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Article

Deinstitutionalisation and the move to community care: comparing the changing dimensions of mental healthcare in the Republic of Ireland and England post-1922.

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Abstract

The advent of deinstitutionalisation and the introduction of community care in the latter part of the twentieth century have revolutionised mental health service provision across Europe, although implementation, timing and services have varied widely in different countries. This article compares the changing dimensions of mental-health provision in post-independence Ireland with England, and will shed light on the current state of mental healthcare in both countries. The article calls for more research into the impact of deinstitutionalisation, such as the challenges faced in the community for those in need of continuing care.

Keywords

Asylums, community care, deinstitutionalisation, England, institutions, Ireland, mental health policy, mental hospitals, oral histories, patients

Introduction

In the western world, psychiatric asylums dominated the care and treatment of people with mental ill health since the early 1800s before being replaced, towards the end of the twentieth century, by the policy of 'care in the community'. The rise and fall of psychiatric asylums has attracted a constant discourse within mental health policy based on the belief in reform in order to address shortcomings in care. This discourse affected the decisions to close the mental hospitals and introduce policies to promote community-based care as the mainstream solution. This move to deinstitutionalise mental healthcare was driven by several factors, including the introduction of psychotropic medication, the rising cost of mental hospitals, and growing public awareness of the injustices and human rights abuses within institutional settings.

The central tenet of twentieth-century policy of community care centred on the hospital being no longer viewed as the preferred location for receiving care; the new ideal heralded integration rather than separation from the community (Kritsotaki, Long and Smith, 2016: 4–7). The underlying assumption that health and social care has positively progressed, in contrast to the outmoded residential care provided in institutions, has influenced official reports and reviews of the literature (for example, see: Townsend,

1962).¹ The dominant perception of institutional care as undesirable assumes the superiority of the community care paradigm. This became a common-sense view that underpinned public policy and professional practice, and a self-evident truth for many, that is not usually acknowledged (Calabria, Bailey and Bowpitt, 2021).

However, despite deinstitutionalisation being heralded throughout the last half century, widespread criticism of it and of the policy of care in the community have emerged from various camps, including the failure of government to make community care work (Busfield, 1997; Jones, 1993; Rose, 1986), with the lack of access to safe spaces during crisis (Calabria, 2022a; Taylor, 2011) leading to 'more problems than it solved' (Bacopoulos-Viau and Fauvel, 2016: 2). For instance, in England there is little investment in long-term therapeutic community-type services in the mental health system for people with enduring mental ill health (Spandler, 2020). This lack of investment, coupled with the reduction of services due to budget cuts, have given rise to a new wave of campaigns in which service-user groups and their allies now fight to keep services open, and demand access to them (Moth, Greener and Stoll, 2015; Spandler, 2006: 7–8). Another example of the problems created by the move to community care is reinstitutionalisation, where service-users who would have been long-term hospitalised before deinstitutionalisation are now being transferred between different institutional settings such as residential homes, forensic hospitals and prisons (Chow and Priebe, 2013; Kritsotaki et al., 2016). Oral history research conducted by Calabria (2022a) 30 years after the closure of mental hospitals in England explored the impact of the changing dimension of the provision of mental healthcare from institutional to community settings and revealed hidden positives of British institutional spaces. These include access to meaningful and therapeutic practices for service-users and freedom of movement within the old state mental hospitals in the latter part of the twentieth century, perceived to be lost in current mental health services.

It is important to note that it is not the purpose of this article to form a blanket criticism of deinstitutionalisation of mental healthcare services in Ireland and England. On the contrary, the authors recognise numerous benefits of closing the decaying Victorian asylums that still housed patients well into the late twentieth century (and in some cases, into the twenty-first century). Instead, the aim of this article is to challenge and problematise the dominant linear and progressive notion of current literature that closing

institutions in favour of community care improved both quality of care and access to mental healthcare services in Ireland and England.

This article will compare Ireland's legislative developments in mental healthcare post-independence with developments in England, to shed light on the state of current mental healthcare in both countries.² Ireland makes for an important and unique comparator, having recently celebrated 100 years of independence. Its mental healthcare policy and provision was controlled by Westminster until 1922. Upon independence, Ireland's mental healthcare policy stalled, with the Victorian Lunacy Laws ruling provision until the Mental Health Treatment Act of 1945, which in turn remained unchanged until the *Planning for the Future* Green Paper of 1984. In contrast, England introduced far more frequent mental healthcare legislation over the course of the twentieth century. However, in both Ireland and England, admission rates rose and fell apparently irrespective of legislation, and by the end of the twentieth century community care was favoured over institutionalisation. This article will examine the reasons for deinstitutionalisation in both settings and the effects for service-users themselves.³

First, mental healthcare legislation in post-independence Ireland will be compared with England to highlight the current linear historiography, which promotes and justifies the progressive shift from institutional to community care in both settings. The article will then examine work by scholars and activists who have sought to demonstrate some of the failings of the community care policies and the care in the community settings that replaced psychiatric long-stay institutions. The article concludes that community-based mental healthcare is in need of investment and reform, and it calls for more research into the effectiveness of community care from the perspective of the individuals who depend on it.

Background

Literature on mental healthcare in Ireland and England since 1922 is extensive. Institutional, legislative and social histories stretch from the early asylum system to modern-day community care. Histories have primarily focused on legislation, population numbers and mental healthcare treatment. Historians including Prior (2012: 373–392) have examined legislation in considerable detail, but how the practical policy and treatment in Ireland diverged after independence from Britain has not been compared. Equally, many histories examine the patterns of numbers of patients in Ireland and England, but they have not been

compared post-1922 for differences reflective of independence (Conlan-Trant and Kelly, 2022; Malcolm, 2003). There have also been histories of treatment and policy in Ireland and England (Barrington, 1987; Healy, 1996; Kelly, 2008; Prior, 2012; Walsh, 2012) but comparative works that focus on post-1922 are surprisingly few.

During the early twentieth century, Ireland underwent considerable political and social change which would reshape the development of its mental healthcare system for the following century (Kelly, 2008: 47–8). The establishment of the new political party Sinn Fein (which sought an Ireland independent from Britain) and the creation of the Ulster Volunteers both happened against the backdrop of Britain's intention to pass another Home Rule Bill. The resulting Easter Rising and victory for Sinn Fein in the 1918 election led to the Irish parliament declaring independence. The 'War of Independence' with Britain followed, resulting in the 'Anglo-Irish Treaty' in 1921 and the establishment of the Irish Free State in 1922, which became the Irish Republic from 1948 (Kelly, 2008; Malcolm, 2003). Upon independence, Ireland gained legal and political control of its healthcare system and subsequently shaped it separately from Britain over the coming century.

In the early nineteenth century (while under British rule), Ireland began building an extensive institutional-based mental healthcare system (Brennan, 2012; Kelly, 2004; McCarthy, 1998; Prior, 2003, 2012: 373–392; Walsh O, 2004). Growing concern at the apparent rapid increase in mental illness in Ireland after 1800 had caused the British government to 'begin building a network of state asylums, well in advance of the comparable English system' (Malcolm, 2003: 317). The number of beds in new state asylums increased from only 250 in 1815 (when the first such institution, the Richmond Asylum, was built in Dublin) to 16,600 by the turn of the twentieth century (pp. 317-18). This exponential increase in mental healthcare provision across Ireland (and the rest of Britain) was built against the backdrop of a series of legislation known as the lunacy laws, which the current historiography explores extensively (including Kelly, 2008; Malcolm, 2003; Prior, 2012: 373–392; Walsh, 1992). As explained by Prior (2012), Kelly (2008) and others, asylum committal in Ireland during the nineteenth century was regulated by a number of these laws, but arguably the most important two were the Dangerous Lunatics Acts of 1838 and 1867.

Legislation in Ireland and England post-1922

Upon partition, the new government of the Irish Free State had inherited an overcrowded and underfunded mental healthcare system (Prior, 2012: 380). Asylum admission was 'subject to one of seven separate laws, depending on the categorisation of the patient', most being of 'unsound mind', though many still as 'dangerous lunatics' under the Dangerous Lunatics Act of 1867 (p. 380).

It was a different story in England, where the old lunacy laws had been replaced with various new mental healthcare legislation prior to 1922. The 1886 Idiots Act was the first to specifically define 'idiots' as separate from the 'insane', which had until that point been treated as the same (Walmsley, Atkinson and Rolph, 1999: 182). Those defined as 'idiots' or 'imbeciles' were those believed to have 'severe degrees of impairment sufficient to prevent them from being self-supporting even in favourable circumstances' (p. 182). The growing eugenics movement sought to control and limit the numbers of 'idiots' in society (the Eugenics Education Society was founded in 1907). Walmsley et al. (1999) link the lobbying and ideology of eugenicists to the passing of the 1913 Mental Deficiency Act, which aimed to control the 'feeble minded' through segregation. The 1913 Act provided three forms of treatment through 'care, supervision and control', or namely 'institutional care, guardianship and supervision' (Walmsley et al., 1999; Welshman, 1999: 206). It aimed to use time in institutions to rehabilitate patients and get them back out into the community, place them under the care of a guardian in the community, allow them to live alone but with supervision, or undergo visits from salaried officials or health visitors (Walmsley et al., 1999: 185). The Act was updated in 1926 following the report of the "Royal Commission on Lunacy and Mental Disorder" of the same year, which informed the English Mental Deficiency Acts of 1927 (Prior, 2012: 373–392; Walmsley et al., 1999). This Act made it the duty of local authorities to ensure that necessary provision for the four options was undertaken.

By the end of the 1920s, perceptions of psychiatric treatment and mental hospital care for those deemed 'insane' in England had changed from those reflected in the old Victorian lunacy laws. Favour now fell on voluntary treatment and the need for outpatient and non-residential care (Prior, 2012: 373–392; Welshman, 1999). The Mental Health Act of 1930 made additional provision for voluntary treatment and encouraged outpatient clinics and observation wards. In the Irish Free State, the lunacy laws governed mental healthcare until the Mental Treatment Act of 1945, which transformed, which transformed mental health services and brought them in line with international developments in law and

medicine (Kelly, 2008; Prior, 2012: 382). As Kelly (2008) and others have explained in detail, the Act changed the old lunacy discourse of the Victorian laws to reflect an updated approach to mental healthcare. Inmates were now patients, and asylums became hospitals. Crucially, the judicial authority for admission was removed, allowing people to admit themselves voluntarily to mental hospitals (Malcolm, 2003: 328). Admissions could be on a voluntary, temporary (compulsory for up to six months) or indefinite basis (compulsory certification) (Prior, 2012: 382).⁴ The Act also established outpatient clinics and a 'boarding out' system for the mentally ill, and it allowed for the release of involuntary patients on a trial basis, though their discharge was still at the discretion of the medical superintendent (Malcolm, 2003: 328).

Historians have questioned why it took so long for Ireland to update its mental health legislation from the old Victorian lunacy laws, especially in comparison with England (see Table 1). Some, including Barrington, believed it was a result of the tough financial situation in which the Free State found itself upon independence (Barrington, 1987: 22, 86–8; Malcolm, 2003: 328; Prior, 2012: 382). The new government in the south of Ireland was preoccupied with 'attempting to consolidate its existence amid extremely difficult economic circumstances' during the first decades after independence (Malcolm, 2003: 328). Some attempts were made to disassociate itself from the British social welfare system, such as the abolition of poor law institutions under the Local Government (Emergency Powers) Act in 1923, but mental healthcare reform was left behind (Sweeney, 2010: 97). It has also been suggested that the culture in Ireland was reluctant to change. For example, Feeney (2012: 850) discusses the Irish State's reluctance to interfere legislatively with issues which affected family welfare, over which the Catholic Church held moral authority. Perhaps the same was true of its reluctance to update mental healthcare policy.

Table 1. Key activity in mental healthcare policy in Ireland and England since 1922.

IRELAND	ENGLAND
<p>1927: Report of the Commission on the Relief of the Sick and Destitute Poor (including the Insane Poor).</p> <p>1945: The Mental Treatment Act in the Republic of Ireland. The old discourse of ‘lunacy’ and ‘pauperism’ replaced by medical terminology: ‘inmate’ became ‘patients’. Recourse to a judicial authority for admissions was abolished completely and outpatient clinics were introduced.</p> <p>1966: Report of the Commission of Inquiry on Mental Illness. Recommended incorporating community care into mental health care provision.</p> <p>1981: The Health (Mental Service) Act passed, but never implemented.</p> <p>1984: Report of the Study Group on the Development of Psychiatric Services (established in 1981) published: <i>Planning for the Future</i>. Recommended community-based treatment/housing.</p> <p>1986: <i>Regional Strategy for Health and Personal Social Services 1987-92</i>. Set to shift the balance from institutional to community care, with planned reduction of people in psychiatric hospitals by twenty percent.</p> <p>1992: Green Paper on Mental Health.</p> <p>2001: Mental Health Act. Established basis of Mental Health Tribunals and a Mental Health Commission.</p> <p>2004: Health Act. Regional programmes for mental replaced by centralised directorate for mental health services.</p> <p>2006: <i>A Vision for Change</i>. Promoted the provision of accessible community-based services.</p> <p>2015: The Assisted Decision-Making (Capacity) Act 2015</p> <p>2021: Mental Health (Capacity to Consent to Treatment) Bill 2021 – Defeated by vote.</p>	<p>1930: Mental Health Act, which allowed hospitals to treat mentally ill patients without certification.</p> <p>1948: Mental hospitals incorporated into the National Health Service.</p> <p>1957: The Percy Committee (1954–7). Hospitals should be the primary means of treating patients who required specialist mental healthcare, but strongly advocated the use of community care for those who did not require long-term inpatient care.</p> <p>1959: Mental Health Act. Implemented the Percy Report.</p> <p>1975: Better Services for the Mentally Ill.</p> <p>1983: Mental Health Act. Strengthened protection for the civil rights of mentally ill patients.</p> <p>1988: Community care: agenda for action (the Griffiths Report). Led to the 1990 NHS and Community Care Act.</p> <p>1998: <i>Modernising Mental Health Services</i> White Paper.</p> <p>1999: Nations Service Framework for adult mental health.</p> <p>2003–9: <i>New Ways of Working</i> initiative for mental health professionals.</p> <p>2004: <i>National Service Framework for children, young people and maternity services</i> (including guidance on child and adolescent psychiatric services).</p> <p>2004: Social Inclusion Unit report.</p> <p>2005: Mental Capacity Act. Protected those who lacked mental capacity to make their own decisions.</p> <p>2006: <i>Everybody’s Business</i>: integrated mental health services for older adults.</p> <p>2007: Mental Health Amendment Act. Gave health professionals the power to detain and treat people with mental disorders in the interest of their health or public safety. 2014: Care Act. Aimed to bring about personalisation of care and support services.</p>

Although the 1945 Act undoubtedly improved many aspects of mental health services in Ireland, the problem of over-institutionalising people with mental illness, which had been the main drive for legislative change in Ireland by this point, did not go away (Prior, 2012: 388).⁵ By the late 1950s the number of patients receiving hospital care for mental illness in Ireland was at an all-time high of 20–22 thousand (Brennan, 2012; Prior, 2012: 388).⁶ The 1945 Act had introduced voluntary admissions; inpatient numbers did not decline and the Act had limited overall impact on outpatient clinics (Walsh, 2012: 114). Mental health services in Ireland remained institutionalised, with nearly all inpatient care still being conducted in the old nineteenth-century asylum buildings, the only exception being the Ardee (County Louth, opened in 1933), built in the twentieth century (Walsh, 2012: 114).

By the 1950s, England's restrictions on capital expenditure had stalled its mental healthcare treatment (Welshman, 1999: 208). The Percy Committee (1954–7) published the Royal Commission on Mental Health report in 1957, which stated that hospitals should still be the primary means of treating patients who required specialist mental healthcare treatment, but strongly advocated the use of community care for those who did not require constant hospital care (Welshman, 1999: 209). It emphasised the need for treatment rather than confinement (Prior, 2012: 385). Moreover, local authorities were identified as being primarily responsible for preventative services, social work and community care, for which there should be no need for formal 'ascertainment', making it more widely and easily available (Welshman, 1999: 209). Community care was considered essential to the future of mental healthcare. The report formed the basis for the 1959 Mental Health Act in England, and claims to have laid the basis for community care in Britain, though Welshman argues that while it set 'important legal precedents, it failed to ensure adequate financial backing for the development of mental health services' (p. 210).

In Ireland, there was an attempt to bring about legislative change in the early 1960s to update the 1945 Mental Health Act; a government commission established in 1961 (reported in 1966 in the Commission of inquiry on mental illness) recommended 'a move away from large, isolated, specialist mental hospitals towards smaller psychiatric units based in general hospitals and community facilities such as day hospitals and clinics' (Walsh, Daly and Moran, 2016: 761). The short-term units in general hospitals would be able to treat acute illnesses requiring inpatient care when needed (Walsh, 2012: 117). These recommendations were not, however, acted upon and admissions to institutions increased

from over 18,700 in 1970 to nearly 23,700 in 1982 (Malcolm, 2003: 332). There was no real attempt to make any serious changes to mental health law in Ireland until the Health (Mental Services) Act 1981 was passed. This aimed to simplify the process of admission to mental hospitals by abolishing the prior need for certification by medical recommendation (Walsh, 2012: 120). Just like the recommendations from the government Commission of inquiry on mental illness in 1966, however, the Act was never implemented, due to either a lack of finance, inherent legal problems, or 'because of the belief in some quarters that it was logistically too difficult to implement' (Prior, 2012: 389; Walsh 2012: 120).

In England, the 1975 White Paper *Better Services for the Mentally Ill* influenced the passing of the Mental Health Act 1983 (Payne, 1999: 253–4; Prior, 2012: 385). It called for more care outside institutions, which had been slow to materialise after the White Paper recommendations and 'clarified the consent to treatment provisions', providing additional safeguards for patients detained against their will (Cummins, 2020: 220; Payne, 1999: 253). The Act was introduced in response to the moral panic that ensued after a series of scandals emerged surrounding the poor treatment of patients at mental hospitals across the country (Cummins, 2020: 219). But by the turn of the century, media coverage of violent crimes committed by psychiatric patients living in the community turned public opinion against large-scale community care (Conlan-Trant and Kelly, 2022; Payne, 1999). The Mental Health Act 2007 (an amendment to the 1983 Act) questioned 'the risk posed by the patient, primarily to others; a result of both the social and political impetus behind the reform process and mounting public anxiety at the management of the 'mentally disordered'' (Glover-Thomas, 2011: 581). The 2007 Act endeavoured to find a balance between the personal freedoms of the individual patients and public safety (Glover-Thomas, 2011: 583). But during the two decades that followed, concerns that the Act may have got this balance wrong became increasingly apparent. Following years of austerity, Theresa May's Conservative government ordered an independent review of mental health services in Britain, chaired by psychiatrist Sir Simon Wessely. The report (Wessely, 2018) outlined deep-seated issues with the current system and a need for change. It addressed concerns over the process of admission, patient experience in inpatient units which were likened to institutions, and the disproportionately high rates of black people being subject to community treatment orders compared with white citizens (Cummins, 2020: 224). The

Wessely Review proposed a move to more human-rights-based approach to mental health treatment, with choice and autonomy, and therapeutic benefit being the optimal standard.

In Ireland, although the 1981 Act was passed but not implemented, a study group was established in the same year by the Development of the Psychiatric Services. This group published a Green Paper report later entitled *Planning for the Future* (1984), which again called for the more urgent process of moving patients from hospitals to community-based residential and day-care facilities by closing large institutions and rehabilitating long-term patients (Prior, 2012: 289; Walsh, 2012: 120). *Planning for the Future* recommended that mental health services should be community-based, sectorised and – echoing the 1966 report – acute inpatient services should be moved to specialist general hospital psychiatric units (Malcolm, 2003: 331–2; Walsh, 2012: 121). Unlike the report of 1966, the Green Paper was put into action, and by 1995 ‘the resident population of public and private Irish psychiatric hospital units was down to a little over 5,800, and plans were in place to close all psychiatric hospitals by ... 2005’ (Malcolm, 2003: 332). It prompted the publication of the 1995 White Paper *A New Mental Health Act* and the subsequent Mental Health Act 2001 (Prior, 2012: 389). The Act updated policy from the 1945 Act and was primarily concerned with involuntary detention and assuring standards of mental healthcare (Kelly, 2007: 21).

Overall, it is clear that Ireland was incredibly slow to update its mental healthcare legislation after it gained independence. It took until the Mental Health Act in 1945 for Ireland to update the Victorian lunacy laws (which were quickly deemed outdated), then another half a century for the next shift in policy in 2001. England updated mental healthcare policy far more frequently throughout the century, with Northern Ireland and the rest of the UK frequently following suit.

The move to community care

While legislation varied between Ireland and England, the general trend of figures relating to the institutionalised population did not. The numbers of people in psychiatric institutions grew in both Ireland and England, from the asylum-building boom of the nineteenth century, through the period of Irish Independence, and well into the twentieth century, when institutional treatment was eventually phased out in favour of care in the community (Brennan, 2012: 340). The population of people in asylums (or psychiatric hospitals) in Ireland grew annually from the early nineteenth century until it reached a peak of over

21,000 by the late 1950s and early 1960s, when it had 'the highest rate of psychiatric bed utilisation in the world' (Brennan, 2012: 340; Kelly, 2004: 55; Kilgannon, 2020: 815; Malcolm, 2003: 324; Prior, 2012: 388; Walsh, 2015: 348).⁷ Figures in England followed a broadly similar pattern, although Ireland's numbers remained proportionately higher (Walsh et al., 2016: 763), and the number of hospitalised patients grew from '8941 in 1829 to peak at 155,000 in 1955' (p. 767). The subsequent decline in admission numbers in both Ireland and England from the 1950s onwards and the shift to community care is argued to have been the result of several social, economic and medical factors.

Brennan asserts that in Ireland the implementation of provisions set out in the Mental Health Act of 1945, especially the removal of judicial dominance in admission procedures, was part of the reason for the decline in institutional admissions from the late 1950s. Psychiatrists 'had a narrower set of admission criteria that were applied through a more tightly regulated legal procedure for admissions' (Brennan, 2012: 367). The Act also called for more routine and regular patient reviews, making it harder to legitimately keep patients in institutions long-term. However, others have claimed that the Act had little effect on lowering admission figures, as admission numbers continued to rise long after the Act was passed. (Kelly, 2008: 62; Malcolm, 2003: 328; Prior, 2012: 383). Perhaps the implementation of the 1945 Act took time to have any real effect. By the mid-1960s, the Commission of Inquiry on Mental Illness (1966) stated that 40% of all hospital beds in Ireland were in mental hospitals, but only a quarter of all non-capital health expenditure was spent on their running costs, making it an important driving factor in the push for deinstitutionalisation (Walsh, 2015: 348).

The international standardisation of diagnostic criteria and the creation of new psycho-pharmaceutical interventions have also been deemed to have contributed to declining admission rates, along with the eventual closing of institutions in favour of community care (Brennan, 2012: 367-8; Prior, 2012: 38, 383). During the first half of the twentieth century, the treatments for mental patients in both Ireland and England were mainly 'physical'.⁸ By the 1950s the pharmaceutical industry began marketing anti-psychotic drugs including chlorpromazine (marketed as Largactil) (Welshman, 1999: 209). These major tranquillisers (Walsh, 2012: 133) controlled the worst symptoms, such as anxiety and violence, while enabling psycho-social reforms in psychiatric hospitals in the 1950s, including the ability to be treated outside of the institution (Fussinger, 2011). The positive

impact of these medications became an argument for outpatient treatment and care in the community instead of long-stay institutionalisation in Ireland and in England.

In England there was a shift to community care during the latter part of the twentieth century. Between 1954 and 1982, the number of psychiatric beds fell by 55%, from 152,000 to 72,000 (Payne, 1999: 247). By 1994 this had dropped even further to 43,000, meaning there was a 72% total drop in bed numbers between 1954 and 1994. Most were the result of the closure of large psychiatric institutions. Over 40 such institutions closed in England in the 10 years between 1972 and 1982 alone (Payne, 1999: 247). Although the number of psychiatric institutions and beds dramatically decreased over this period, psychiatric admissions increased by nearly 50% between 1964 and 1994. This was due to a faster turnover of patients in the remaining psychiatric institutions, as Payne (1999: 247) explains. More patients were being treated in the community, with shorter stays in institutions. However, many patients ended up in a cycle of discharge and readmission known as the 'revolving door' phenomenon, which must be remembered when examining the rising admission rates during this period.

Prior (2012: 38) claims that by the mid-twentieth century, 'it became clear throughout the western world, that the institutional approach to mental healthcare was neither financially viable nor medically necessary'. Attitudes towards mental healthcare were changing, with growing scepticism around institutionalised treatment (Welshman, 1999: 209). There was also a growing anxiety about demographic changes, with 'rapidly increasing numbers of elderly people' reflected in the 1959 general election campaign, which expressed concern over the rising costs of hospital care (p. 209). New pharmaceutical advances, along with advances in the understanding of mental health, coupled with the changing public attitudes towards mental health, made community care a viable alternative.

However, attempts at legislative change and a shift to community care in Ireland fell flat before the 1980s, and Malcolm (2003: 331) states that in 1984 there were still nearly 13,000 patients in psychiatric institutions across the country. Moreover, admissions had increased from over 18,700 in 1970 to 23,000 in 1982. According to Connolly (1980), these admissions would have been into old Victorian asylum buildings, which were by this point in a state of terrible disrepair. In addition, in 1980 there was a decrease of real current expenditure on psychiatric services in Ireland by over £2 million. This came at a time when Connolly exposed many large psychiatric hospitals in Ireland as having been in a state of

‘physical disintegration, oppressive congestion, demoralisation ... squalor and inadequate staffing’. The 1984 study group report *Planning for the Future* stressed the need for community care over the use of institutions and, as a result, many of the old psychiatric hospitals began to close (Malcolm, 2003: 331–2). Likewise in England, the impetus to close psychiatric institutions from the middle of the twentieth century onwards was also fuelled by growing concerns about the poor environmental and social conditions of patients, highlighted by hospital inquiries. John Martin (1984) documented 15 major scandals in mental and learning disabilities hospitals that led to a series of official inquiries, TV programmes and press campaigns during the period 1968–79. In Ireland, the total number of psychiatric beds decreased by almost 70%, from 12,484 in 1984 to 4121 in 2004 (Prior, 2012: 39). By 2006, the number of psychiatric units in general hospitals, along with the number of community-based residences and day-care centres had all increased, but the extent of the community care model set out in *Planning for the Future* had not yet materialised.

In the 2006 report *A Vision for Change* (Department of Health and Children), a radical shift was called for, ‘from hospital to home’ (Prior, 2012: 39). The report recommended that a plan be drawn up to bring about the closure of all mental hospitals in Ireland, with expenditure on mental health services adjusted in line with inflation (Walsh, 2015: 350). Almost a decade after the report, Walsh (p. 350) claimed that Ireland’s hospitalisation rate was at 66 per 100,000 compared with 60 in England and Wales, and hardly any patients remained in nineteenth-century psychiatric hospitals in Ireland by 2014.⁹ In addition to *A Vision for Change*, The Department of Health and Children (2006) and the Mental Health Commission (2008) called for the involvement of service-users and their carers in the ‘development, delivery and evaluation of interprofessional education for mental health practitioners’ (Higgins, Maguire, Watts and Rani, 2011: 519). The ethos of such a partnership would value the expertise of users and carers to underpin service delivery and education. However, according to Higgins et al., there was very little evidence of such a partnership in practical terms (pp. 523–4).

By 2020 much of the policy goals set out in *A Vision for Change* were still not met, resulting in the new report *Sharing the Vision*.¹⁰ This report sets out aspirations for a community-based recovery model, with step-by-step pathways – including family and social support – to well-staffed specialist mental health services in the community, and specialist

residential services. It also recommends innovations, such as online psychological services, crisis cafes where people can go instead of A&E at times of mental health emergencies, and recovery colleges to educate and empower people about their mental health. Much like *A Vision for Change*, the ideals in this report seem to have been widely welcomed, but there are concerns about its viability. An article in the *Irish Times* in 2021 quoted Ray Burke, Senior Communications and Advocacy Officer with Mental Health Reform, who stated that local health services in Ireland still only had 60% of the staffing recommendations proposed in *A Vision for Change* (Freyne, 2021). Setting out a new vision when the old one was still not fully implemented does not bode well for its success in the future.

In both Ireland and England then, psychiatric admission to large institutions rose until the late 1950s, when they declined until the mid-1960s in England and 1970s in Ireland, before they rose again. This rise occurred as bed numbers in large institutions decreased (earlier in England than in Ireland) following a call to shift care from hospitals to the community during the latter decades of the twentieth century. Although many of the Victorian asylum buildings began to close in England from the 1980s, many continued to function in Ireland through the 1990s (Brennan, 2012: 367–8). In Ireland, it was not until the Mental Health Act of 2001 and a politically-backed closure policy proposed in 2006 that the physical asylum structures finally started to become a thing of the past. By 2013, the national census of Irish psychiatric units and hospitals showed a total of 2401 patients, equalling an institutional rate of 52 per 100,000 (Walsh et al., 2016: 766). This was a 14% reduction from 2010 and an 88% reduction from 1963. According to Brennan (2012: 348), the rates of expansion and decline of Irish institutional mental healthcare provision were extreme by international standards.

Conlan-Trant and Kelly (2022) report that now the number of involuntary psychiatric admissions in England is double that of Ireland.¹¹ They explain these figures are the result of the broader definition of mental illness and criteria for involuntary admission in England. In addition, England spends proportionately more on mental health services than Ireland and has proportionately more inpatient beds, which they argue could contribute to more admissions, including voluntary ones (p. 66). That said, despite this higher investment in England, there has still been a steady decline in the number of beds available in the NHS in the last 30 years (Ewbank, Thompson J and McKenna H (2017)).

Challenging historical perceptions of institutional versus community care

The current historiography focuses on admission rates and the legislative history of mental healthcare services in Ireland and England, but rarely problematises or challenges deinstitutionalisation for current service-users. The shift from institutional to community care was neither inevitable nor straightforward; linear and progressive histories of mental healthcare provision often fail to discuss the many issues that have resulted from deinstitutionalisation in both countries.

In England, the 1975 White Paper *Better Services for the Mentally Ill* stated that, despite the Mental Health Act of 1959, financial restraints had meant that community care was still minimal, and that ‘the failure to develop adequate social services was perhaps the greatest disappointment of the previous fifteen years’ (Welshman, 1999: 215). By the end of the century, community care provision faced various issues, including the problem that patients could not be made to medicate themselves while living in the community (Payne, 1999: 262).¹² These patients needed to re-enter an institution, but beds were becoming limited, and this continues to be a problem today. Service-users who would have been hospitalised long-term before deinstitutionalisation are now being transferred to different institutional settings (Chow and Priebe, 2013). The Royal College of Psychiatry reported in 2020 that two-fifths of patients waiting for mental health treatment contact emergency or crisis services, with one in nine of these patients ending up in accident and emergency.¹³ Ireland faces the same problem. A report published by the Foundation for European Progressive Studies (FEPS) in 2023 states that there is a lack of access to certain key services in Ireland, especially for those experiencing a mental health crisis or emergency (Mitchell et al, 2023: 31-37).

In addition, the lack of policy for mental health rehabilitation services has led to ‘disinvestment and expansion of out-of-area placement in in-patient, nursing, and residential care settings’ (Killaspy and Meier, 2010: 265). This has become known as the ‘OATS’ (out of area treatment) issue, which raises concerns regarding the social dislocation caused by placing a service-user miles away from family and their local care system (Caldas de Almedia and Killaspy, 2011). In England, the lack of investment in long-term therapeutic services for people with enduring mental health issues, coupled with the coalition government’s policy of austerity and neoliberal restructuring of mental health services from 2010 onwards in response to the fiscal crisis of 2008, have given rise to a new wave of

activism in which service-user groups and their allies now fight to keep these services open and demand access to them (Moth et al., 2015; Spandler, 2006: 7, 2020). Access to safe spaces during times of crisis are especially important, but these spaces are not provided on anywhere near the scale required (Calabria, 2022a; Taylor, 2011: 199–200).

Moreover, the policy claim that consumerism gave mental health service-users choice and autonomy was undermined by a lack of investment in community-based services (Barham and Hayward, 2002; Spandler 2020). Taylor (2011) has argued that choice and personal autonomy born out of the consumerism agenda in the 1990s can be a form of neglect, as the closure of mental hospitals without adequate provision in the community left patients vulnerable to cuts in public expenditure. It echoes Peter Sedgwick's (1982/2015) attempt more than 30 years ago to defend state provision of mental health services in the face of deinstitutionalisation and the recent shift of priorities of activist service-users and their allies towards a defence of mental health services and disability benefits in the age of austerity (Moth et al, 2015). Mental health services were arranged according to the interests of the medical profession rather than social needs, but service-users and their families lacked social and political power (Sedgwick, 1982: 40–45). Deinstitutionalisation has resulted in the replacement of the psychiatric hospitals with fragmented services in both hospital and community settings (Patel, 2019; Taylor, 2011) and the consequent lack of investment to provide continuous forms of care for individuals who needed more than short-term interventions post-deinstitutionalisation (Spandler, 2020).

It is also important to note the role of institutions as places of safety and sanctuary, with some residents having liked life in the psychiatric hospital and regretting its demise (Calabria, 2016; Gittins, 1998: 9–12). These narratives have not usually been told in published accounts because they do not easily fit within the prevailing discourse of residential care as undesirable and with government policies on deinstitutionalisation (Calabria et al., 2021: 196). One of the few accounts that do exist, Barbara Taylor's (2014) memoir *The Last Asylum*, challenges the dominant perceptions of institutions as outmoded and undesirable. Her memoir speaks to the narrative of changing mental health provision in Britain, highlighting the importance of support structures for inpatients and service-users. Taylor, who is both an academic and a mental health service-user, emphasises the dual nature of the asylum as a place of relative safety in times of need. She recalls her three

spells of hospitalisation in Friern Barnet Hospital, London, in the late 1980s positively, seeing it as a place of refuge during a time in which caring for herself was not an option. Taylor traces how mental health provision in Britain has changed since the closure of mental hospitals, with individual independence and self-reliance becoming dominant ideals based on individual responsibility and self-management, even for those who may not be capable of exercising them (Repper and Perkins, 2003). From 2004 onwards, the policy imperative of inclusion as part of the modernisation agenda in mental health (Office of the Deputy Prime Minister, 2004; National Social Inclusion Programme, 2008) can be seen to deny inpatient care to those that need it. This has resulted in the closure of community day centres, rehabilitation facilities and other psycho-social services.

In addition, Calabria and Ellis (2024 forthcoming) have analysed an in-depth, archived oral history conducted with Keith Shires, a patient at Shenley Hospital in Hertfordshire in 1961 and again in 1971. Despite experiencing some of the totalising features of institutions, Keith valued the care he received in the old state mental hospital and emphasized the importance of being removed from an urban environment during a mental health crisis. He developed close interpersonal relationships with staff and other male patients during his hospitalisation at Shenley. These relationships were instrumental in helping him to recover and in reducing the length of his second hospitalisation. However, following deinstitutionalisation, Keith found it difficult to establish and maintain such relationships in the mental health system due to the shortage of beds and the fragmentation of mental health services that ensued (Calabria and Ellis, 2024 forthcoming). This fragmentation has resulted in a shift towards crisis management rather than therapeutic practice within services (Patel, 2019).

In addition, the oral histories of former staff and patients of two mental hospitals in Nottinghamshire, collected 30 years after their closure, reveal that the hospitals were more welcoming and relaxing than the current acute inpatient services, which focus on crisis management (Calabria et al., 2021; Calabria, 2022a). Former patients found that meaningful occupation and the ability to move within the mental hospitals' spaces were important for their recovery. They expressed a sense of loss of therapeutic environments after the shift to community care. Despite England investing in more inpatient beds than Ireland, as discussed earlier, therapeutic practice has been largely unattainable in acute inpatient settings since the 1980s because of rising demand for beds, coupled with the steady

reduction of available beds, as more than half of NHS hospital beds have been cut in the last 30 years (Ewbank et al., 2017). Moreover, patients and staff in inpatient wards have consistently reported the lack of therapeutic activities and meaningful interaction due to staff shortages and too many demands placed on staff, such as dealing with crises. The wards have been reported by Both patients and staff have described the wards as prison-like environments, not conducive to recovery due to the shortage of beds and the concentration of people who are most unwell (Csipke et al., 2014; Wykes et al., 2018).

In Ireland, a recent account by Gary Kiernan tells of his lived experience of accessing mental health services in Dublin ‘from a dual lens; that of service user and social worker’ (Kiernan, Donohue and Kirwan, 2022: 280). As in England, the only places to go in times of mental health crisis are GPs and A&E departments, and after going to his GP and informing them that he did not feel safe, Kiernan was met at the nearest A&E department by a doctor who was expecting him. He stayed in a secure unit for a week or so, before being transferred to a private psychiatric hospital which was a two-and-a-half-hour drive away. Kiernan states that, on arrival, ‘I do remember being spoken to by an empathetic young doctor and my relief at feeling that she understood better than I did as to why I needed to be there’ (p. 281). He was initially admitted to the acute care ward where he was monitored every 15 minutes, before being moved to a more relaxed three-bed area, where he could watch TV or play a board game, before eventually being assigned his own room. Kiernan described the hospital as having a warm atmosphere, with access to a garden. The hospital offered a variety of recreational activities, which Kiernan enjoyed (p. 281). Overall, Kiernan clearly required long-term hospital care and he reflects fondly on the treatment he received there.

Beyond the legislative history of mental healthcare in Ireland and England, the lived experiences of people at the receiving end of mental healthcare complicate dominant perceptions of institutions. Prior’s research (1991) challenges the perceptions of psychiatric institutions as isolated and closed environments in Northern Ireland for long-stay patients (Goffman, 1961; Scull, 2004). Prior used case notes and oral history interviews to piece together the life of a long-stay patient in Sixmiletown Mental Hospital in Northern Ireland. Despite being in the institution for 40 years, Samuel maintained a strong sense of personal identity and social network through his involvement in the local choir and work for various businesses, evidencing that some sections of his community did not engage in social

distancing. He refused to move into the community when this was offered to him, and described the hospital as 'a handy place to keep the bicycle'. His experience questions the portrayal of mental hospitals in the literature as dysfunctional and closed institutions (Prior, 1995: 665).

As Wynter, Wallis and Ellis (2023: 1–16) have argued, it is impossible to discuss the history of psychiatry, mental health and asylums without also considering the reform, changes and continuities that have occurred over time. They interrogate how the constant recalling of the trope of the 'bad old days' (p. 3) has been essential to the development of modern mental healthcare. This pattern of myth and memory about the inherent nature of progress in mental healthcare continues to be repeated in public discourse today. The ideal future of mental healthcare contributed to a cycle of despising the past and failing to acknowledge the present reality of mental healthcare. The enduring popular perception of the brutality of psychiatry's past and the incremental nature of progressive reform remains ingrained in public perceptions of past models of care, despite ongoing academic debates. As Ellis and Coleborne (2022) have recently argued, examining the fact that the treatment and life chances of people with mental illness have not significantly improved since deinstitutionalisation can help not only to move past institutional histories, but also to demonstrate the relevance of historical inquiry to current debates about treatment and care (2022: 144). Transdisciplinary researchers focusing on the social history of mental healthcare have a vital role to play in challenging the prevailing belief that progress is an inherent aspect of mental health policy.

Concluding remarks

Overall, the shift from institutional care in the old state mental hospital to care in the community was a long and complex process in both the Irish and English settings. Ireland was reluctant to introduce mental healthcare legislation after 1922, and it was not until the Mental Health Act of 1945 that legislation finally changed from the Victorian lunacy laws. Ireland would then have to wait another four decades for a push for further legislation. Prior (2012: 38) blames Ireland's slow deinstitutionalisation on 'the economic and political interests surrounding the downgrading or closure of mental hospital services', while Malcolm (2003: 333) concludes that the question of why Ireland used mental hospitals more intensively and for longer than England and most other countries still awaits a wholly

satisfactory explanation. Interestingly, while the legislation in Ireland and England was issued at different times across the twentieth century, the admission numbers in psychiatric institutions were largely similar across the board. This would suggest that the law had little effect on the patterns of people admitted to psychiatric institutions, and that the rise and fall of hospitalisations was due to a variety of social factors.

While the current historiography provides a thorough picture of policy, admission rates and mental healthcare treatments, it often does so in a manner that, consciously or not, pushes the idea of medical progression. Few have questioned if community care is better for service-users than institutional provision. Walmsley, Atkinson and Rolph (1999: 185) have argued that community care has too often been viewed as superior to institutional care, when it could, in fact, be just as controlling. By the late 1990s, New Labour identified numerous problems with community care, including: inadequate care, poor management, underfunding, the proper range of services not always being available, families who willingly played a part in providing care having been overburdened, problems in recruiting and retaining staff, and an outdated legal framework which failed to support effective treatment outside hospital (Cummins, 2020: 223). While community-based services have the intention and potential to allow for greater care and user satisfaction, the resources allocated are often limited (Caldas de Almeida and Killaspy, 2011). In such instances, service-users may well have received a higher standard of attention and treatment if they were still being treated in the institutional setting. By 2018, issues with community care had not gone away, as highlighted by the Wessely Review.

In the last decade there have been increased efforts to give voice to former patients and service-users so that historians and social care researchers might better understand care and treatment practices in the late twentieth century (see, for example: Coleborne, 2020). Often, the published narratives from previously marginalised individuals reflect the negative aspects of institutional care and relate to a lack of investment in services on the one hand and issues of (social) control on the other. Overall, patient experiences of the changing dimension of mental healthcare continue to remain an unexplored area of research. As this article has indicated, critiques of institutional care overlooked the relevance of residential care for people undergoing crisis and in need of a place of respite; residential provision may be the preferred choice for some who may need time out from environments not conducive to their recovery. Historians and researchers working in

interdisciplinary contexts are increasingly recognising the value of the patient voice by producing collaborative research through sustained engagement with individuals and communities (see, for example: Calabria, 2022b; Ellis, 2017). This participatory approach to researching the past requires a shift in focus to widen the horizon and consider the concerns of the communities being researched, in this case the experiences of those at the receiving end of mental healthcare, who have remained underserved all along, albeit in different ways. While more research is needed across a range of settings and disciplines to understand fully the effects of deinstitutionalisation on the people who lived it, this work needs to embed the priorities of those who rely on mental health services to produce research that reflects their needs and thus can effect social change.

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[Notes]

¹ An example is Peter Townsend's 1962 seminal social study of residential homes for elderly people. The study concluded that their depersonalizing regime involved patients becoming institutionalized after a long stay in a residential institution, recommending the phasing out of this type of residential care.

² Throughout the article you are dealing with the area that is now the Republic of Ireland (called the Irish Free State in 1922, then the Irish Republic in 1948).

³ Throughout the article, we will be moving interchangeably between the terms ‘patient’, ‘service-users’ and ‘people with lived experience’ to reflect how dominant perceptions of people using mental health services have shifted and developed as a result of changes in policy imperatives.

⁴ For a publicly funded or ‘chargeable’ patient, the application for admission could be made by the nearest relative, or an ‘assistance officer’, with one medical certificate by an authorised medical officer. For a private patients two medical certificates were required.

⁵ During the 1950s the number and use of outpatient clinics expanded, but, nevertheless, over-institutionalisation continued to persist.

⁶ Brennan puts this all-time high at 21,720 in 1956, while Prior records it as 20,619 in 1958.

⁷ Brennan states that the high point was reached in 1956 with a total of 21,720 patients in psychiatric beds in Ireland; Malcolm states it was in 1958 with 21,046; Kilgannon states 1958 at 21,075; Prior states it was 1958 with a total of 20,619; Kelly states that in 1960 it was at a high of 20,506.

⁸ These treatments included insulin comas to treat schizophrenia, electroconvulsive therapy, and leucotomy.

⁹ According to Walsh (2015: 350), ‘with the exception of one nineteenth-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 the 19th century psychiatric hospitals’.

¹⁰ In 2019, a further €189 million was still needed to fully implement the staffing requirements the report had set out to achieve, according to Freyne (2021) writing in the *Irish Times*.

¹¹ According to Conlan-Trant and Kelly (2022), in Ireland there were 49.4 involuntary admissions per 100,000 population in 2019. In England there were 90.4 per 100,000 population in 2019–20.

¹² This was stipulated under the Mental Health Act of 1983.

¹³ Royal College of Psychiatrists (2020) reported that two-fifths of patients waiting for mental health treatment forced to resort to emergency or crisis services; accessed

01.07.2023) at: [https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services#:~:text=Two%2Dfifths%20\(38%25\)%20reported,decline%20in%20their%20mental%20health.](https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services#:~:text=Two%2Dfifths%20(38%25)%20reported,decline%20in%20their%20mental%20health.)