

ANALYZING THE CHANGES IN THE DEINSTITUTIONALIZATION PROCESS. A SYSTEMATIC REVIEW OF GLOBAL PSYCHIATRIC BED TRENDS

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1. BACKGROUND

Since the 1950s, mental healthcare in many developed nations has witnessed a trend towards deinstitutionalization, with national reforms differing in speed, approach, and specific outcomes. The establishment of comprehensive community mental health care is often considered an ongoing process that has not yet been fully realized. Community integration serves as both a facilitator and an outcome in the recovery journey of individuals with psychiatric disorders and is a crucial predictor of their quality of life. Throughout their recovery process, individuals with mental health conditions strive to achieve their life goals and maintain a satisfying existence within their communities. It is essential to prevent them from enduring lifelong stays in remote and inaccessible institutions while ensuring that they receive the necessary support in their own surroundings. [1]

Even forty years after the enactment of the 'Basaglia Law' in Italy, the country's psychiatric care system continues to rely on community-based approaches. Reforms, which are ongoing in many countries, emphasize the decrease in psychiatric hospital beds and the duration of admissions, promoting the importance of community-based care. Although the complete removal of psychiatric beds is not anticipated, as there may be situations in which hospital admission remains the best course of action, the emphasis is on integrating a multidisciplinary approach. Involving patients within their communities can serve as a proactive measure in addressing the stigma, which frequently serves as a substantial obstacle to improving mental health. [2]

Reforms in the care of psychiatric patients and the number of available psychiatric beds have transformed over time, reflecting the changing perspectives on mental health treatment, human rights, and healthcare systems. A significant reform movement known as deinstitutionalization

The BACKGROUND: The transition towards deinstitutionalization in the mental health field represents an essential step in how societies approach the well-being of people dealing with mental health issues. It signals an important change from the traditional practice of extended admissions in psychiatric institutions, advocating instead for a model grounded in community-based care and supportive networks. This substantial change has been driven by a combination of factors, including the development of public perspectives, progress in treatment methods, and a greater focus on human rights and individual autonomy.

AIM: This article aims to analyze the existing literature on the evolving patterns of psychiatric and forensic psychiatric bed numbers across various regions, cultures, and political systems.

METHODOLOGY: A search of the PubMed database was conducted by using "psychiatric beds" as keywords. Out of the 1482 initial results, 105 articles were analyzed by title and abstract. Twenty articles were assessed for eligibility and six were included in the review.

RESULTS: A decrease in the number of psychiatric beds was observed in post-communist countries, Western European nations, Sub-Saharan Africa, Central Eastern European countries, and Central Asian countries. The correlations between psychiatric bed numbers and prison populations were influenced by political and societal changes, as indicated by their relationship with gross domestic product.

CONCLUSIONS: In wealthier nations, there is often the capacity to invest in mental health infrastructure, whereas less-affluent areas frequently face challenges in accessing care. Closing this discrepancy calls for global cooperation, policy adjustments, and greater financial commitment to mental health services on a global scale. This article explores the complex connection between deinstitutionalization and the global count of psychiatric beds.

Keywords: psychiatric, bed, deinstitutionalization, process, review

emerged in the mid-20th century. This movement entails a shift in the care of individuals with mental illnesses away from large, centralized psychiatric hospitals and towards community-based care and support services. Although deinstitutionalization and the reduction of psychiatric beds have brought about positive changes, they have also encountered challenges. In certain instances, concerns have arisen regarding insufficient funding for community-based services, resulting in gaps in care. Furthermore, issues such as homelessness and the involvement of individuals with mental illnesses in the criminal justice system have become pressing concerns in specific regions. [3, 4]

The concept of a 'psychiatric bed' has evolved significantly over time and now refers to designated spaces within healthcare facilities, including psychiatric hospitals or specialized units within general hospitals in which individuals with severe mental health conditions receive inpatient care and treatment. Psychiatric beds represent a crucial component of the mental health care system, and comprehending their importance and characteristics is essential for providing appropriate care to individuals in crisis and to those in need of intensive psychiatric treatment. [5]

According to the "Presidential Report on the Assessment of Psychiatric Bed Needs in the United States" by the American Psychiatric Association, an inpatient psychiatric hospital bed is a specialized facility where individuals dealing with mental health issues receive continuous psychiatric supervision and care. The primary focus is →

on addressing the symptoms of psychiatric illnesses, with an additional emphasis on providing support for any concurrent medical conditions. According to data collected from the Mental Health Atlas 2020, there were 14.5 mental health beds per 100,000 people, but their distribution was uneven across regions and income groups. Notably, the European Region had more beds compared to the African Region. High-income countries reported a significantly higher number of mental hospital beds and admission rates compared to low-income countries. [6]

Interestingly, the data revealed a decrease in the reported number of inpatient beds since 2017, dropping from 12.5 beds per 100,000 people in 2017 to 10.8 beds per 100,000 people in 2020. However, it's important to note that the median number of admissions increased during this period. This could suggest shorter stays at inpatient facilities and more efficient utilization of available beds, reflecting potential improvements in mental healthcare delivery. According to Eurostat, there were 73 psychiatric care beds per 100,000 inhabitants in the European Union in 2018. Belgium reported the highest rate of psychiatric care beds, with 135 beds available per 100,000 people. In contrast, Italy had the lowest rate, with only 9 psychiatric care beds per 100,000 people. [7]

Community-based residential care facilities provide overnight accommodation for individuals with mental health conditions. These facilities are typically not hospital-based. In countries with low- and lower-middle-income, the reported number of such facilities was less than 0.05 per 100,000 people. In contrast, high-income countries have a notably higher number of these facilities, with approximately 1.90 per 100,000 people. [7, 8]

Outpatient care encompasses a wide range of services, including public and private, non-profit, and for-profit facilities. This includes hospital-based outpatient facilities as well as community-based mental health outpatient facilities offering various levels of care and support to individuals with mental health needs. [8]

The primary objective of this systematic review is to conduct a comprehensive analysis of trends in the number of psychiatric beds across various large geographical regions. Additionally, this review aims to examine arguments in support of and against the Penrose hypothesis. Ultimately, this article aspires to foster informed discussions and guide potential

2. METHODOLOGY

2.1. Search strategy

A literature search was conducted in the PubMed online database, using "psychiatric beds" as keywords. The selection process was directed manually by reviewing titles, abstracts, and full-text articles in order to evaluate their relevance to the topic of the current review. The selec-

tion process followed the PRISMA 2020 flow diagram guidelines for new systematic reviews, ensuring a rigorous and structured approach for identifying pertinent research articles. The detailed PRISMA flow diagram is shown in Figure 1. [9]

2.2 Inclusion/exclusion criteria

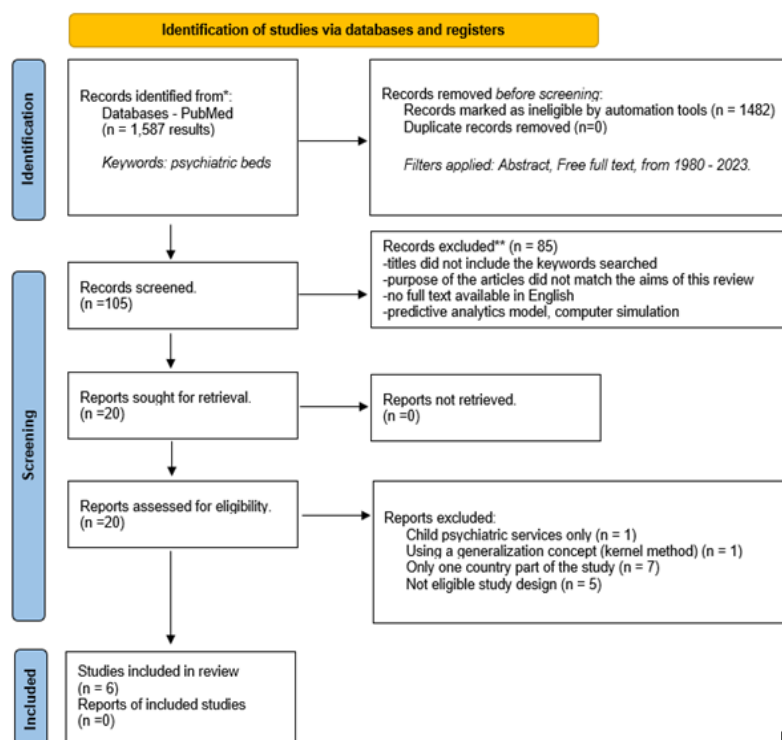
The inclusion criteria for the literature search in the PubMed database were as follows: (1) studies published between 1980 and 2023; (2) retrospective database studies or longitudinal descriptive studies; (3) studies conducted in large geographical areas with populations sharing similar demographic or economic features; (4) studies assessing the trends of psychiatric bed numbers and/or the prison population; and (5) full text of the studies available in English. These criteria were used to ensure that the selected articles would be relevant to the research topic and would provide valuable insights into the trends related to psychiatric beds and prison populations in specific geographic regions.

Articles were excluded from the analysis if they met any of the following criteria: (1) inappropriate study design or article format; (2) studies not related to the medical field or the concept of "psychiatric beds"; (3) no abstract available in English; and (4) no full text available in English.

2.3 Data collection

Eligible articles were examined in full text. The general characteristics of the included articles are listed in Table 1. This review involved information extraction from articles, including the mean and median number of psychiatric beds, prison populations, forensic psychiatric beds, and outpatient care facilities. The rates were calculated as the number of beds per 100,000 individuals.

PRISMA flow diagram illustrating the selection of articles.



3. RESULTS

Following the PRISMA 2020 flow diagram guidelines initially 1587 studies were identified. A total of 1482 studies were marked as ineligible by automation tools (filters applied in PubMed Database: Abstract, Free full text, from 1980 – 2023). In the screening phase, 105 articles were analyzed by title and abstract and 85 were excluded. A

pool of twenty articles underwent eligibility assessment, resulting in the inclusion of six articles in the review, followed by a comprehensive analysis of their full texts. The comprehensive results were summarized in Table 1 to provide a convenient reference for readers to easily interpret the findings and Table 2 provides a definition of the terms used in each of the articles.

Table 1. Synthetic presentation of extracted data

Author Year	Area	Aim of the study	Psychiatric beds number	Forensic psychiatric beds and prison population	Residential facilities/ Protected housing places	Conclusions
1. Mundt et al. (2022)	46 countries in Sub-Saharan Africa (SSA)	To assess rates and trends of availability of psychiatric beds and the prison population across SSA countries from 1990 to 2020	-Median rates decreased from 3.0 to 2.2 per 100,000 population. (27 out of 46 countries showed decreased psychiatric bed rates)	-The total number of forensic psychiatric beds increased by 358.8% (28 out of 46 countries did not have information on specialized forensic psychiatric beds) -Prison population rates increased in 19 countries and decreased in 23 countries. -Median prison population rates decreased from 77.8 to 71.0 per 100,000 population -The total number of imprisoned individuals reported: 788 699 à 853 351.	-Median rates of places in residential facilities increased from 0.1 to 0.2 per 100 000 -Mean rates of places in residential facilities increased from 0.5 to 0.8 per 100 000 -The total number of reported beds in residential facilities: 1281 à 3912 (+205.4%).	Comparison with OECD countries -In 2019: the mean rates of psychiatric beds in SSA countries were on average about 25 times lower than in OECD countries. -The mean psychiatric bed rates in SSA decreased between 1990 and 2020, which was in line with reductions in OECD countries. -The mean prison population rates also decreased in both groups of countries. -Rates of psychiatric beds decreased in most SSA from initially very low rates. -Prison population rates showed heterogeneous trends from rates comparable to OECD countries. Both indicators showed a direct relationship with the income level.
2. A.P. Mundt et al. 2021	30 countries in CEECA - Central Eastern Europe and Central Asia -Albania, Armenia, Azerbaijan, Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kosovo, Kyrgyz Republic, Latvia, Lithuania, Moldova, Montenegro, North Macedonia, Poland, Romania, Russian Federation, Serbia, Slovak Republic, Slovenia, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan	To assess changes in rates of psychiatric beds and prison populations in all CEECA countries from 1990 to 2019	-In 29 out of 30 countries, there was a documented decrease in the rates of psychiatric beds. -Total number of psychiatric beds decreased from 444 737 to 279 739 (-37%)	-Specialized forensic psychiatric beds: 24.7% median increase The median change in rates of prison populations: -17% decrease in 15 post-Soviet republics -95% increase in all 15 remaining Eastern European countries -115% increase in the seven countries that were formerly part of Yugoslavia. -Rates of prison populations decreased in lower-middle-income countries, while they increased in upper-middle-income and high-income countries.	-Rates of beds in residential facilities were reported for only 13 countries. Data was mainly reported by high-income countries. In most middle-income countries, data were unavailable.	-In line with the Penrose Hypothesis, 57% of countries exhibited a pattern of declining psychiatric bed rates, coinciding with an uptick in prison population rates. -In 40% of countries, there was a simultaneous decline in both prison population rates and the availability of psychiatric beds. -Kosovo stands out as a unique country experiencing rising trends in both indicators. -Countries that were formerly part of the Soviet Union (lower income levels): -showed a greater decrease in psychiatric beds than the other countries in CEECA. -also showed a decrease or lower levels of increase regarding prison population rates when compared with higher-income economies or non-Soviet countries.
3. Chow WS, Priebe S. 2016	Western Europe -11 European countries from different regions: -Northern Europe, including the British Isles (UK and Ireland) and Scandinavia (Denmark); -Central Europe (Austria, Belgium, France, Germany, Switzerland, the Netherlands) -Southern Europe (Spain and Italy) -excluding the post-communist countries	To identify changes in the number of places in built institutions providing mental healthcare in Western Europe and to explore the association between changes in psychiatric bed numbers and changes in other institutions between 1990-2012	1990-2000 - the average decrease was 42.5 beds per 100,000 inhabitants 2000-2012 - the average decrease was 22.44 beds per 100,000 inhabitants	1990-2000 -prison population: an average increase of 21.82 - forensic psychiatric beds: An average increase of 0.49 2000-2012 - prison populations: An average increase of 17.05 - forensic psychiatric beds: An average increase of 0.76	1990-2000 -protected housing places: few data 2000=2012 -protected housing places: An average increase of 5.03 facilities per 100,000 residents.	- The number of psychiatric hospital beds decreased substantially. - At the same time, the number of forensic beds and prison populations have increased, while changes in protected housing have been inconsistent across countries with a tendency to increase too. - Reducing bed numbers and rising prison populations appear to go together, but they are not necessarily causally linked. - Wider political and social changes in society, as reflected by the gross domestic product, are the drivers for the changes. - Higher gross domestic product was linked with a larger prison population

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Author Year	Area	Aim of the study	Psychiatric beds number	Forensic psychiatric beds and prison population	Residential facilities/ Protected housing places	Conclusions
4. Mundt et al. 2012	Post-Communist Countries -Azerbaijan, Belarus, Croatia, Czech Republic, East Germany, Hungary, Kazakhstan, Latvia, Poland, Romania, Russia, Slovenia	To assess indicators of institutionalized mental health care in post-communist countries between 1989-2009, following the political change and to explore whether the data are consistent with the Penrose hypothesis in that historical context.	1989-1999 - decreased in all participating countries 1999-2009 - increased in the Eastern part of Germany, Kazakhstan, Poland	1989-1999: Forensic psychiatric bed numbers: increased in East Germany, and Russia, decreased in the Czech Republic, unchanged in Romania and Hungary 1999-2009: Forensic psychiatric bed numbers: increased in East Germany, Russia, Belarus, Poland; decreased in the Czech Republic; unchanged in Romania and Hungary -Rates of the prison population per general population differ considerably: lowest rates in the former Yugoslavian countries; highest rates in former Soviet countries.	Supported housing: 76% increase in the Czech Republic; a decrease in Russia; no data available from Romania and Kazakhstan	- A decrease in psychiatric bed numbers occurred in all countries ranging from 11% in Croatia to 51% in the Eastern part of Germany. - No significant correlation between general psychiatric bed numbers and prison population rates, forensic treatment places, or supported housing capacities. -De-hospitalization from general psychiatric hospitals occurred in all countries in the post-communist era, most pronounced in the decade directly after the political change in 1989–1999.
5. Shields et al. 2022	United States of America	To explore trends in the quantity of inpatient psychiatry beds and in-facility characteristics between 2010-2016	-decreased by 0.9% -The number of psychiatric beds operated by: - system-owned hospitals increased by 39.8% - non-system-owned hospitals decreased by 23.2% - for-profit hospitals increased by 56.9% -not-for-profits decreased by 5.4% - public hospitals decreased by 10.7%	-The number of facilities and beds providing care to forensic patients increased by 19.4% and 11.2%, respectively.	-no data	-The overall number of psychiatric facilities and beds remained stable from 2010 to 2016. -The composition changed in terms of profit status, ownership, chain affiliation and service characteristics. -The number of psychiatric facilities and beds operated by for-profit companies increased substantially, especially beds in freestanding psychiatric hospitals.
6. Blüml et al. 2015	26 European countries: -Austria, Bulgaria, Croatia, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Latvia, Lithuania, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom	To investigate the association between psychiatric hospital beds and prison populations between 1993-2011	-The number of psychiatric beds decreased in all 26 countries ranging from -2.0% in Croatia to -88.2% in Italy.	-Changes in the sizes of the prison population were more heterogeneous ranging from a considerable increase (+158.4% in Malta) to a marked decrease (-22.3% in Romania). -The mean and median of the Spearman correlation coefficients between psychiatric beds and prison population are -0.35 and -0.49 ($p \leq 0.01$), respectively, showing a significant negative association. -There is a notable positive correlation between the prison population and both the passage of time (year) and a country's gross domestic product.	-no data	-While Spearman correlation calculations showed a significant inverse relationship between the number of psychiatric hospital beds and the sizes of the prison population, these associations failed to be statistically significant in a mixed multivariable regression model. -A reduction in psychiatric bed numbers is not associated with an increased prison population per se.

4. DISCUSSIONS

The global decline in the number of psychiatric beds over the past decades emphasizes the importance of developing and implementing effective out-care strategies for psychiatric patients. While hospitalization may be necessary for some patients, particularly those experiencing acute psychotic episodes, outpatient care and community-based support can effectively promote recovery, reduce stigma, and improve quality of life. [16, 17]

Eighty years after the inception of the Penrose hypothesis, which suggests an inverse relationship between the availability of psychiatric hospital beds and the size of the prison population, neither confirmation nor rejection of this hypothesis has been conclusively established [18].

The concurrent trends of decreasing bed numbers and increasing prison populations may seem correlated, but they do not necessarily have a causal relationship. These changes are driven primarily by political and societal changes, as evidenced by the gross domestic product. Additionally, higher gross domestic product has been associated with a larger prison population. [13, 14]

The global median expenditure on mental health is 2.5 dollars per person annually, ranging from 0.1 to 21.7 dollars across World Health Organization regions. This expenditure accounts for less than 2% of the overall governmental health spending, and this disparity can be identified as a major contributing factor to the substantial gap between the demand for mental health services and the availability of interventions [19].

Low-income countries had the lowest levels of psychiatric beds, with a small increase over time. There are significant differences high income and middle and low income countries in terms of the number of psychiatric beds, prison population, and outpatient facilities. In addition, specialized forensic psychiatric beds were typically unavailable in low and lower middle income countries. The exact numbers and trends of psychiatric and forensic psychiatric beds can vary significantly from one region or country to another due to differences in healthcare systems, policies, and cultural factors. [10, 11]

Countries that were formerly part of the Soviet Union have witnessed substantial declines in psychiatric bed

Table 2. Indicators collected

Study	Indicators collected
1. Mundt et al. (2022)	Psychiatric beds = all beds in hospital settings provided to treat people with mental health problems in psychiatric hospitals or in psychiatric units in general hospitals, including beds for children and adolescents (private psychiatric beds were excluded when separately reported). Forensic psychiatric beds = any bed assigned for the assessment or treatment in forensic psychiatry ordered by law or courts. Beds in residential or housing facilities for people with mental disorders = included community-based mental health care facilities that provide overnight residence, mostly serving patients with stable mental illnesses and patients that do not require acute medical treatment (facilities for people with substance use disorders or intellectual disabilities, for elderly people, were excluded). Prisoners = all people in full-time incarceration in jails or prisons (excluding people on probation, parole, or serving alternative sentences that imply only daytime or nighttime in prison) [10].
2. A.P. Mundt et al. (2021)	Psychiatric beds = any bed in hospital settings assigned to mental health treatment in psychiatric hospitals or in psychiatric units of general hospitals (+beds assigned to children and adolescent psychiatric care) Forensic psychiatric beds = any bed reserved for the evaluation or treatment in forensic psychiatry ordered by courts of law. Beds in residential or housing facilities for mentally ill people - including non-hospital community-based mental health facilities that provide overnight residence, usually serving users with relatively stable mental disorders not requiring intensive medical interventions. (facilities for people with substance use disorders, intellectual disabilities, and elderly people, were excluded). Prison populations = all individuals confined day and night in jails or prison facilities as pre-trial detainees or convicted offenders [11]
3. Chow WS, Priebe S. (2016)	'Deinstitutionalization' term refers to the closure or downsizing of former large asylums and the development of various services in the community [12].
4. Mundt et al. (2012)	Penrose hypothesis: the availability of psychiatric hospital beds was inversely related to the prison population. General psychiatric bed numbers - all inpatient services in general adult psychiatry, child, and adolescent psychiatry (excluding day hospitalizations, psychosomatic or psychotherapeutic wards). Forensic psychiatric beds. The number of forensic treatment cases was taken as an indicator only if the number of beds was not available. Prison population rates include pretrial detainees and convict offenders. The supported housing services - services for the chronically mentally ill, the mentally disabled (if separate from the physically disabled), persons with chronic substance use, homes and communities for the mentally ill, and various forms of protected accommodation schemes (homes for old people and dementia facilities were not considered) [13].
5. Shields et al. (2022)	Key hospital characteristics used: - psychiatric bed count - hospital ownership (system-owned, non-system-owned) - hospital profit status (for profit, not for profit, public) - hospital type (free-standing psychiatric, general acute care) - chain ownership (common ownership with at least two freestanding psychiatric hospitals) Secondary characteristics included: - treatment of forensic psychiatric patients - provision of outpatient psychiatric care - provision of substance use disorder treatment [14].
6. Blüml et al. (2015)	Penrose hypothesis: Inadequate provision of psychiatric treatment for individuals with severe mental disorders is believed to be associated with elevated rates of criminal activity and subsequent incarceration among this population. The prison population and psychiatric bed variables were adjusted to a scale of 100,000 inhabitants, in relation to the gross domestic product (GDP) per capita [15].

rates, with a median percentage change that is more than twice as high compared to other nations. A decrease in psychiatric bed numbers occurred in all post-communist countries and countries in Western Europe, Sub-Saharan Africa, Central Eastern Europe, and Central Asia. In the United States of America, between 2010 and 2016, the total number of psychiatric facilities and available beds remained relatively consistent, but there were notable changes in profit status, ownership, chain affiliations, and service characteristics. [12, 13, 14]

A study from 2022 using the Delphi method, involving experts from high-income countries and low- and middle-income countries, provided the first expert consensus on the minimum and optimal number of psychiatric beds globally. The suggested range for a suitable psychiatric bed rate was 30 to 60 beds per 100,000 population, with 30 beds considered the minimum and 60 beds as the optimal number. The mental health budget has emerged as a significant factor in reaching a consensus on psychiatric bed planning. Insufficient budgets can contribute to both shortages and the inefficient allocation of mental health resources. [20]

A global consensus has been reached regarding the critical significance of effective discharge planning and the capabilities of outpatient and residential services in the management of inpatient mental health facilities. The quality and standards of mental health care were a significant concern, particularly in low- and middle-income countries. This likely reflects the need for basic care standards, which not only include the physical infrastructure of beds but also require an adequate supply of human resources, medications, and equipment to effectively operate existing facilities. [19, 20]

27 In a systematic review conducted in 2021, encompassing insights from 106 publications across 25 coun-

tries, expert opinions on trends in psychiatric bed numbers were found to be partially contradictory, with no overarching consensus on the preferred direction of these trends. Some arguments in favor of maintaining or even increasing psychiatric bed numbers included concerns about insufficient and ineffective outpatient services, overly brief lengths of stay, and a shortage of beds impacting the quality of care. Conversely, opposing viewpoints suggested that maintaining or improving the quality of care can be achieved with fewer beds and that bed reductions can promote more effective utilization and development of existing community-based care options [16].

Adequate funding is essential for the development and maintenance of strong mental health systems. Budget constraints can limit the availability of important resources such as mental health facilities, trained professionals, and access to modern treatment methods. This can result in long waiting lists, limited access to care, and inadequate treatment options. Underfunded systems may resort to outdated or suboptimal treatment approaches due to resource limitations, which can negatively impact patient outcomes and quality of care. Investing in mental health can yield long-term cost savings by alleviating the economic burdens associated with untreated mental illnesses. This includes mitigating losses in productivity, reducing the need for heightened healthcare services, and reducing disability claims.

5. CONCLUSIONS

Within a well-structured care system, the expenses associated with supporting dependent individuals tend to be substantial, regardless of their place of residence. Transitioning individuals from single-budget institutions, which are typically managed from a single →

financial source to community-based settings with multiple budgetary streams can lead to a variety of outcomes and effects. The array of services should be designed to accommodate individuals who can thrive with minimal assistance, enabling them to live independently, as well as those who require continuous support from staff to perform various daily activities. In addition, the service spectrum should include provisions for evaluating and addressing their psychiatric needs.

The establishment of new services can be a time-consuming process, often requiring several years to set up. Moreover, existing services may display resistance to change. As a result, decision-makers should strategically plan for a flexible and adaptive system of community-based services capable of meeting the diverse needs. People with mental disorders requiring transition from institutional to community settings.

The concept of “psychiatric beds” is not without its share of challenges and controversies. These include concerns

about the excessive use of inpatient care, lengthy waiting lists for available beds, and the need to find a balance between offering inpatient care and providing community-based services in order to establish a comprehensive and efficient mental healthcare system.

In summary, psychiatric beds play a crucial role in mental healthcare, serving as a vital resource for individuals experiencing acute crises or coping with severe and persistent mental illnesses. Effective mental health care systems strive to find a balance between inpatient and community-based care to provide individuals with the most appropriate and least restrictive treatment options.

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References

1. Foot J. Franco Basaglia and the radical psychiatry movement in Italy, 1961-78. *Crit Radic Soc Work*. 2014 Aug 1;2(2):235-249. DOI: 10.1332/204986014X14002292074708. PMID: 25984302; PMCID: PMC4430803. [Link: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4430803/>].
2. Fioritti A. Is freedom (still) therapy? The 40th anniversary of the Italian mental health care reform. *Epidemiol Psychiatr Sci*. 2018;27(4):319-323. doi:10.1017/S2045796017000671.
3. Mundt AP, Delhey Langerfeldt S, Rozas Serri E, Siebenförcher M, Priebe S. Expert Arguments for Trends of Psychiatric Bed Numbers: A Systematic Review of Qualitative Data. *Front Psychiatry*. 2021 Dec 24;12:745247. DOI: 10.3389/fpsyt.2021.745247. Erratum in: *Front Psychiatry*. 2022 Aug 02;13:957272. PMID: 35002794; PMCID: PMC8738080. [Link: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8738080/>].
4. Johnson S, Dalton-Locke C, Baker J, Hanlon C, Salisbury TT, Fossey M, et al. Acute psychiatric care: approaches to increasing the range of services and improving access and quality of care. *World Psychiatry*. 2022 Jun;21(2):220-236. doi: 10.1002/wps.20962. PMID: 35524608; PMCID: PMC9077627.
5. American Psychiatric Association Presidential Report on the Assessment of Psychiatric Bed Needs in the United States. The Psychiatric Bed Crisis in the United States: Understanding the Problem and Moving Toward Solutions. *Am J Psychiatry*. 2022;179(8):586-588. DOI: 10.1176/appi.ajp.22179004.
6. World Health Organization. *Mental Health Atlas 2020*. Geneva: World Health Organization; 2021. Accessed June 2023. [Link: <https://www.who.int/publications/i/item/9789240036703>].
7. EUROSTAT. Glossary: European Union (EU). [accessed 20 Jun 2023]. Available from: [https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:European_Union_\(EU\)](https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Glossary:European_Union_(EU))
8. Hautala-Jylhä PL, Nikkonen M, Jylhä J. Continuity of care in psychiatric post-ward outpatient services--conceptions of patients and personnel concerning factors contributing to the continuity of care. *J Psychiatr Ment Health Nurs*. 2005 Feb;12(1):38-50. DOI: 10.1111/j.1365-2850.2004.00790.x. PMID: 15720496.
9. Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71. DOI: 10.1136/bmj.n71.
10. Mundt AP, Delhey Langerfeldt S, Maphisa JM, Sourabié O, Yongsi BN, Serri ER, et al. Changes in rates of psychiatric beds and prison populations in sub-Saharan Africa from 1990 to 2020. *J Glob Health*. 2022;12:04054.
11. Mundt AP, Rozas Serri E, Siebenförcher M, et al. Changes in national rates of psychiatric beds and incarceration in Central Eastern Europe and Central Asia from 1990-2019: A retrospective database analysis. *Lancet Reg Health Eur*. 2021;7:100137. Published 2021 Jun 5. DOI: 10.1016/j.lanepe.2021.100137.
12. 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(4):e010188. Published 2016 Apr 29. DOI: 10.1136/bmjopen-2015-010188.
13. Mundt AP, Frančišković T, Gurovich I, et al. Changes in the provision of institutionalized mental health care in post-communist countries. *PLoS One*. 2012;7(6):e38490. DOI: 10.1371/journal.pone.0038490.
14. Shields MC, Beaulieu ND, Lu S, Busch AB, Cutler DM, Chien AT. Increases in Inpatient Psychiatry Beds Operated by Systems, For-Profits, and Chains, 2010-2016. *Psychiatr Serv*. 2022;73(5):561-564. DOI: 10.1176/appi.ps.202100182.
15. Blüml V, Waldhör T, Kapusta ND, Vyssoki B. Psychiatric Hospital Bed Numbers and Prison Population Sizes in 26 European Countries: A Critical Reconsideration of the Penrose Hypothesis. *PLoS One*. 2015;10(11):e0142163. Published 2015 Nov 3. DOI: 10.1371/journal.pone.0142163.
16. Mundt AP, Delhey Langerfeldt S, Rozas Serri E, Siebenförcher M, Priebe S. Expert Arguments for Trends of Psychiatric Bed Numbers: A Systematic Review of Qualitative Data. *Front Psychiatry*. 2021 Dec 24;12:745247. DOI: 10.3389/fpsyt.2021.745247. Erratum in: *Front Psychiatry*. 2022 Aug 02;13:957272. PMID: 35002794; PMCID: PMC8738080.
17. Fonseca Barbosa J, Gama Marques J. The revolving door phenomenon in severe psychiatric disorders: A systematic review. *Int J Soc Psychiatry*. 2023;69(5):1075-1089. DOI: 10.1177/00207640221143282.
18. Mundt AP, Chow WS, Arduino M, et al. Psychiatric hospital beds and prison populations in South America since 1990: does the Penrose hypothesis apply? *JAMA Psychiatry*. 2015;72:112-18.
19. Saxena S, Sharan P, Saraceno B. Budget and financing of mental health services: baseline information on 89 countries from WHO's project atlas. *J Ment Health Policy Econ*. 2003 Sep;6(3):135-43. PMID: 14646006.
20. Mundt AP, Rozas Serri E, Irrázaval M, et al. Minimum and optimal numbers of psychiatric beds: expert consensus using a Delphi process. *Mol Psychiatry*. 2022;27(4):1873-1879. DOI: 10.1038/s41380-021-01435-0.