



What drives changes in institutionalised mental health care? A qualitative study of the perspectives of professional experts

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Abstract

Background Since 1990, the provision of mental healthcare has changed substantially across Western Europe. There are fewer psychiatric hospital beds and more places in forensic psychiatric hospitals and residential facilities. However, little research has investigated the drivers behind these changes. This study explored qualitatively the perspectives of mental health professional experts on what has driven the changes in Western Europe.

Methods In-depth interviews were conducted with twenty-four mental health experts in England, Germany and Italy, who as professionals had personal experiences of the changes in their country. Interviewees were asked about drivers of changes in institutionalised mental health care from 1990 to 2010. The accounts were subjected to a thematic analysis.

Results Four broad themes were revealed: the overall philosophy of de-institutionalisation, with the aim to overcome old-fashioned asylum style care; finances, with a pressure to limit expenditure and an interest of provider organisations to increase income; limitations of community mental health care in which most severely ill patients may be neglected; and emphasis on risk containment so that patients posing a risk may be cared for in institutions. Whilst all themes were mentioned in all three countries, there were also differences in emphasis and detail.

Conclusions Distinct factors appear to have influenced changes in mental health care. Their precise influence may vary from country to country, and they have to be considered in the context of each country. The drivers may be influenced by professional groups to some extent, but also depend on the overall interest and attitudes in the society at large.

Keywords Mental health services · Institutional care · Deinstitutionalisation · Re-institutionalisation · Driving factors

Introduction

The provision of institutions in which patients with mental disorders are being cared for has substantially changed across Western Europe over the last few decades. Whilst the number of psychiatric hospital beds decreased, forensic psychiatric hospital beds, places in supervised housing services and prison populations with a significant proportion of people with mental disorders considerably increased in many countries. In England, for example, the number of psychiatric hospital beds fell from 132 per 100,000 persons

in 1990 to only around 59 by 2006, whilst in Germany there was a slight increase of psychiatric hospital beds [9, 12]. In both England and Germany, an increase in forensic psychiatric hospital beds and places in supervised and supported housing was observed. Detailed descriptions of the de-institutionalization process in Western Europe have been published elsewhere [6, 9, 12]. Institutions in this context are care settings defined by bricks and mortar [1–3].

These changes have been analysed for a range of Western European countries. Previous analyses focused on two related issues: (a) the question as to whether these changes reflect a trans-institutionalisation, in which the total number of people with mental disorders in institutions remain consistent and just the type of institution changes, or even a re-institutionalisation, in which the total number of people with mental disorders in institutions has risen; and (b) the Penrose hypothesis, which suggests an inverse relationship between the number of psychiatric hospital beds and the size of the prison population [4–6]. The findings on both questions

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appear inconclusive: the available data do not provide consistent evidence for either trans- or re-institutionalisation, and analyzing the Penrose hypothesis leads to complex methodological problems preventing any straightforward conclusion. Whilst the analyses on the above questions have been presented in previous publications [6–15], this study addressed a different aspect and explored the potential drivers behind the changes.

There are several suggestions in the literature for what factors might have driven the changes since 1990, the year which historically has been regarded as the end of the post-war and the beginning of a new era in Europe [16]. They include: a potential increase in psychiatric morbidity; wider public concern about the risk that people with mental disorders might pose and a focus of services on how to contain that risk; diminished social support because of social isolation and reduced support from families; and interests of provider organisations to expand their services and income [8–13]. However, these suggestions were expressed as individual speculations or as the interpretations of authors who published data on mental health care institutions.

We, therefore, conducted a qualitative study to explore the perspectives of mental health professionals who had experienced the changes since 1990 in their professional role and have an expertise in the field. We included professional experts from England, Germany and Italy. The three countries had all experienced extensive reforms of de-institutionalisation in the second half of the twentieth century, although with different onsets, paces and outcomes, and had all experienced signs of increases of some form of institutionalised mental health care provision since 1990.

Method

Sampling and materials

Interviewees met the following inclusion criteria: (i) mental health professional with expertise in service development, care delivery and/or research, and (ii) professionally active since before 1990. These experts were considered ‘insiders’ with first-hand knowledge and experience of the changes in mental health care [17–19]. To minimise potential bias and obtain a wider range of perspectives we purposively selected different experts considering the criteria: (i) educational and professional background, i.e. psychiatrist versus other health professionals; (ii) current role, i.e. being professionally active versus retired; and (iii) setting; i.e. working in an academic versus non-academic organisation. Participants were recruited in England, Germany and Italy. Recruitment took place between November 2012 and May 2013.

Semi-structured in-depth interviews were conducted by the first author (WSC). The topic guide focused on seven

areas: (i) the provision of mental health care institutions in the given country, (ii) alternative residential mental health services, (iii) forensic mental health care, (iv) society’s attitudes towards patients with mental illness in the given society, (v) funding and financial resources, (vi) the organisation of mental health institutions, and (vii) relationships between clinicians and patients.

Analysis

Recordings of the interviews were transcribed, coded line-by-line and analysed using thematic analysis [20]. Each of the transcripts was first read as a life history case study as recommended by Murray [21], allowing the authors to explore the individual reflections of each participant, and then again to identify intersecting ideas.

An inductive approach was used to identify themes [22]. The first two authors independently coded the transcripts and categorised the themes. Following the guidelines of Braun and Clark [19], the authors scrutinised each transcript, highlighting relevant passages to identify recurring patterns of meaning or ‘themes’. Next, related passages were grouped under the same theme into one broad category of themes. Themes, categories and related memos were entered into a database, which was used for ongoing comparisons and referencing across interviews. Finally, each theme was examined in accordance to the research question. Themes and categorisations were regularly compared and discrepancies discussed with the third author before they were finalised.

The first author (WSC) is a counselling psychologist with a public health background and has worked mainly in an academic context in Germany and England. The second author (AA) is a clinical forensic psychiatrist in England, whilst the third author (SP) is a clinical and academic psychiatrist and psychologist with professional experience in Germany and England.

Results

Thirty-one mental health professionals who fulfilled the inclusion criteria were identified as they had published relevant papers in the literature or were personally known to the authors. They were invited to participate in the study, and 24 took part (two did not respond, two had insufficient command of English, two did not have time, and one cancelled because of a personal emergency). Table 1 shows the demographic characteristics of the sample.

Of the interviewees, 23 were male and one female. Twelve were professionals in England, seven in Germany, and five in Italy. Nineteen participants were currently professionally active and five were retired. The average professional experience was 32.7 years (range 24–53). Thirteen

Table 1 Demographic characteristics of the interviewed participants

Participants (ordered by date of interview)	Country	Qualification background	Academic or clinical	Active or retired	Gender
P01	England	Psychiatrist	Non-academic	Retired	Male
P02	England	Psychologist	Non-academic	Retired	Male
P03	England	Psychiatrist	Academic	Retired	Male
P04	England	Psychiatrist	Academic	Active	Male
P05	England	Psychologist	Both	Active	Male
P06	England	Psychiatric Nurse	Academic	Active	Male
P07	England	Psychologist	Academic	Active	Male
P08	England	Psychiatrist & Public Health	Both	Active	Male
P09	England	Psychiatrist	Both	Retired	Male
P12	England	Psychologist/Policy	Non-academic	Active	Male
P15	England	Manager	Non-academic	Active	Male
P25	England	Psychiatrist/Policy	Both	Active	Male
P10	Germany	Sociologist	Academic	Active	Male
P11	Germany	Sociologist/Manager	Non-academic	Retired	Male
P13	Germany	Forensic Sociologist	Both	Active	Male
P16	Germany	Psychiatrist	Both	Active	Male
P17	Germany	Psychiatrist	Non-academic	Active	Male
P18	Germany	Psychologist	Non-academic	Active	Male
P19	Germany	Social Worker/Public Health	Non-academic	Active	Male
P20	Italy	Psychiatrist	Non-academic	Active	Male
P21	Italy	Psychiatrist	Academic	Active	Male
P22	Italy	Psychiatrist	Both	Active	Male
P23	Italy	Psychiatrist	Both	Active	Male
P24	Italy	Psychiatrist	Both	Active	Female

of the experts were psychiatrists, with the others being psychologists, psychiatric nurses, sociologists, or public health specialists.

The analysis identified four interconnected themes: the overall philosophy of de-institutionalisation; finances; limitations of community mental health care; and emphasis on risk containment.

The overall philosophy of de-institutionalisation

Participants described the importance of the overall philosophy in mental health service provision which was dominated by the spirit of de-institutionalisation. This spirit was explicitly linked with experiences of unacceptable practice in old style asylums. The memories of that practice were still present and a powerful driver for establishing new forms of care in the community.

“Inpatient care in England had reached an intolerable point where it was a place that was too busy, too overcrowded, and potentially unsafe. Inappropriate in the way it was providing care for some people who needed a different form of care, not very much liked

by patients, not attracting the best staff and viewed with a certain amount of suspicion by the public.” (P25, England)

“We went through a period of time when people were very frightened and that was the early time of deinstitutionalisation era in this country... it was filled and full of horror stories, this was a very powerful phase.” (P04, England)

“[Care] hasn’t developed from a blank slate. It’s developed of course out of a context... that means asylum based institutions, physical in the Goffman’s sense total institution.” (P07, England)

“The large hospitals in the past have a big amount of long stay patients and the attitude was a bed is no home...” (P11, Germany)

“The official ideology of modern psychiatry would say we don’t need such sort of facilities.” (P18, Germany)

“Nowadays we are downsizing each of these levels of beds [in] hospital inpatient care... The large number of beds and the larger number we used to have that are not a choice but a legacy of the past...” (P21, Italy)

Other comments referred to a more general influence of the philosophy the time and an overcoming of paternalistic attitudes.

“The attitudes toward how you manage disordered souls vary depending on the *Zeitgeist* at the time.” (P01, England)

“Clinicians have gotten far more respectful of patients... It has made quite a significant difference to the nature of the relationship between patients and staff ... Much more taking patients into account in the making of decisions and involvement in making decisions.” (P06, England)

The overall philosophy was promoted by important national policies, in particular the Psychiatry-Enquête in Germany from 1975 and the Law 180 in Italy from 1978.

“[In reference to the changes in mental health care] It was a result of the *Psychiatrie-Enquête*.” (P13, Germany)

“... instead of one level of protection you have several steps of protection from hospital, to sub-acute units to short-term residential care, medium-, long-supported housing and so on... Our legislations, forbids residences larger than 20 beds.” (P20, Italy)

Finances

Finances were described as an important driver in the planning of mental health care. De-institutionalisation and care in the community were seen as a cost-reduction strategy and not only as driven by moral principles. Some experts balanced the importance of finances directly against the overall philosophy of care and emphasized that both factors played a role.

“The biggest driver was actually moral and philosophical, but money has always been a huge part in it... The two gets yoked... There is sort of a philosophy that said ‘Let’s not have people in institutions’. Then there is a hard pragmatism of how much it costs to not have people in institutions...” (P04, England)

“Enoch Powell back in the 1960s gave us the famous water tower speech, where he essentially set the direction of travel, saying that institutionalised care was of a bygone age... No longer fit for purpose and effectively one of the ways in which our society measures its compassion is to change the existing model of care... He also said—which I don’t think people tend to give as much attention to – ... that not only was it not moral but it wasn’t cost effective.” (P15, England)

Most experts mentioned the high costs of in-patient care and the pressure to reduce such costs. This drove the

development of alternative services in the community that were less expensive.

“People see acute care as a cash-out. They assumed that acute inpatient care is much more expensive than community care. Therefore, the pressure is to make admissions shorter, uh to make them less frequent, and cash in some of those acute beds and transfer the fund into community care.” (P06, England)

“To generate alternatives in the community you have to reduce the more expensive inpatient options” (P09, England)

“In the past, it was not so very difficult to keep patients in the hospitals for years and years and years until the time when the cost is so high that [it] was not possible and it came to a fundamental change...” (P13, Germany)

“But if you think the costs of those beds, they cost too much. I mean with the same amount of money, once the same sum is shifted to the outpatient level, you can do much more for patients with the same amount of money... So what we are trying to do is to shift the resources from the inpatient to the outpatient care.” (P21, Italy)

The problem of high costs for mental health care institutions applied not only to conventional hospital beds, but also to new residential facilities in the community that operated with high staffing levels.

“We face a serious financial problem and health costs have been booming over the last 15 years or so. So all regions have a sort of priority that cost containment is inevitable. ... These residential facilities are costly and patients have to be cared for 24 h a day and there is the need to limit the opening of new facilities and to limit the costs of these facilities.” (P23, Italy)

Whilst interviewees mentioned pressures to limit the costs of mental health care and to make the best use of available resources, they also pointed towards the interest of provider organisations to increase income and generate a financial surplus. This applied especially to organisations providing residential facilities, and the influence of these interests appeared stronger in Germany than in the England and Italy, but existed there too.

“The most important things... the privatisation of health care and of complementary care in Germany. It’s a very complicated [system]... I think about 70% [of hospitals] are private... In Psychiatry in general about 30–35% are private/for-profit. 65% are non-profit or public.” (P17, Germany)

“Welfare organisations, the church and private owners [all running residential facilities]... They are profit-oriented...” (P16, Germany)

“Also economic reasons because some providers [of residential facilities] invested in that and they may have been also some cases in which the opportunity drove the need ... More than half of them are private...” (P20, Italy)

“There are some unpleasant private sector units, which seem to be, you know holding onto people for too long...the incentives are not engineered to move people down.” (P12, England)

Limitations of community mental health care

De-institutionalisation was seen as having led to a new system of services in the community which provides better care for many patients, but also has gaps and limitations, particularly for some patients with severe mental illnesses who struggle to live in the community. This may have led to the rise of new forms of institutionalized care, in particular, protected housing and forensic services.

“After the reform the number of beds in residential facilities increased... Due to the fact that we closed the mental hospitals. So, the patient has to be placed there, because there is a gradual accumulation of chronic patients that need to be placed in some place.” (P22, Italy)

“The increase in residential facilities was not because of political will... In the law, there was no one single word about long-term residential facilities but of course over time it became extremely clear that there were long-term patients to be accommodated and to be care for... So something has to be done with these patients and so regions decided to set up these residential facilities.” (P23, Italy)

“Perhaps it’s a problem because with the de-institutionalisation of mental hospitals, you lose the asylum function... And because we don’t have it ...there are problems with severe and or difficult patients, or heavy users... So the chances that they come into the forensic system are very high.” (P11, Germany)

Emphasis on risk containment

Linked to the theme of limitations of community care, was an increased emphasis on risk. This led to better overall risk management.

“The risk management is much better...A high conscious of risk in general... All steps of clinical treatment, from the beginning to discharge, all steps. The management of coming into the clinics, the informed

consent, ...safety is the first... More safety for self but also safety for others.” (P16, Germany)

The emphasis on risk came with a perception that some form of long-term institutionalized care needed to be provided for a group of patients who posed a risk to themselves or others.

“The de-institutionalisation created one problem. ... it has become more evident that if your services remained community based there were people who often represented a risk towards others and needed something more than short term hospitalisation...” (P05, England)

Options to provide some form of institutional settings for patients who might pose a risk included medium secure forensic units and also prisons.

“Major reports in the 1970s talked about what services were necessary for people representing risks to others. And what services were necessary for people representing ongoing problems even if the risk towards others wasn’t major... As a result of that, in this country, the kinds of medium-secure numbers of services were set up around the country.” (P05, England)

“So we are not as bad as America where the default position is penalty. But there is still a relationship, which is why the government is investing in diversion services, special designed services, which divert people away from prison and provide [them] with community-based mental health care. But as we reduced the number of inpatient beds, and you know for people that seem to be particularly risky, the default position has up to until recently been prison.” (P15, England)

The emphasis on risk containment featured in all countries, but was particularly raised in England where concerns about the danger that psychiatric patients might pose were shared by the media, the public and clinical services.

“People started to worry about all the ‘mad’ people out in the community... The homicide inquiries building up and people [saying] ‘Ah I’m afraid we got to put them back again’ because they are being neglected. You let them out and then you realised you have gone too far and then you put them back again.” (P01, England)

“We also have a particular kind of government and legislative climate where people became quite frightened of the idea of patients with difficult problems roaming around in the community and not properly being looked after. And there were a series of scandals where members of the public were attacked, particularly the famous one Jonathan Zito.” (P02, England)

“In England it’s a sort of obsession, so it’s not that far in Italy... But it’s a concern. It’s not so systematised and organised as in England with forms and reviews and everything, but surely there’s one corner in the head of doctors in which dangerousness and risk are important.” (P20, Italy)

The public perception of risk, however, did not ignore the past experiences of poor conditions in old-fashioned hospitals.

“Events drive a lot of these things. The events sort of oscillate between the scandal of how badly people are abused in hospitals and the scandal of how badly people are neglected and allowed to go crazy outside hospitals. And public policy sort of oscillates between those two poles.” (P08, England)

International differences

All the themes were raised by interviewees in each country. Yet, as reported above, there were differences in emphasis. In Germany and Italy the *Psychiatrie-Enquête* and the Law 180, respectively, represented national political decisions that in themselves drove mental health care planning in the subsequent decades, whilst in England such a dominating political decision and document did not exist. In Germany, the economic interest of provider organisations was seen as stronger. In England, there was even more emphasis on risk and on the public’s perception of it.

There was one aspect, however, that was mentioned only in Italy. It was the role of families and their associations.

“It became clear in the 1990s that we needed more beds in these small-scale facilities because of the difficulties of families in caring for patients... Also new patients, not patients who were long-stay patients in the hospital, needed independent accommodation from their families. So there was a strong action of family association for opening these small-scale facilities.” (P20, Italy)

Discussion

Mental health professionals with a clinical and/or academic expertise from three countries, who had experienced mental health care since 1990 identified four major drivers of changes: the overall philosophy of de-institutionalisation; finances; limitations of community mental health care; and an emphasis on risk containment. These themes were raised in all countries, but there were also differences in emphasis and specific aspects of themes.

Strengths and limitations

To our knowledge, this is the first study exploring the views of experts on what drives changes in the provision of institutionalised mental health care in a systematic manner and across countries. We interviewed experts from different disciplines and included three countries with different traditions of mental health care and different current systems of care provision, and interviewed experts from different regions in each country. Interviewees were purposively sampled from different backgrounds and the response rate was high, i.e. most of the potential interviewees that we approached accepted and were interviewed. There was saturation for the identified themes. The study also suggests some differences between countries.

The study also has several limitations. The selection of interviewees followed defined criteria, but the decisions of whom exactly to contact may have been biased through personal familiarity with the given expert. The study included only professional clinical and academic experts; politicians, managers, patients and carers might all have had different views. The sample had only one female interviewee, which may reflect the dominance of male experts in mental health in the past and can have influenced the findings [22, 23]. Whilst there was saturation for the themes, the evidence for the differences between countries is weaker, as the numbers of interviews per country were rather small. The analysis did not allow us to compare the importance of the different drivers and weigh their potential influence. And finally, whilst the research question was about changes in Western Europe, we interviewed experts from only three countries, and it is unclear to what extent the themes would apply to other countries.

Interpretation

The themes cover very different factors that may have driven the planning and development of institutionalised mental health care. The overall philosophy of de-institutionalisation, as captured in the highly influential *Psychiatrie-Enquête* in Germany and Law 180 in Italy, determined the values and considerations of professionals for decades. The experience of old-style asylums was still vivid, and the aim of establishing more humane alternative services without putting patients behind walls dominated attitudes and planning. Since 1990, the main focus may have been shifting from the abolishing of asylums to the building up of effective services in the community. Asylums have now been completely closed—or at least sufficiently downsized to change their character—in most of Western Europe and a new generation of professionals will have no personal experience of care in asylums anymore. Therefore, it remains to be seen whether

the spirit of de-institutionalisation may gradually become less important and cease to be a major driver.

Whilst the influence of the philosophy of de-institutionalisation may change over time, one can assume that finances are always a relevant factor for the planning of mental health services. Yet, this factor includes more than just the general aim to save money and be efficient in service delivery [24]. Particularly, but not only in Germany, the privatization of health care providers has created an economic interest in more institutionalised care. All experts who mentioned this used a rather critical tone, as it not only defies the philosophy of de-institutionalisation but complicates all rational and needs-led service planning.

The perceived limitations of community mental health care have been frequently discussed in the literature [3, 5, 25; 5, 25], and there is certainly a challenge to provide effective care for a group of severely distressed and difficult to engage people in the community. Whether wider provision of care in institutions with bricks and mortar is the appropriate response to such problems, remains debated. Yet, when shortcomings of community care are considered among politicians and in the media, there seems to be a tendency to argue for more hospital beds and residential facilities rather than more investment in community services.

The emphasis on risk is linked to the limitations of community care and adds another angle, which seems to have come up in the 1990s, primarily in England. This was driven by the media and the public more than from inside professional groups. Experts were rather critical of this influence too, but acknowledged its impact. The public interest in the risk potentially posed by psychiatric patients may change over relatively short periods of time, so that its role in the future is difficult to predict. In the past, the emphasis on risk was reported as stronger in England, and one can only speculate on the reasons. A different tradition of the function of the press and the direct link of the government with the delivery and funding of the health service may have played a role in this.

All these drivers may be influenced by professional groups to some extent. They may shape the overall philosophy of mental health care, lobby for more funding, improve community care for the most severely ill and help the public to obtain an appropriate understanding of the risk that psychiatric patients pose. Yet, all of the drivers are also to some extent external. Only the interest of the wider society helped the philosophy of de-institutionalisation to become dominant and drive major reforms; facilitated the increase in the overall funding levels for mental health care in all three countries since 1990; can promote or hinder the privatization of health services; and determines the perception of risk that impacts on mental health care. Of all these drivers, the focus on more effective community care for very vulnerable patients is

probably the area in which professional experts have the greatest direct influence. It is a driver that may be clarified through further research evidence, which also applies to the costs of care and actual risks associated with different forms of care. However, addressing ideologies and financial interests may require more debate on underlying values and political priorities.

Finally, it may be noted that experts did not mention at least two other factors that might potentially have been raised. They did not argue that increased morbidity led to more institutionalised care and they did not mention macro-economic factors that had been suggested in time series analyses as influential [26].

Conclusions

Understanding why mental health care has changed since 1990 may be seen as being of mere historical interest. However, such analysis might help to identify more generally the drivers behind changes in the provision of institutions in mental health care, institutions that affect many thousands of patients in the three countries and absorb high spending in health and social care budgets. This understanding is still poor, and there is no widely accepted method for how to study these drivers. This study has used a new angle and studied the views of professional experts who had personally experienced the changes. Other perspectives and research methods may complement or challenge the findings of this study. Yet, it appears important for the discussion and planning of mental health care institutions to be aware of the potential drivers. The findings of this study suggest that there is more than one driver and that drivers can be distinct in their origin and type.

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Compliance with ethical standards

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

Ethical approval Ethical approval for the study was obtained from the ethics committee of Queen Mary University of London.

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