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Deinstitutionalisation, imprisonment and homelessness

In May 2016, Winkler *et al* published a systematic review on cohort studies following up patients after discharge from long-term psychiatric hospital care.[1] The study did not show relevant numbers for imprisonment or homelessness after discharge. The authors concluded that the study contradicted ecological studies reporting a relationship between prison population rates and psychiatric bed numbers. They propose ecological fallacies as a possible explanation. In the related editorial, the ecological studies are referred to as arguing against deinstitutionalisation.[2]

As an author of one of those ecological studies, I would like to comment. Rather than arguing against deinstitutionalisation of mentally ill people, the studies express concern that deinstitutionalisation does not occur in societies with massively increasing prison populations[3] and very high rates of severe mental illness among prisoners.[4] Although the relationship between psychiatric bed numbers and prison population rates in South America was rather strong, findings from Europe were less robust.[5] In quantitative terms, prisons have become the most important facilities institutionalising mentally ill people in the Americas. Mentally ill people in prisons cause much more concern with respect to human rights than those in psychiatric hospitals. A way forward could be to improve care for people in prison, as well as improving community care for mentally ill people at risk of criminal justice involvement to prevent imprisonment. There is a broad consensus that short-term hospital admission is more efficient than longer stays, and that psychiatric hospital admission should be linked with community services in care systems. In the ecological studies, all types of psychiatric hospital beds were acknowledged.[3] The majority of beds nowadays are used to provide short-term care, including in low- and middle-income settings. Long-term hospital admission is no longer a common type of service provision in general psychiatry in the countries in which the studies that Winkler *et al* included in the review were conducted.[1] Therefore, the study seems rather of historical value.

It is not surprising that elderly people, after decades spent in hospital, have low criminogenic energy. Young people with severe mental illness and comorbid substance use disorders are of much more concern. For understanding the interdependence of penal justice systems and psychiatric in-patient care systems, recently published large linkage studies of registries are more relevant. These show very high rates of psychiatric hospital admission prior to imprisonment and in the year after release from imprisonment. They also show markedly elevated risks for people with mental disorders to commit violent crimes and to be victims of violence compared with the general population. What contribution short-term hospital care can make to postponing or preventing criminal justice involvement and protecting people with mental disorders is still unresolved. However, to reject findings from ecological studies, as in Winkler *et al*'s review, may be a fallacy of categories.

1 Winkler P, Barrett B, McCrone P, Csémy L, Janoušková M, Höschl C. Deinstitutionalised patients, homelessness and imprisonment: systematic review. *Br J Psychiatry* 2016; **208**: 421–8.

2 Salisbury TT, Thornicroft G. Deinstitutionalisation does not increase imprisonment or homelessness. *Br J Psychiatry* 2016; **208**: 412–3.

3 Mundt AP, Chow WS, Arduino M, Barrionuevo H, Fritsch R, Girala N, et al. Psychiatric hospital beds and prison populations in South America since 1990: does the Penrose hypothesis apply? *JAMA Psychiatry* 2015; **72**: 112–8.

4 Mundt AP, Kastner S, Larrain S, Fritsch R, Priebe S. Prevalence of mental disorders at admission to the penal justice system in emerging countries: a study from Chile. *Epidemiol Psychiatr Sci* 2015; doi: 10.1017/S2045796015000554.

5 Chow WS, Priebe S. How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. *BMJ Open* 2016; **6**: e010188.

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As the authors of a previous review of deinstitutionalisation and homelessness,[1] we were interested to see our 1992 findings confirmed by Winkler *et al*'s recent paper[2] and the accompanying editorial.[3] We particularly agree with the notion that apparent relationships between deinstitutionalisation and homelessness can often be mediated by substantial confounding factors. In London in the 1980s, it was the unheralded and unpublicised closure of most of the city's homeless hostel beds that seemed the most likely culprit.

Although this issue may well still be pertinent in other health-care and social systems, it was of decreasing relevance in the UK even when we published our paper in 1992. The process of deinstitutionalisation was, by then, irreversible and substantially accomplished. This leads us to our concern that these papers might support an unhelpful sense of complacency.

Taylor Salisbury & Thornicroft's statement that 'instances of homelessness . . . among those discharged are rare'[3] is clearly correct in referring to the institutional closures and hospital discharges that are now several decades in the past. However, it is at odds with the situation of hospital discharge as it stands today, at least in London. I work in a psychiatric outreach team for homeless people in South London, where homelessness following hospital discharge is common among referrals to our service. We looked at 3 months of our referral data last year and found that 60% of our homeless referrals (mainly with a diagnosis of psychosis) had had previous contact with our local mental health service. They had had, on average:

- contacts with 4 separate trust services
- 35 contacts (face-to-face/phone triage), 2 of these would have been emergency contacts, seen in an accident and emergency department, or in a section 136 suite
- 65 days as an in-patient in the local trust service.

These people had sometimes been discharged to the street, or referred to local community services, but without effective plans to prevent them becoming homeless again. We note that observations we made in 1992 still stand – the excessive bed occupancy of in-patient services is driving an emphasis on short episodes of in-patient treatment.

It seems clear that a small but significant number of people are simply ill-served by the existing format of mainstream mental health services. It may be (as I have heard in a European 'quality' forum) that such people are just peculiarly difficult. This seems unlikely, given a recent outcomes study we did of the most alienated and intractable of our referrals – people who live on the street and who have not been engaged by the sustained efforts of experienced street outreach teams. The intervention concerned was involuntary admission to hospital under a section of the Mental Health Act.[4] One year later, the majority were still engaged with the specialist mental health team and were still in accommodation. Here is an area ripe for research – the vital factors that enable such teams to engage effectively, and to maintain that engagement, with homeless people with psychotic disorders.

1 Craig TKJ, Timms PW. Out of the wards and onto the streets? Deinstitutionalization and homelessness in Britain. *J Ment Health* 1992; **1**: 265–75.

2 Winkler P, Barrett B, McCrone P, Csémy L, Janoušková M, Höschl C. Deinstitutionalised patients, homelessness and imprisonment: systematic review. *Br J Psychiatry* 2016; **208**: 421–8.

3 Salisbury TT, Thornicroft G. Deinstitutionalisation does not increase imprisonment or homelessness. *Br J Psychiatry* 2016; **208**: 412–3.

4 Timms P, Perry J. Sectioning on the street – futility or utility? *BJPsych Bull* 2016; doi: 10.1192/pb.bp.115.052449 [Epub ahead of print].

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Author's reply: I am grateful for the letters published by Mundt and Timms & Craig as they raise several important points. Regarding the comments by Mundt, I agree that the mental health of prison populations is of serious concern and it deserves to be urgently addressed by developing and implementing cost-effective services.

I also agree that in countries which underwent deinstitutionalisation and were included in our review,[1] excessively long-term hospital stays for psychiatric patients no longer commonly occur. After all, this was one of the main reasons that deinstitutionalisation was pursued. However, in the Czech Republic, for instance, 16% of in-patients with schizophrenia still stay in hospital for more than a year and hundreds remain in psychiatric hospitals for decades.[2] Therefore, unfortunately, our review is not just of historical value but conveys an important message for current mental health systems in the majority of Central and Eastern European countries.

I acknowledge that neither our review nor ecological studies can (dis)prove whether new cohorts of patients who became imprisoned in the era after deinstitutionalisation would have also become imprisoned if the mental care systems were still hospital based. We have also admitted that the cohort of patients followed or traced in studies included in our review are not representative of all deinstitutionalized patients.[1] However, what our study shows is that – contrary to some interpretations – there is scant evidence of adverse consequences for people who have been discharged from long-term institutional care. Our main point is that despite the importance of the data provided by ecological studies, these can be hardly helpful in showing whether there is a direct link between deinstitutionalisation and criminality. Moreover, it seems that ecological studies testing the Penrose hypothesis may have further important limitations,[3] and as such are arguably of inherently limited value. Indeed, linkage studies could be theoretically much more relevant, but, regrettably, Mundt does not cite any of them.

Our review[1] casts doubts on statements such as 'the general prison population has increased in all the countries, and this may be linked to the processes of deinstitutionalisation and reinstitutionalisation'[4] or 'changes in capacities of psychiatric hospitals and prisons appear to be linked'[5] contained in the discussions and conclusions of some of the ecological studies. Our paper shows that at the individual level these statements have negligible empirical support, and they might be detrimental to mental health care reforms in countries of Central and Eastern Europe.[1] As Salisbury & Thornicroft[6] argued, individual countries should focus on developing optimally balanced mental health care systems suitable to their setting.

There seems to be a clear consensus that substantial investment in community care is a *condicio sine qua non* of successful deinstitutionalization, which is why I suggest that cost-effective investments into mental health should replace the number of psychiatric beds as the 'hydraulic' in the updated Penrose hypothesis.

I would like to thank Timms & Craig for complementing our review with their depiction of some of the pressing issues related to the current homelessness among people with mental health problems in South London. Their insights are extremely valuable and should be considered when pursuing mental health care reforms in the countries of Central and Eastern Europe. Unfortunately, although we know that homelessness associated with mental illness is a serious problem in the Czech Republic as well, this issue is extremely under-studied and only anecdotal evidence is available. I agree with the suggestion that more research is needed to understand what enables community teams to engage effectively with 'the most alienated and intractable' patients. This might be especially important when it comes to the period immediately following a discharge from in-patient psychiatric care, which is associated with other concerning phenomena, such as re-admissions[2] and suicides.[7]

1 Winkler P, Barrett B, McCrone P, Csémy L, Janoušková M, Höschl C. Deinstitutionalised patients, homelessness and imprisonment: systematic review. *Br J Psychiatry* 2016; **208**: 421–8.

2 Winkler P, Mladá K, Krupchanka D, Agius M, Ray MK, Höschl C. Long-term hospitalizations for schizophrenia in the Czech Republic 1998–2012. *Schizophr Res* 2016; **175**: 180–5.

3 Tsai AC, Venkataramani AS. Penrose Hypothesis not supported. *JAMA Psychiatry*; 72: 735–736.

4 Priebe S, Badesconyi A, Fioritti A, Hansson L, Kilian RT, Torres-Gonzales F, et al. Reinstitutionalisation in mental-health care: comparison of data on service provision from six European countries. *Br Med J* 2005; **330**: 123–6.

5 Mundt AP, Chow WS, Arduino M, Barrionuevo H, Fritsch R, Girala N, et al. Psychiatric hospital beds and prison populations in South America since 1990: does the Penrose hypothesis apply? *JAMA Psychiatry* 2015; **72**: 112–8.

6 Salisbury TT, Thornicroft G. Deinstitutionalisation does not increase imprisonment or homelessness. *Br J Psychiatry* 2016; **208**: 412–3

7 Winkler P, Mladá K, Csémy L, Nechanská B, Höschl C. Suicides following inpatient psychiatric hospitalization: a nationwide case control study. *J Affect Disord* 2015; **184**: 164–9.

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Trial of an intervention to reduce suicidal ideation and behaviour

We take issue with the presentation of the findings of the study by Armitage *et al*,[1] on two counts. First, the title is misleading