innovations, implicating a turn away from biomedical models, in central Europe itself largely played a minor role and came to an end in the 1930s, they proved enduring in the Netherlands. The same was true of the counselling centres for alcoholism and family and marriage problems, established around 1910 and 1940 respectively. Before and especially after the Second World War, Dutch psychiatry also followed models from the United States and Britain: the mental hygiene movement, child guidance clinics, psychiatric social work, counselling methods and new forms of psychotherapy, the therapeutic community and the community health centre. Again, some of these were longer lasting in the Netherlands than in the countries in which they originated.

Now, Marijke and I have completed our research-project on Dutch psychiatry and mental health

[3] To what extent did **religion**, orthodox protestant as well as catholic, make a difference as far as actual care and treatment of patients and clients in mental health care are concerned? A reservation towards somatic treatments and a preference for didactic, moral, social and psychological approaches.

care, the next logical step would be to consider the possibilities for **further systematic international comparative research** into the twentieth-century history of psychiatry and mental health care, in particular in the European Community. (Pragmatic reasons, that is possible funding from Brussels.) This rest of my paper is a first effort to **set the agenda** for such a project. Which similarities, differences and contrast can be discovered between European countries? And do growing internationalisation and European social policies have an impact on national cultures of psychiatry and mental health care?

[Volgende alinea eventueel schrappen]
Now, international comparison in psychiatry and its history is not new of course. From the nineteenth century on, there offer numerous examples of cross-national reports by travelling psychiatrists themselves, who wished to learn about psychiatry in other parts of the Western world, and perhaps seek models to adopt in their home-country. International study trips and international conferences on psychiatry and mental health were and are a favourite way to collect information first hand. After the Second World War, the World Health Organisation played an active part in generating information about the state of mental health care in various countries, largely in order to set international standards for it. The European Community has also functioned as a framework for fact-finding, policy-orientated research, and reporting on the organisation of mental health care in the member states. Historians of psychiatry have only hesitantly followed, focused as most of them were on their home-countries. An early exception was *Bürger und Irre: Zur Sozialgeschichte und Wissenschaftssoziologie der Psychiatry* (1969) by the German psychiatrist Klaus Dörner about the development of institutional psychiatry in Britain, France, and Germany in the eighteenth and nineteenth centuries. The French psychiatrist J. Postel and historian C. Quetel, in their *Nouvelle Histoire de la Psychiatrie* (1983), also followed an international perspective. In recent years other attempts have been made at international history. Next to Edward Shorter's *History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (1997) about the United States and several European countries - which in my view, by the way, is very biased and politicised) collections have appeared - to mention some recent examples - on the institutionalisation in the nineteenth and early twentieth centuries world-wide, on the United Kingdom and some of its former colonies; on neurasthenia around 1900 in Great-Britain, Germany, and the Netherlands; on social psychiatry and psychotherapy in the twentieth century in these same three countries; and on post-war psychiatry and mental health care in Britain and the Netherlands.[4] Marijke and I have organised some Anglo-Dutch-German workshops on psychiatry and mental health care and in 2003 we organised an international conference entitled *Cultures of Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, which has resulted in the publication of a collection of papers two years later. Some conferences of the European Society for the History of Psychiatry, founded in 1993, have resulted in collections of papers about several European countries - albeit without any systematic comparison.[5]

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[4] Joseph Melling and Bill Forsythe (eds), *Insanity, Institutions and Society, 1800-1914. A Social History of Madness in Comparative Perspective* (London & New York: Routledge, 1999); Roy Porter and David Wright (eds), *The Confinement of the Insane. International Perspectives, 1800-1965* (Cambridge: Cambridge University Press, 2003); Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Neurasthenia from Beard to the First World War* (Amsterdam & New York, NY: Rodopi 2001); Marijke Gijswijt-Hofstra and Roy Porter (eds), *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (Amsterdam & Atlanta: Rodopi, 1998) Michael Neve and Harry Oosterhuis (eds), *Social Psychiatry and Psychotherapy in the Twentieth Century: Anglo-Dutch-German Perspectives*, special issue *Medical History*, 48, 4 (2004).
[5] Leonie de Goei and Joost Vijselaar (eds), *Proceedings of the 1st. European Congress on the History of*

Whereas most comparative historical studies on psychiatry are about the nineteenth and early twentieth centuries, it is time to focus more on the twentieth century, on which synthetic, comprehensive national studies are still thin on the ground, and systematic and contextual comparative research is lacking. So there is the problem of the inadequate availability of historical research with a sufficiently similar focus. In general, comparative research seems to be most rewarding when it is problem-orientated. Taking our insights and conclusions about Dutch psychiatry and mental health care as a point of reference, I would like to discuss **a number of trends, themes, subjects, and questions**, which in my view, would be important and interesting for comparative research.

But let me first point out a major, but also interesting **difficulty surrounding international comparison**: the **methodological problem of the translation and comparability of terminology and data** from different countries and periods. The very definition of what psychiatry and mental health care are, is not the same in every country. The external and internal boundaries of the psychiatric and mental health domain were and are far from self-evident and vary in time and from nation to nation - the idea of 'boundary-work', which we used in our book on the Netherlands, is relevant here. The same holds good for their relation to adjacent fields, such as poor relief, philanthropy, general somatic health care, medical specialties like neurology, social hygiene and social work, pastoral care, education, and judicial and the penal system. The very term 'mental health care', and also 'psycho-hygiene' and 'public mental health' do not have the same meaning in various national cultures. I referred to the fact that the Dutch term 'geestelijk' is so ambiguous that is very difficult to translate. The fact that I am talking about psychiatry *and* mental health care may in itself betray a specific Dutch, and perhaps also Anglo-Saxon perspective. In some countries, it refers to a wide sphere of activity, including the care for the mentally handicapped and demented elderly as well as, like in the Netherlands a great variety of outpatient facilities and counselling centres. In fact, in the Netherlands institutional and clinical psychiatry on the one hand and mental health care on the other have long been more or less separate spheres of action. In many other countries, mental health care mainly concerns clinical or social psychiatry in a narrower sense: the care and treatment of the mentally ill. In some countries the concept of mental health care appears to have no meaning it all and there is no current term for it in the native language.

Concepts like 'psychiatric institution' or 'hospital', 'psychiatric beds', 'social psychiatry', 'outpatient facility', 'psychotherapy', 'de-institutionalisation', 'anti-psychiatry' and 'mental health professions' or 'workers' and also the demarcation of their fields of work, may also give rise to confusion. Do psychiatric institutions include beds or separate care provisions for mentally handicapped, demented elderly, nervous and/or neurological patients, alcoholics, drug-addicts, and psychopathic criminals? The national diversity in this respect makes it difficult to establish the numbers of psychiatric beds in various countries, let alone to compare them. Comparing outpatient mental health care provisions is even more problematical because of their multifariousness and variations in shape and form and because what in one country might be considered as a mental health provision, might belong to different field of action in another. In some countries, psychotherapy and counselling, for example, were part and parcel of psychiatry and (public) mental health care, but in others they developed in the context of private practice, psychosomatic medicine, or social work.

Psychiatry and Mental Health Care (Rotterdam: Erasmus Publishing, 1993); F. Fuentenebro, R. Huertas, and C. Valiente (eds), *Historia de la psiquiatría en Europa: Temas y tendencias* (Madrid: Frenia, 2003).

Of course such conceptual confusion is not only a problem, but also an interesting object for comparative research in itself. Let me now discuss some of **the main trends and questions** that would be relevant for comparative historical research.

In the field of **institutional psychiatry** the more or less **closed asylums**, where patients were admitted only or mainly with legal certification, were gradually transformed into more **open mental hospitals**, with increasing numbers admitted on a voluntary basis. This is not to say that in the past asylums were by definition isolated, total institutions of social control and that there was something like a great confinement resulting from increasing intolerance of mental disorders in society and families. Such a revisionist view has been convincingly refuted in recent British, Dutch, and Italian research, based on medical records. It shows that many patients stayed in asylums for only a limited time-period, not so much because of their illness in itself as their disturbing behaviour, and that their relatives played a central role in the decisions over the options that were or were not used to take care of a mental patient. **Patterns of care and the social mechanisms surrounding institutional admission and discharge** were complicated and divergent.[6] However, the revisionists were to some extent right that far into the twentieth century social, political, administrative, financial considerations as well as family-interests and gender and class relations were crucial rather than medical criteria in themselves.

Closely connected to the transformation just mentioned, is that the emphasis shifted from **shelter and care** for social reasons to **care and treatment according to medical criteria,** although we should be aware of the fact that the shelter-function of mental institutions may have been dominant far into the twentieth century.[7] In many countries **the early 1950s appear to mark a turning point**. More and more patients were actually treated instead of just being sheltered and cared for. Also from the 1950s on, more differentiated options for treatment were realised and co-existed: in this context the introduction of psychopharmacological drugs and socio-psychological approaches were often mutually reinforcing rather than excluding or opposing each other.

Reform efforts aimed at a renewal of psychiatric hospitals by reducing their size, breaching their isolation, separating the functions of treatment, rehabilitation, care, and custody and, connected to that, by **differentiating** between various categories of patients. Mentally handicapped, demented elderly, epileptic and alcoholic patients for example, moved to specialised institutions, thus leaving behind patients with 'pure' psychiatric disorders, who were also differentiated into new categories of care such as chronic and acute cases, and in-, halfway- and outpatients. More and more psychiatric patients were treated, supported or cared

[6] They often depended on the funding of the various care options, statutory regulations, the policies of (local) authorities, and they might also be related to the gender of patients. Priority was given to the hospitalisation of male patients, because their symptoms were perceived to be of a more public nature and more threatening to others. Female patients were more frequently cared for at home, while their symptoms tended to be regarded as more private and more directed against themselves.

[7] 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. They 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.

for in **new alternative facilities** such as psychiatric wards of general hospitals, outpatient clinics, day hospitals, night shelters, halfway houses, social-psychiatric services, and rehabilitation and work facilities. One of the consequences was a continuing **reduction of the average length of a psychiatric patient's hospitalisation** from the 1950s on. There was clearly a general international trend away from reliance on long-term hospitalisation towards a more varied and more extramural pattern of care and treatment.

The social integration psychiatric patients came to be considered as a priority, and therefore the idea gained ground that **psychiatry should be integrated into the overall health and social care-providing system**. Of crucial importance were the changes in the way mental institutions were **financed and administered**. [More research into the politics and funding of mental health care (public or voluntary; centralised or on a regional or local basis) may in general lead to new insights, as we experienced in the Dutch research-project. In many ways funding may determine the organisation of mental health care and its accessibility.] In the context of a welfare state, **collective medical insurance and social security** schemes replaced poor relief. After the Second World War, a period characterised by democratisation and social emancipation, **central governments in western welfare states** have subsumed the former role of local and provincial governments or charitable organisations, although in many countries responsibilities have been decentralised again during the two last decades of the twentieth century. More collective funding and the growing involvement of national governments often contributed to the improvement of the quality of care and living conditions for the mentally ill. Also, the accessibility of care, both in terms of legal or financial regulations and of geographical distance, was considerably broadened.

De-institutionalisation, which some scholars refer to as the third psychiatric revolution[8], is of course a crucial general development in the second half of the twentieth century. It is about the demise of the public system of mental institutions, or at least a considerable reduction of its size, in combination with a shift towards outpatient and community care. This development was advanced by a diversity of factors which included practical considerations or necessities as well as ideological and ethical principles: the introduction of psychotropic drugs from the 1950s; nationally designed plans to integrate psychiatry into the overall health and social care-providing system; the anti-psychiatric criticism of institutional and medical psychiatry; the striving for humanistic reform of the care and treatment of psychiatric patients and enhancement of their social integration and civil rights; and last but not least, financial and political considerations.

In the last decades of the century we see **de-institutionalisation** and efforts to establish alternative forms of **community care** in most countries, but its timing, form, and scale varied substantially. For example, whereas in England, the US, 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. As the available data suggest, the decline of the total number of beds in psychiatric hospitals was much stronger in Great Britain, the US, and Italy than in other European countries. (But one should take into account that probably around 1950 numbers of psychiatric beds in various countries differed substantially to begin with.) Here is

[8] 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.

a **tabel with numbers of psychiatric beds in some European countries around 2000**, which show, as far as they are reliable, substantial differences.

Numbers of psychiatric beds in six European countries around 2000

	Population	**PH**	**GH**	**Total**	**Permillage**
Germany	80 million	38.000	16.000	54.000	0,67
England	53 million	34.000[9]	34.000	34.000	0,64
France	66 million	44.000	13.000	67.000	1,01
Italy	58 million	8.000	11.000	19.000	0,32
Netherlands	16 million	20.000	2.100	22.000	1,37
Spain	40 million	15.000	2.400	17.000	0,42

PH = psychiatric hospitals
GH = psychiatric clinics/wards in general hospitals

(Sources: Bauer et al. 2001, 28-29; Provost en Bauer 2001, 65; Burti 2001, 43, 45; Vázquez-Barquero, García en Torres-González 2001, 90; Johnson, Zinkler en Prieve 2001, 51; Becker en Vázquez-Barquero 2001)

Apparently the country with the highest numbers, the Netherlands, has more than the fourfold of Italy, the country with the lowest numbers. I doubt whether these differences can be explained by different national policies of de-institutionalisation only.

Compared to the Anglo-Saxon countries and Italy, where there was a demise of the public system of mental institutions, in Germany, France, Belgium and the Netherlands as well as the Nordic countries de-institutionalisation started later and it was carried through **more gradually and moderately**. In the last countries policies were rather aimed at a scaling down and reform of mental hospitals and an expansion of halfway and outpatient facilities, not so much as a substitution of hospitals, but as an extension of a more or less integrated mental health care system. Also the way and the extent in which complementary or alternative facilities were realised, differed considerably, both in timing and cross-nationally, and even regionally within the larger nations. There appears to be no simple relation between de-institutionalisation on the one hand and the growth of outpatient services and community care on the other, in the sense that more or less de-institutionalisation was paralleled by the creation of more or less outpatient services. In countries with relatively highly developed outpatient facilities and community services - France and the Netherlands for example - de-institutionalisation was introduced rather late and cautiously, compared to some other nations.[10]

[9] In psychiatric as well as general hospitals.
[10] France and the Netherlands especially succeeded in building and maintaining a network of alternative outpatient facilities and community services on a national scale. As indicated earlier on, in Holland 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 were rather successful compared to the fragmented and understaffed situation in Germany, Great Britain, Italy, and the US, which were sometimes lacking in community care facilities. Germany, with considerably fewer outpatient services, likewise pursued de-institutionalisation in a gradual and moderate way. In Italy, the United States, and the United Kingdom, on the other hand, de-institutionalisation was implemented earlier and more

In addition it should be noticed that the term ‘de-institutionalisation’ may be inaccurate or even misleading in the sense that a reduction of psychiatric beds did not automatically imply more community care. What often happened was the reduction of *long-term* hospitalisation in mental hospitals. This did not inevitably implicate a reduction of institutional care as such, because some psychiatric patients were now treated by inpatient psychiatric departments of general hospitals, and many demented elderly and mentally handicapped patients were increasingly housed in nursing homes and other specific institutions. In this respect, **'trans-institutionalisation'** rather than de-institutionalisation would be a fitting term.

Apart from considerable national differences and trans-institutionalisation, de-institutionalisation should be put in historical perspective. The idea that psychiatric patients should preferably be discharged from a mental institution as soon as possible, or even that it was better to keep them as much as possible outside it, can be traced back to the late nineteenth and early twentieth centuries. Officially sanctioned and subsidised **family-care** was then practised on a small scale in most Western countries, and on a larger scale in some, like Belgium (Gheel), Italy, Norway, and Schotland. We are still relatively uninformed about the spread and practice of family-care.

Issues that are essential for a 'history from below' are generally unexplored in historical research: **the patient’s perspective**, their profile, and complaints, the way people experienced mental disorders and articulated their needs and demands, and their care and treatment trajectories in psychiatry and mental health care provisions, should receive more attention, including the role of their families and other parties involved, and that of volunteer aid and self-help. Also, the perspective of **psychiatric nurses or attendants**, the professional group that is the most intensively involved with care for psychiatric patients, has been rather neglected until now and appears to be a promising topic for future research.

Histories of psychiatry still largely centre on mental institutions and clinical psychiatry. Historical research on **outpatient mental health care** as well as private practices[11] leaves much to be desired. This void is all the more reason for more comparative international research in this field because the most drastic overall trend in the twentieth century is **the expansion of the psychiatric domain**[12] and, closely connected to that, **the development of outpatient mental health care**. Whereas in the nineteenth century psychiatry was predominantly confined to asylums, and in certain places, sanatoria and spas, in the course of the twentieth, it also gained ground in newly established facilities such as psychiatric wards in general hospitals, outpatient clinics, private practice, social-psychiatric services, and counselling centres. The first small-scale outpatient facilities were set up before the Second World War and they mainly depended on scattered local or private initiatives. In the second

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drastically, whereas outpatient facilities or community care lagged behind. Although the expansion of public community care facilities was orientated towards psychiatric patients in most countries, this appears to have been only partly the case in the United States and the Netherlands where a broader clientele with minor mental complaints and psychosocial problems was also included. To what extent this also happened in other countries has yet to be clarified.

[11] 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.

[12] Although one should not forget that psychiatry also more or less lost some fields such as the care and treatment of the mentally handicapped and what developed as psycho-geriatrics.

half of the twentieth century, outpatient mental health care grew more prominent and, at least in some countries, became more centrally co-ordinated. This expansion was accompanied by a **growing number and diversity of professionals**. From the 1950s, psychiatrists and nurses or attendants began to be confronted with growing numbers of psychologists, social workers, and other, often new professions, who claimed more and more responsibilities and who put up for debate the medical character of psychiatry. Probably there are considerable national variations as far as the role of medical and non-medical professionals in mental health care are concerned and the professional policies they pursued.

This institutional and professional expansion and diversification reflected **an increasingly wider spectrum of patients and clients**. The development of the psychiatric domain since the late nineteenth century, appears to have been driven by an internal dynamic to include new groups such as nervous and psychosomatic sufferers patients, psychopathic criminals, so-called sexual perverts, and alcoholics. Some psychiatrists began to present themselves as social-hygiene experts, focusing on public mental health.[13] An increasing variety of milder nervous and psychosocial complaints and personality and relational problems became part of the mental health sphere of action. In the late twentieth century this extension was questioned, primarily in the wake of the eclipse of the welfare state and also because the boom of what critics characterized as 'cosmetic psychiatry' often was at the cost of people suffering from serious and chronic mental illnesses.

The extending mental health domain was the result of an intricate interaction between growing supply of and demand for care, and in particular, as I hypothesise, **a recurring cycle of therapeutic optimism, and subsequent re-evaluation and disappointment leading to therapeutic pessimism.** Time and again, experts argued that the existing facilities fell short in providing adequate treatment to patients, let alone cure them. Following this it was often believed that organising alternative ways of care, creating new facilities and introducing new therapies would lead to successes where prior efforts had failed. Repeatedly, these new provisions did not so much improve the treatment of existing patients, but (unwittingly) caused an expansion of the mental health domain, and in its wake the emergence of new groups of patients or clients, whereby again and again a distinction was made between those who were treatable and those who were not. In this way the focus might easily shift from serious disorders to milder problems and even leading to the neglect of chronic patients. Anyway, such a development can be clearly seen in the twentieth-century history of Dutch mental health care[14], especially in the outpatient sector, which manifested a strong tendency to

[13] The first national psycho-hygienic movement was established in 1909 in the United States and after the First World War, the ideal of mental hygiene began to spread internationally.

[14] Around 1900, increasing doubts were raised about the beneficial effects of a patient's stay in a closed asylum. As a result, the therapeutic optimism began to be orientated towards other institutions: the specialised sanatoria and clinics for patients with nervous disorders and alcohol addicts, private practice, and mental wards and hospitals where acute and 'neurotic' patients were admitted and treated on strictly medical grounds, without certification. From a therapeutic perspective, however, the partly open and partly closed institutions for the mentally ill continued to be a source of concern, especially given their over-crowding with chronic cases. In the 1920s, this therapeutic pessimism led to new outpatient facilities for psychiatric patients, the pre- and aftercare services, and to the psycho-hygienic effort to prevent mental disorders. This second objective caused a substantial expansion of psychiatry's domain: children and youngsters with learning, educational, and developmental problems were now potentially included, as were adults with problems in the sphere of marriage, family, relationships, procreation, sexuality and work. From the 1960s, mental health expanded to comprise welfare and individual well being as well: to a large extent psychotherapy catered to people who were basically healthy but who nevertheless were troubled by personality flaws, relational problems, existential uncertainties

keep patients with serious psychiatric disorders, who were difficult to treat, out of its system. I wonder whether it is also true for other countries.

The mental hygiene movement, the prescription and consumption of psychiatric drugs and even anti-psychiatry, despite it's radical criticism of psychiatry, may be cases in point. The psycho-hygienic effort that was geared toward the prevention of mental disorders gradually caused a substantial expansion of psychiatry's patient group, because people who were basically still healthy, but who were considered to be at risk of becoming mentally ill, were included. More treatment facilities for more people was the psycho-hygienic message. Various drugs that were basically developed for treatment of serious mental illnesses, sooner or later were consumed by people suffering from rather milder psychological disorders and emotional problems. And ironically anti-psychiatry may have strengthened rather than weakened the expansion of mental health care in Western societies - it certainly did in the Netherlands. In fact anti-psychiatry may be a rather misleading term, because in fact it does not refer to a total rejection of psychiatry at all. What was rejected was medical and institutional psychiatry, but at the same time an improvement, broadening and intensification of mental health care along psychosocial lines was embraced, especially psychotherapy, the therapeutic community, or family therapy. In the Netherlands, for example, the expanding mental health care system had few problems absorbing elements of the anti-psychiatric critique. Psychotherapists catered to individuals who were not suffering from mental but who were troubled by personality flaws, their potential for self-development, or existential questions about finding meaning in one's life.

This dynamic of therapeutic optimism and pessimism suggests that to some extent **supply increasingly created demand**, as I already pointed out with reference to Dutch development. However, next to this push factor, some external pull factors in modern society, should be taken into account to explain the expansion of mental health care. For example, the Western world in the twentieth century witnessed in general a growing dependence of lay people on expert knowledge. According to the sociologist Anthony Giddens, this is part of the **'reflexivity of modernity'**: the regularised use of expert knowledge, often in popularised forms, about personal and social life as a constitutive element in its organisation and transformation. In this connection, the Dutch sociologist Abraham de Swaan has coined the term **'proto-professionalisation'** to indicate the growing tendency of lay people to adopt professional language and modes of interpretation. Rising levels of education and heightened communication among the general population play an important role in this process.

Also, to a much lesser extent than in the past, people are willing to accept individual shortcomings or unhappiness as an inevitable part of life, as God's will, or simply a matter of bad luck. Rising expectations about the ability to treat and solve personal problems, to fashion individual lives by free choice, and to create or recreate the self have furthered the demand for mental health services, although their expansion and organisation - public or private - differ substantially between countries. The growth of mental health care, especially in the second half of the last century, reflected a more general process of **psychologisation** - a change of mentality combining growing individualisation, expression of emotions, internalisation, and self-guidance, related to changing social manners and relationships. [This fits in with Norbert

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and their potential for self-development. Only since the mid-1980s, partly because of financial considerations, the continuing expansion of the mental health sector began to be questioned more often and attention focused again on the seriously and chronically mentally ill.

Elias's theory of the civilisation process, the dynamic by which *Fremdzwang* (external control or force) was transformed into *Selbstzwang* (internal self-control). The psychological interpretation of the self and of other people's motives and behaviour can be traced back to the late eighteenth century, but until far into the twentieth it was largely restricted to intellectual and bourgeois circles and mental health professionals themselves. In general, it was not until the 1950s and 1960s, when socio-economic, developments enabled the definitive breakthrough of individualisation on a massive scale, that psychological ways of self-understanding gradually spread among the populations of Western societies.] Especially since the 1960s, a new psychological morality emerged in public and private life, focussing on authenticity, self-determination, and self-expression. However, in this respect there seem to be considerable national differences. My impression that in Europe, psychologisation was even stronger in the Netherlands than in other countries. In this respect the developments in the Netherlands were more similar to those in the US than to those in its neighboring countries. In this respect, probably there are also considerable differences between North-Western Europe and Latin countries.

A subject which hardly has been researched systematically from an international perspective are **political and legal developments in the field of psychiatry and mental health**, especially their relation with **democratic citizenship**. In the nineteenth and early twentieth centuries, the relationship between institutional psychiatry and citizenship was **'negative' or 'exclusive'** in the sense that institutionalisation generally implied legal certification meaning that the civil rights of psychiatric patients were suspended for a shorter or longer period of time. In this context mental illness counted in fact as the opposite of liberal-democratic citizenship as it had been articulated on the basis of the ideals of freedom and equality since the American and French Revolutions. Also, both liberal democracies and totalitarian regimes have tended to give psychiatry an increasingly important role in the management of social order and hygiene, and (ab)normality, which in several countries have resulted in serious infringements of basic civil rights. In Nazi-Germany as well as in some American states and Scandinavian countries, for example, psychiatry was involved in eugenics policies subordinating individual rights to state interests and collective values. In the communist world, psychiatry was used to confine dissidents in order to discredit their political opposition.

In the course of the twentieth century, however, **a more 'positive' or 'inclusive' connection** between psychiatry and liberal-democratic citizenship was established in two ways. Firstly, from about 1970, there was a growing attention to and recognition of **the civil rights of the mentally ill**. In the post-war period and especially since the 1960s, when ideals concerning better, more humane care, a greater autonomy of patients, and discouraging prejudices against them played a major role, psychiatry was brought up for public debate. 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 and psychiatric patients against themselves, supposedly for their own good, to voluntary admission, patients' civil rights, and their right to receive adequate care and therapeutic treatment. The legal position, self-organisation and influence of psychiatric patients, whether hospitalised or not, merit particular notice - especially in the European context because patients can apply to the European Human Rights Court if they feel treated unjustly in one way or another. In fact, some Dutch patients, who were hospitalised or treated against their will, have done so successfully in the 1970s and 1980s. However, the increased rights to self-determination of the mentally ill, in combination with de-institutionalisation, would also 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.

Secondly, from the 1920s or so, in psychiatry as well as in the broader field of mental hygiene and mental health care, **psychological definitions of citizenship** were advanced, aimed at the entire adult population. Expressing views about the position of individuals in modern society and their possibilities for **self-development**, psychiatrists and other professionals connected mental health to ideals of democratic citizenship and civic virtue. Thus, they were clearly involved in the modern liberal-democratic project of promoting not only virtuous, responsible, and adaptive citizens, but also autonomous, assertive, and emancipated individuals as members of an open society. I already pointed to the link between mental health and democratic citizenship in the Netherlands. Also in Britain for example, from the 1920s on, mental health provided a paradigm to articulate in psychological terms a secular ideal for self-development as the groundwork for responsible democratic citizenship. In the United States the mental hygiene movement displayed a strong impulse to formulate a diagnosis of modern American society from the perspective of psychiatry and psychoanalysis. The ills of modern society and the malaise in individuals were linked together and mental health experts used theories of personality development to show how they could contribute to the formation of robust and self-reliant democratic subjects. In Germany it was especially at the time of critical reflection on and the striving for fundamental reforms in psychiatry in the 1960s and 1970s, whereby the Nazi past was explicitly used as a spectre, that mental health care acquired a strong political dimension. Against the complicity of psychiatry in the atrocities of the Third Reich, a democratic counter vision of mental health care emerged, based on a conception of citizenship that stressed political awareness, independence of mind, and the social rights of the infirm and indigent.

The link between the democratisation and psychological notions of citizenship is part of **a more general historical process in the Western world**. In traditional systems of social control and political domination, which mainly subjected people by external coercion and (the threat) of violence, no matter whether they accepted it or not, their inner selves were rather irrelevant. The shaping of a proper mentality, the need to form individuals and make them internalise certain values and behaviour-patterns became greater the more a society was democratised. Democratic citizenship is generally about what draws individuals together into a political community or civil society on the basis of rights and entitlements on the one hand and with responsibilities and obligations on the other. It presupposes a sense of public commitment on the basis of individual autonomy, self-determination and self-direction; citizenship can hardly be reconciled with subordination and dependence. It is in democratic societies, which rejected force and coercion and which presupposed that the social and political order was basically founded on the autonomous consent of individual citizens, where their inner motivation was considered of crucial importance for the quality of the public domain. Ironically, the pursuit of individual autonomy and self-determination went hand in hand with gentle but persistent pressure on people to open their inner selves for scrutiny by others and account for their urges and motivations, for example to mental health experts.

Another question concerns to what extent can **continuity and discontinuity**, ruptures or watersheds, be discerned in the twentieth-century history of psychiatry and mental health care? Was **the Second World War**, including the impact in some countries of totalitarian regimes, Nazism in particular, a decisive rupture? The centre of gravity shifted to the Anglo-Saxon

World, where under the influence of developments in military psychiatry, new methods of in- and outpatient treatment along social and psychological lines were introduced and then picked up by innovative psychiatrists in other Western countries. Or should the **1950s** rather be characterised as a watershed, because of the introduction of new psychotropic drugs as well as the realisation of more differentiated options for treatment and care, both within and outside mental hospitals? To what extent could these developments in the 1950s be considered as the foreboding of growing criticism of institutional psychiatry culminating in anti-psychiatry in **the late 1960s and after**? Or should that period itself, rather than the 1950s, be marked as a watershed? 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 and government interference made it possible to increase budgets for mental health care and thus expand provision, enhance its accessibility and employ increasing numbers of mental health professionals. Also one might argue that de-institutionalisation or the setting a different 'moral agenda', for example concerning patient's rights and their 'emancipation', was a rupture. Or did the **1980s** with its turn from psychosocial approaches to biomedical psychiatry and the introduction of a new generation of psychoactive drugs, followed by new techniques as brain scanning and genetic research in the **1990s** mark a new era in the history of psychiatry?

Another issue, that we also addressed in our book, concerns the assessment of **the quality of institutional or other types of care and treatment**. On the one hand, everybody seemed to agree that it is quite legitimate or even imperative for an historian to look into the quality of care according to the standards of the period itself and of the different parties concerned. On the other hand, there is less consensus about whether or not historians should make broader evaluative judgements, for example in terms of the degree of 'humanity' or therapeutic effectiveness. Of course there is the risk of finding oneself on the slippery slope of Whiggish thinking in terms of 'progress', as Edwards Shorter's very biased *History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (1997) shows. Yet it is legitimate, I think, to pose questions about quality and even progress. Risks can be considerably contained, first, by making explicit how and according to which contemporary criteria the quality of mental health care is being assessed, and second, for example, by making a clear distinction between the quality of mental health care as it was actually realised, and what was aspired, planned or intended.

Perhaps the whole history of psychiatry can be written in terms of **the tension between good intentions and disappointing results**, **the recurring gap between lofty ideals and harsh realities**. At a very basic level the reality of mental illness, especially as a serious social handicap, is at odds with the core values of modernity, which psychiatry and mental health care have embraced: the belief in rationality, progress, and improvement and the capability of social engineering, of purposively shaping man and society. The recent efforts to socially integrate and emancipate psychiatric patients are a case in point. The socialisation of psychiatry was complicated under increasing pressure on people by the dynamic of high-modernity and the ever increasing (mental) demands of our neo-liberal achievement-oriented society in terms of proper training, social skills, performance, assertiveness, competition, flexibility, and being immune to stress, which many people suffering from mental disorders were unable to meet. Also, in the Netherlands at least, since the late 1980s the tolerance of the population regarding those with psychiatric disorders, in particular when accompanied by disturbing conduct, began to decrease the more one was directly confronted with them in everyday life.

The gap between **ideals and rhetoric with respect to mental health care on the one hand, and what was actually realised on the other** also manifested itself in the implementation of the bold plans of policy-makers for reforms of mental health systems, especially for de-institutionalisation. [Plans aimed at 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.] More often than not outcomes fell short of or deviated from the original intentions and expectations. [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 realised, the economic tide had turned and, in many cases, the political tide as well. As a result of the economic crisis of mid-1970s, governments cut back on collective services - a policy to which especially the public facilities for mental health care fell victim.] The United Kingdom, Italy, and the US in particular 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 the emphasis shifted from public to voluntary and informal care. [As the ideals of the 1960s movement paled, the welfare state came under attack, and neo-liberalism gained ground the pace of reform slowed down or the plans were used to legitimate cut backs on care provisions.] One of the negative results was that chronic and former long-stay institutional patients in particular were sometimes neglected and ended on the streets, whereas overburdened community mental health facilities 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 patient' group.

To conclude, an important topic of comparative research would be **the present and future impact of European policies in the field of psychiatry and mental health care**. I have yet not much information about this, but what I see is that at the beginning of the twenty-first century, some **convergence** may be taking place in European 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 institution 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. In many other countries there also appears to be a turn away from the self-determination of psychiatric patient and a growing tendency to shift back the balance to more force and pressure on them to comply with psychiatric supervision and treatment.