INNOVATION IN DEINSTITUTIONALIZATION:

A WHO EXPERT SURVEY

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INNOVATION IN DEINSTITUTIONALIZATION:

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This publication is part of a broader series of thematic papers, co-produced by the World Health Organization and the Calouste Gulbenkian Foundation's Global Mental Health Platform. The series consists of four publications and covers the following topics.

- Innovation in deinstitutionalization: a WHO expert survey;
- Integrating the response to mental disorders and other chronic diseases in health care systems;
- Social determinants of mental health;
- Promoting Rights and Community Living of Children with Psychosocial Disabilities (forthcoming).

INNOVATION IN DEINSTITUTIONALIZATION: A WHO EXPERT SURVEY

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FOREWORD

Mental health is an integral and essential component of health, but is often neglected within national health policy and plans. As the awareness of the importance of mental health increases, international organizations—including the World Health Organization (WHO)—face the challenge of providing evidence-based guidance and good practices to assist countries in their mental health planning. The Gulbenkian Mental Health Platform and WHO have collaborated to generate information to help meet this challenge, in the form of a series of thematic papers on pressing mental health issues of our time. Topics were identified by the Platform's advisory and steering committees, and prioritized based on the issue's potential significance in making a substantial improvement in the global mental health situation. It is perhaps not surprising, therefore, that the topics of the thematic papers are highly consistent with the four key objectives of WHO's Mental Health Action Plan 2013-2020.

The topic of this thematic paper, *Innovation in deinstitutionalization: a WHO expert survey*, was chosen due to the urgent need for a radical shift in the way mental disorders are managed, away from long-term hospitalization and towards community-based mental health care. Despite decades of promoting deinstitutionalization, mental hospital-based care still dominates service delivery, consuming on an average more than 70% of the entire mental health budget in low- and middle-income countries. If deinstitutionalization is to start happening on a wider scale, it is imperative to understand how some mental health systems have been able to overcome the odds and successfully transform their services. This paper reports results of an expert survey and captures important lessons learnt from those who have been involved directly with deinstitutionalization and/or expanding community-based services.

One of the most interesting findings from the survey is the reported importance of political skill in fostering mental health reform. In this regard, the survey reveals that 'innovation in deinstitutionalization' is not so much a particular set or sequence of health policy-level interventions, or even a new way of managing people with long-term mental disorders, but rather, the ability to understand the motivation of local stakeholders and changing situational demands and to use that knowledge in strategic ways. Rethinking 'innovation' along these lines implies the need for greater investment in current and future mental health leaders in terms of building their capacity to use political skill to promote deinstitutionalization.

We trust that you will find this paper both thought provoking and useful, and we encourage you to read the accompanying thematic papers from this series, too.

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This paper was written by JoAnne Epping-Jordan (Seattle, USA) with extensive input from Mark van Ommeren (WHO Department of Mental Health and Substance Abuse).

The survey reported in this paper was designed by Gordon Shen (University of California at Berkeley, USA), Mark van Ommeren (WHO Department of Mental Health and Substance Abuse), and Julian Eaton (CBM International, Togo), with key inputs from Dévora Kestel (PAHO/WHO), Anita Marini (Rimini, Italy), and Yutaro Setoya (WHO Department of Mental Health and Substance Abuse). The survey was analysed by Gordon Shen and Emily Ng (University of California at Berkeley, USA).

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JoAnne Epping-Jordan (Seattle, USA) served as editorial manager of the overall series of thematic papers.

All thematic papers were produced under the overall guidance of the Gulbenkian Global Mental Health Platform's Advisory and Steering Committees (below).

Advisory Committee: Paulo Ernani Gadelha Vieira (Fiocruz, Brazil); Marian Jacobs (University of Cape Town, South Africa); Arthur Kleinman (Harvard University, USA); Sir Michael Marmot (University College London, United Kingdom); Mirta Roses Periago (Former Director, Pan American Health Organization); P. Satishchandra (National Institute of Mental Health & Neurosciences (NIMHANS), India); Tazeen H. Jafar (The Aga Khan University, Pakistan); and Observer to the Advisory Committee, Shekhar Saxena (WHO Department of Mental Health and Substance Abuse).

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EXECUTIVE SUMMARY

KEY MESSAGES

- **Although community-based services are widely regarded as the best approach for providing mental health treatment and care, most low- and middle-income countries continue to spend the vast majority of their scarce mental health resources managing people with mental disorders in mental hospitals.**
- **To better understand this vexing issue, 78 mental health experts representing 42 countries were surveyed on the relative usefulness of different methods to expand community-based mental health services, and/or to downsize institution-based care.**
- **Results indicate that there are several successful paths to deinstitutionalization. Most respondents emphasized—directly or indirectly—the importance of political skill and timing.**
- **Based on the survey, five principles for deinstitutionalization were identified: community-based services must be in place; the health workforce must be committed to change; political support at the highest and broadest levels is crucial; timing is key; and additional financial resources are needed.**

BACKGROUND AND CONTEXT

Despite decades of promoting deinstitutionalization and community-based care, mental hospital-based care still dominates service delivery in most countries. Some health systems have been successful in deinstitutionalizing people with mental disorders and transitioning towards community-based care. Yet most countries continue to spend the vast majority of their scarce resources on the inefficient and frequently inhumane approach of managing few people with mental disorders exclusively in long-stay institutions.

If deinstitutionalization is to start happening on a wider scale, it is imperative to understand how some mental health systems have been able to overcome the odds and successfully transform their services. This paper captures important lessons learnt from those who have been involved directly with deinstitutionalization and/or expanding community-based services. It reports results of both quantitative and qualitative analyses aimed at identifying innovative strategies and methods associated with success.

METHODS

The main method of data collection for this paper was an electronic survey, for which 78 mental health experts responded. For the purpose of this survey, experts were defined those who had been substantially involved in the strategic work or management of expanding community based-mental health services and/or downsizing hospital-based care. Respondents completed a questionnaire on the perceived usefulness of commonly used methods to achieve these aims. If respondents had worked in numerous countries, they were asked to identify one country for which they would respond to all questions. A total of 42 countries were represented.

The resulting paper was presented at the Gulbenkian Global Mental Health Platform's International Forum on Innovation in Mental Health, where numerous additional comments were received from mental health experts.

MAIN FINDINGS

Respondents were asked to rate how useful they found 24 different methods to downsize institution-based services. The 10 most highly-rated methods (in rank order) are displayed in the following table.

Table 1: Most highly-rated methods for downsizing institution-based services: percentage of respondents rating the method as 'quite useful' or 'very useful'.

RANK ORDER	PERCENTAGE OF RESPONDENTS	METHOD
1	67.4%	Mobile clinics/outreach services
2	64.3%	Psychiatric beds outside mental hospitals (e.g. in general hospitals)
3	58.3%	Discharge planning/hospital to community residence transfer programmes
4	57.7%	Residential care in the community
5	56.5%	Stopping new admissions in institutions or 'closing the front door'
6/7/8	55.8%	Reducing admissions through new admissions procedures
6/7/8	55.8%	Local catchment area or hospital-level plans
6/7/8	55.8%	Supported employment
9	54.2%	National or regional mental health policy, strategies, plans
10	51.0%	Self-help and user groups

Respondents were also provided with opportunities to write freely about other important factors in downsizing institution-based care. Four additional methods emerged, which were: managing the workforce; aligning financing; rallying support; and capitalizing on timing and sequencing. These qualitative responses were complementary to quantitative ratings in that they elaborated on these highly-ranked methods and situated them in country contexts. In addition, most respondents emphasized - directly or indirectly - the importance of political skill in moving towards deinstitutionalization.

PRINCIPLES AND ACTIONS

Based on the survey, five principles for deinstitutionalization were identified.

- **Community-based services must be in place.** Former institutional residents need access to mental health services, including evidence-based clinical care, and also access to social services for help with housing, employment, and community reintegration.
- **The health workforce must be committed to change.** As reported by respondents, the health workforce has dual potential: to be either a great asset or a great liability to deinstitutionalization. As such, health workers and their professional associations must be consulted widely in planning and implementation.
- **Political support at the highest and broadest levels is crucial.** Building support across broad groups of stakeholders helps overcome resistance and foster momentum for change. Generating this type of political support is a skill that can be taught.
- **Timing is key.** Moments of openness, such as emergency situations and changes in political leadership, provide opportunities to rally support and introduce reform.
- **Additional financial resources are needed.** Although institutional care tends to be inefficient, the process of deinstitutionalization requires additional funds, at least in the short term. If resources are limited, it is useful to start work with available funds while strongly advocating for more support.

CONCLUSION

Long-stay psychiatric institutions tend to be inefficient and too frequently inhumane, yet continue to consume the majority of mental health budgets in low- and middle-income countries while managing relatively few people. This survey of 78 mental health experts provides insight into the innovations that led to successful deinstitutionalization in selected mental health systems around the world. The path to deinstitutionalization is not linear: change tends to be complex. Political skill, or the ability to understand the motivation of stakeholders and changing situational demands and to use that knowledge in strategic ways, appears to be a key facilitator of deinstitutionalization

BACKGROUND AND CONTEXT

MENTAL HOSPITALS CONTINUE TO DOMINATE MENTAL HEALTH CARE

Despite decades of promoting deinstitutionalization and community-based care, mental hospitals (defined here as specialized hospital-based facilities that provide inpatient care and long-stay residential services for people with severe mental disorders) continue to consume the majority of mental health budgets in the 80% of countries that have them. Median expenditures on mental hospitals, expressed as a percentage of total mental health spending, are greatest in upper-middle income countries (median of 74%), low-income countries (median of 73%), and lower-middle income countries (median of 73%). Expenditures are also sizeable (median of 54%) in high-income countries.[1]

When countries spend the great majority of their mental health budgets on mental hospitals, relatively little is left for all other forms of mental health services. By diverting scarce human and financial resources for mental health away from community-based services, mental hospitals undermine community-based services' capacity to be effective.[2]

From the perspective of universal health coverage[3], the dominance of mental hospitals limits overall availability and accessibility of mental health services. Mental hospitals tend to operate at a much higher cost per service user than community-based services. As such, they are an inefficient way to treat those in need.[4] In addition, they typically manage only the small minority of people with mental health problems: a subset of those with the most severe mental disorders. Meanwhile, all others with mental disorders are overlooked by the system. And because mental hospitals are by their very nature consolidated in a small geographic area, typically near urban centres, they are not readily accessible by people living in other parts of the country.

INSTITUTIONS CAN BE PARTICULARLY TROUBLING

Perhaps most troubling, mental hospitals serve all-too-often as a long-term residence for people with mental disorders. In these contexts, people with mental disorders often live in sub-standard conditions and separated from their families and communities.4 Many of these facilities are associated with human rights violations (Box 1), including unhygienic and inhumane living conditions, and often, harmful and degrading treatment practices. In many countries, people are confined arbitrarily to institutions - against their will - for months or even years. Once committed, they may be restricted to cell-like seclusion rooms or restraints.[5] These are the 'institutions' that are the focus of this paper.

Box 1. Historical country examples of poor-quality institutional care[6]

In Ghana, the Accra psychiatric hospital has a 'special ward' in which 300 men are locked in a set of cells designed for 50 people. These men have no access to the outside world or to treatment. One voluntary sector worker commented on this situation, stating "About one third of our residents have been chained, beaten, or whipped at shrines or churches."[1]

A survey of 52 social care homes in Hungary in 2001 by the Mental Health Interest Forum in Budapest, documented that residents experience restrictions in their freedom of movement, invasion of their privacy, inadequate communication facilities, ineffective complaint and monitoring mechanisms, a lack of access to medical treatment, and the use of outdated medication. Residents sometimes are held in 'cage-beds'. These restraint devices, which consist of metal cages or plastic netting around and on top of a standard hospital bed, prevent people from standing. Some residents are kept in these beds on a more or less permanent basis, and are forced to eat, urinate, and defecate within the confines of the cage. [2]

An investigation by the National Institute of Mental Health and Neurosciences in Bangalore, India found that in 16 of the 37 hospitals examined, residents were forced to live together in overcrowded single-person cells. Many hospitals placed people in cells without water facilities, toilets, or beds, and residents were forced to urinate and defecate in them. In addition, residents received inadequate treatment and care. Less than half of hospitals had clinical psychologists and psychiatric social workers. Comprehensive medical and psychosocial treatments were almost non-existent in one third of the hospitals.[3]

Excerpted from Mental health and development: targeting people with mental health conditions as a vulnerable group. Geneva, World Health Organization, 2010.

1. Roberts H. A way forward for mental health care in Ghana? The Lancet, 2001, 357:1859.

2. Roberts H. Mental health care still poor in Eastern Europe. The Lancet, 2002, 360:552.

3. Sharma D. Mental health patients face primitive conditions. The Lancet, 1999, 354:495.

DEINSTITUTIONALIZATION ≠ DEHOSPITALIZATION

The process of deinstitutionalization is more complex than simply reducing mental hospital beds. It is a long-term strategy that considers not only reducing long-stay beds, but also (a) ensuring that good-quality care is available in community settings, while (b) shifting tertiary resources towards acute inpatient services and accessible secondary-level mental health services. Comprehensive social services are also needed as part of the deinstitutionalization process, to support former institutional residents and their families as they reintegrate into their communities. A small number of long-stay spaces are required for those with ongoing residential needs, but these should not be located in large institutions, but rather for example in smaller group homes integrated in the community.

If deinstitutionalization is managed as dehospitalization, without due consideration of the broader context as outlined above, numerous adverse effects can occur. These include homelessness[7], 'reinstitutionalization' or 'transinstitutionalization' into jails, prisons, and community-based virtual asylums[8 9], and emergency room 'boarding'[10].

The need for a more nuanced view of deinstitutionalization becomes apparent when considering the shortage of mental health beds in many low - and middle-income countries. Globally, there are around 7 mental hospital beds per 100 000 population, but this number varies considerably from region to region and between country income groups (see Figure 1). In lower-income countries, the total number of inpatient beds is often quite limited. In these countries, the challenge is not to reduce the total number of inpatient beds, but rather to transform these beds from institutional care to acute inpatient care, while simultaneously developing complementary outpatient services.

Additionally, in countries with an over-supply of inpatient mental health beds, deinstitutionalization requires strengthening of the community-based services on which service users will rely.

Figure 1. Number of mental hospital beds per 100 000 population, by WHO region and World Bank income group.[1]

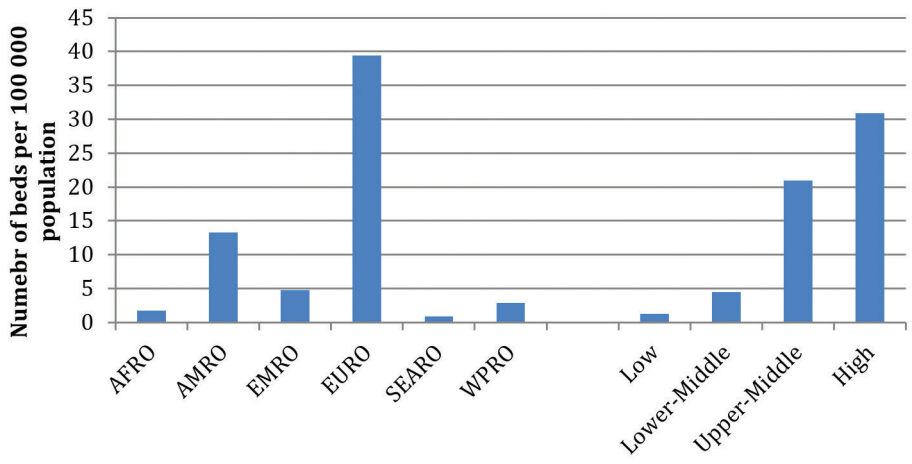

Figure notes: WHO regional estimates derived from n=175 countries; World Bank income group estimates derived from n=172 countries.
AFRO = African Region;
AMRO = Region of the Americas;
EMRO = Eastern Mediterranean Region;
EURO = European Region;
SEARO = South-East Asia Region;
WPRO = Western Pacific Region.

A MENTAL HEALTH SERVICE SYSTEM IS NEEDED

A mental health service system comprised of different levels and settings of care is needed to meet the mental health needs of the population, including former institutional residents. People with severe mental disorders often require social and residential support to live in the community. As such, collaboration with other sectors is crucial to successful deinstitutionalization.[11]

Along these lines, WHO's *Mental Health Action Plan* for 2013 to 2020[12] proposes that countries shift systematically from long-stay mental hospitals towards community-based settings and using a network of linked community-based mental health services, including short-stay inpatient care, and outpatient care in general hospitals, primary and other nonspecialized health care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.

The *WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health*[13 14] provides a specific framework of how different service levels and settings can be integrated into a coherent system of care. According to the pyramid, the majority of care is provided informally by families and community networks, as well as via self-care and peer-support. The first level of care in the formal health system is mental health care provided within general primary care services. Primary care is supported by secondary care, involving the use of mental health specialists. Their functions often include training, supervising, and supporting primary health workers, accepting referrals of complex cases, filtering referrals to the tertiary care level, and supporting people with severe mental disorders in their communities. Inpatient care, when needed, consists mainly of acute hospitalization within general hospitals. The top – and proportionally smallest – level of services depicted in the pyramid is intended for people with the most treatment-resistant, highly complex presentations. It also covers facilities, ideally located within communities, for the few people with mental disorders who need residential care due to their very severe mental disorders and lack of family support. These facilities should not be equated with the institutions that are the focus of this paper.

Some health systems around the world have been successful in deinstitutionalizing people with mental disorders and transitioning towards comprehensive, community-based care as described by the WHO service pyramid. A number of these experiences are referenced within this paper and detailed in Annex 1.

If deinstitutionalization and the expansion of community-based services are to happen on a wider scale, it is imperative to understand how mental health systems - such as those described in Annex 1 - have been able to transform their services. One potentially rich source of information is from mental health experts who have been involved directly with such efforts. This paper taps their experience and expertise, through exploring questions of what has worked - and what has been less successful - in downsizing institutions and expanding community-based care. The following sections of this paper report results of an expert survey, including both quantitative and qualitative analyses.

METHODS

The main method of data collection for this paper was an electronic survey of mental health experts. For the purpose of this survey, experts were defined those who had been substantially involved in the strategic work or management of expanding community based-mental health services, and/or downsizing hospital-based care. If respondents had worked in numerous countries, they were asked to identify one country for which they would respond to all questions.

Experts were identified using purposive and snowball sampling procedures. Of the 152 experts invited to participate, 79 returned a completed survey between February 2013 and May 2013, thus yielding a 52% response rate. Because two participants jointly reported for the same country, the final sample consisted of 78 responses (demographic characteristics of these respondents is provided in Table 1). A total of 42 countries were represented in the final sample.

Table 1. Demographic characteristics of survey respondents

		N (% ROUNDED)	
COUNTRY INCOME GROUP (WORLD BANK)			
	Low	18 (23%)	
	Lower-middle	28 (35%)	
	Upper-middle	13 (16%)	
	High	20 (25%)	
GEOGRAPHIC REGION (WORLD HEALTH ORGANIZATION)			
	WHO African Region	**20 (25%)**	
	WHO Region of the Americas	**8 (10%)**	
	WHO South-East Asia Region	**12 (15%)**	
	WHO European Region	**19 (24%)**	
	WHO Eastern Mediterranean Region	**6 (8%)**	
	WHO Western Pacific Region	**14 (18%)**	
GENDER			
	Male	57 (72%)	
	Female	20 (25%)	

		N (% ROUNDED)	
HIGHEST DEGREE OBTAINED			
	Bachelors	6 (8%)	
	Masters	13 (16%)	
	Medical doctor	25 (32%)	
	Doctorate	11 (14%)	
	Others	9 (11%)	
CURRENT AFFILIATION (MORE THAN ONE AFFILIATION MIGHT APPLY)			
	Government	29 (37%)	Full-time 18 (62%) Part-time 9 (31%)
	International NGO	16 (20%)	Full-time 6 (38%) Part-time 8 (10%)
	National/local NGO	31 (39%)	Full-time 12 (39%) Part-time 17 (55%)
	Academia	34 (43%)	Full-time 16 (47%) Part-time 17 (50%)
	International organization	8 (10%)	Full-time 3 (38%) Part-time 4 (50%)
	User or family association	6 (8%)	Full-time 4 (67%) Part-time 2 (40%)
	Other	12 (15%)	Full-time 1 (8%) Part-time 11 (92%)
Other (in years)	Mean	Standard deviation	
Age	52.7	±10.3	
Professional experience	24.3	±11.4	

Respondents completed a questionnaire on the perceived usefulness of different methods to expand community-based mental health services and/or downsize long-term institution-based care. The questionnaire contained both open-ended and closed-ended, ordinal response scale questions.

The questionnaire was developed using a phased process. First, a literature review was completed to identify the approaches to deinstitutionalization that have been documented in peer-reviewed and grey literature. Based on this review and their collective field experiences, investigators (GS, JE, MvO) then developed the content of the questionnaire. Before finalization, the entire survey was completed as a test run by three WHO staff members with experience in reforming mental health care. Substantive

changes to the survey were made based on their feedback, including the addition of e-mental health and funding as potential facilitators of expanding community-based mental health services and/or downsizing long-term institution-based care.

Using a 1-5 ordinal scale (1 = *not at all useful* to 5 = *very useful*), respondents were asked to rate how useful they found 24 different methods: a) to expand community based services, and b) to downsize institution-based services. They also were provided a *not applicable* option for each method, denoting that the method had not been used in the country on which they were reporting.

Respondents were also provided with opportunities to write freely about other important factors, not included within the 24 pre-defined methods, that they felt were important in expanding community based services, and/or downsizing institution-based services.

The resulting paper was presented at the Gulbenkian Global Mental Health Platform's International Forum on Innovation in Mental Health, where numerous additional comments were received from mental health experts.

MAIN FINDINGS

QUANTITATIVE RESULTS

Respondents' ratings of the usefulness of the 24 pre-defined methods were highly correlated between a) expanding community-based services, and b) downsizing institution-based services. Correlations ranged from 0.58 to 0.96.

Although highly correlated, respondents' ratings of the usefulness of the pre-defined methods tended to be higher for expanding community-based services than for downsizing institutions. Specific findings are provided in Table 2.

Table 2. Average ratings and paired t-test results for 24 pre-defined methods to expand community-based services and downsize institution-based care. Scale: 1= *not useful* to 5=*very useful*. *

	MEAN (STANDARD DEVIATION) EXPANDING COMMUNITY-BASED SERVICES		MEAN (STANDARD DEVIATION) DOWNSIZING INSTITUTION - BASED CARE	MEAN (STANDARD DEVIATION) DIFFERENCE IN RESPONSES	T-STATISTIC	TWO-TAILED P- VALUE
LEGISLATION, POLICY AND PLANS						
Mental health legislation	49	3.39 (1.34)	3.24 (1.39)	0.14 (0.61)	1.63	0.109
National or regional mental health policy, strategies, plans	59	3.97 (1.26)	3.66 (1.28)	0.31 (0.73)	3.23*	0.002
Local catchment area or hospital-level plans	52	3.71 (1.21)	3.44 (1.39)	0.27 (0.12)	2.19	0.033
ADVOCACY AND PUBLIC EDUCATION						
Advocacy and public education by government	49	3.14 (1.26)	3.04 (1.35)	0.10 (0.82)	0.87	0.390
Advocacy and public education by NGOs	56	3.38 (1.20)	3.11 (1.25)	0.28 (0.87)	2.37	0.021
Advocacy and public education by healthcare professionals	56	3.64 (1.12)	3.25 (1.30)	0.39 (1.02)	2.88*	0.006
Advocacy and public education by family members	51	3.33 (1.31)	2.86 (1.37)	0.47 (0.83)	4.03*	0.0002
Advocacy and public education by service users	49	3.47 (1.37)	3.12 (1.49)	0.35 (0.90)	2.69*	0.010

	MEAN (STANDARD DEVIATION) EXPANDING COMMUNITY-BASED SERVICES		MEAN (STANDARD DEVIATION) DOWNSIZING INSTITUTION - BASED CARE	MEAN (STANDARD DEVIATION) DIFFERENCE IN RESPONSES	T-STATISTIC	TWO-TAILED P- VALUE
OUTPATIENT CLINICS						
Outpatient care at general hospitals	58	3.47 (1.40)	3.07 (1.40)	0.40 (1.06)	2.85*	0.0060
Community mental health centres	53	4 (1.09)	3.34 (1.36)	0.66 (0.98)	4.91*	0.0000
Integration of mental health care in primary health care	59	3.88 (1.20)	3.24 (1.33)	0.64 (1.05)	4.73*	0.0000
MENTAL HOSPITALS AND ASYLUMS						
Stopping new admissions in institutions, or 'closing the front door'	43	3.21 (1.34)	3.49 (1.47)	-0.28 (0.98)	-1.86	0.0699
Reducing admissions through new admissions procedures	40	3.38 (1.23)	3.53 (1.20)	-0.15 (0.77)	-1.23	0.2251
Physically removing unused beds / reducing the number of psychiatric beds	38	3.03 (1.44)	3.24 (1.40)	-0.21 (0.96)	-1.35	0.1860
Discharge planning / Hospital-to-community residence transfer programs	45	3.6 (1.32)	3.71 (1.29)	-0.11 (1.19)	-0.63	0.5348
Improving mental hospital information systems	44	3.11 (1.38)	2.95 (1.26)	0.16 (0.68)	1.55	0.1280
EMPLOYMENT, VOCATIONAL AND OCCUPATIONAL REHABILITATION						
Vocational training	47	3.68 (1.30)	3.23 (1.43)	0.45 (0.95)	3.22*	0.0024
Supported employment	41	4 (1.18)	3.54 (1.42)	0.46 (1.05)	2.82*	0.0074
OTHER						
Psychiatric beds outside mental hospitals (e.g. in general hospitals)	54	3.89 (1.21)	3.94 (1.16)	-0.06 (0.71)	-0.57	0.5686
Day care services	45	3.38 (1.30)	3.27 (1.37)	0.11 (0.91)	0.82	0.4172
Residential care in the community	44	3.59 (1.37)	3.61 (1.37)	-0.02 (0.88)	-0.17	0.8641
Mobile clinics/outreach services	42	4.12 (1.23)	3.83 (1.29)	0.29 (0.92)	2.02	0.0503
Self-help and user groups	48	3.92 (1.18)	3.40 (1.41)	0.52 (0.95)	3.82*	0.0004
E-mental health	27	2.81 (1.62)	2.63 (1.62)		1.99	0.0571

Several preliminary interpretations can be drawn from these findings. First, the specific methods that are useful for expanding community-based services are highly associated with those that are useful for downsizing institutions. Second, significant differences in ratings, where they exist, indicate that certain methods are more useful for expanding community-based services than for downsizing institutions. Whereas these are sometimes two sides of the same coin, these results suggest that there is no inevitability about institutions downsizing just because community services are established. This was the case in Norway where, according to Mervyn Morris, community-based services, "*became additional to hospital care, as if treating two separate populations (though of course community [services] do reach significant unmet need).*" He added that current reforms in Belgium are mindful that expanding community services not only fills gaps in existing community care, but also targets pathways into and out of the hospital.

Conversely, no methods were found to be significantly more useful for downsizing institutions than for expanding community-based services. This is consistent with the idea that downsizing institutions is more challenging than expanding community-based services. Survey respondent Anita Marini echoed this sentiment concerning Jordan: "*It is obviously easier to establish something new from scratch than to transform/change something into something else.*"

Responses were tabulated and summarized to identify those methods that participants were most likely to rate as quite useful or very useful in deinstitutionalization. A summary is provided in Table 3, and additional details are provided below.

Table 3. Most highly-rated methods for downsizing institution-based services: percentage of respondents rating the method as '*quite useful*' or '*very useful*'.

RANK ORDER	METHOD FOR DOWNSIZING INSTITUTION-BASED SERVICES	NUMBER OF RESPONDENTS REPORTING USE OF METHOD	PERCENTAGE OF RESPONDENTS RATING METHOD AS 'QUITE USEFUL' OR 'VERY USEFUL'
1	Mobile clinics/outreach services	43 (55%)	67.4%
2	Psychiatric beds outside mental hospitals (e.g. in general hospitals)	56 (72%)	64.3%
3	Discharge planning/hospital to community residence transfer programmes	48 (62%)	58.3%
4	Residential care in the community	45 (58%)	57.7%
5	Stopping new admissions in institutions or 'closing the front door'	46 (59%)	56.5%
6	Reducing admissions through new admissions procedures	43 (55%)	55.8%
6	Local catchment area or hospital-level plans	52 (67%)	55.8%
6	Supported employment	43 (55%)	55.8%
9	National or regional mental health policy, strategies, plans	52 (67%)	54.2%
10	Self-help and user groups	49 (63%)	51.0%

Use of mobile clinics/outreach services was the most highly rated method, deemed as 'quite useful' or 'very useful' by 67.4% of the respondents who reported use of this method in downsizing institution-based services. For example, respondent Sashi Sashidharan reported that in the United Kingdom, "*We had the greatest success (and biggest impact on the service system) through setting up alternatives to hospital admission in the community. This took the form of Home Treatment services providing 24/7 care and managing the access to inpatient beds*." Mobile clinics/outreach services need a relatively low level of infrastructure, and can make use of existing concentrations of mental health expertise. In Uganda, a local nongovernmental organization sends peer support workers to visit discharged patients. "*Our peer support programme has been ongoing since 2012 … our work so far indicates that we are having a good effect on readmission rates,*" according to Joseph Atukunda.

Next, psychiatric beds outside mental hospitals (e.g. in general hospitals) were rated as 'quite useful' or 'very useful' by 64.3% of the respondents who reported use of this method to downsize institutions. Respondent Mauricio Gómez-Chamorro of Chile stated, "*I think [the placement of beds outside of psychiatric institutions] is the cornerstone for reducing psychiatric hospitals, and is the most resisted policy.*" Djibo Douma Maiga wrote that in Niger, "*The creation of beds in the districts improved outreach mental health and some integration of mental health into general health care.*" This view was echoed by Sifiso Phakathi of South Africa, who said, "*Attaching psychiatric units to general hospitals improves access to mental health care. There needs to be an expansion of community-based mental health care alongside downsizing institution based services.*"

Discharge planning or hospital-to-community residence transfer programmes were rated as 'quite useful' or 'very useful' by 58.3% of the 48 respondents who reported use of this method to downsize institutions. The closely-related method of residential care in the community was rated as 'quite useful' or 'very useful' by 57.7% of the 45 respondents who reported use of this method. In the words of respondent Jose Miguel Caldas de Almeida of Portugal, "*The development of a national initiative aiming at the development of residential facilities and day centres for people with mental health problems was one of the most important strategies to downsize institution-based services.*"

The top ranking of these four methods points to the necessity of community-based services as facilitators of deinstitutionalization. Reflecting this sentiment, Gad Paulo Kajiru Kilonzo wrote that, "*At the height of the community care team arrangements in Dar es Salaam [United Republic of Tanzania], it was possible to reduce revolving door admissions, reduce the severity of patients who came for re-admission and reduce bed occupancy rate at the psychiatric unit of Muhimbili National Hospital.*"

Methods directed specifically at institutions were also highly rated. Of the 43 respondents who reported use of stopping new admissions in institutions or 'closing the front door', 56.5% rated this method as quite useful or very useful. Similarly, 55.8% of the 43 respondents who reported use of reducing admissions through new admissions procedures thought this method was quite useful or very useful. Anna Puklo-Dzadey from Ghana noted that, "*Assessment team/unit as a 'gate to the hospital' allowed for better diagnostic processes, shorter admissions, or a community treatment option instead of an admission.*"

Local-level or hospital-level plans were rated as quite useful or very useful by 55.8% of the 52 respondents who reported use of them for downsizing institutions. Anita Marini, for example, reported on the use in Jordan of a "*transformational plan of the psychiatric hospital: re-evaluation of the patients to identify the ones who can be discharge, selection of few wards to start improving the environment conditions and implementing an alternative model of care, development of an admission unit within the*

psychiatric hospital to stop any other admission except for the acute cases."

Supported employment was rated as quite useful or very useful by 55.8% of the 43 respondents who reported its use to support downsizing institutional care. However, as Robert van Voren noted about Georgia, "*Supported employment is good – but work in a 'normal' setting is even better."*

Of the 59 respondents who reported use of national or regional mental health policy, strategies, or plans, 54.1% judged them as quite or very useful in downsizing institutions. As reported by Pau Perez-Sales concerning Nicaragua, "*Each region must be considered as a specific reality and be worked as an individual case. National plans dilute in regions."*

Finally, 51.0% of the 49 respondents who reported use of self-help and user groups rated them as quite or very useful in downsizing institutional care. Francis Simenda from Zambia noted that, "*The consumer movement, the Mental Health Users Network of Zambia, have been in the forefront in the expansion of community mental health services, with support from government and non-governmental organizations. This has resulted in the reduction in the number of admissions to psychiatric institutions."*

Fourteen additional methods were rated as less useful overall for downsizing institution-based services. Table 4 displays these methods, all of which were rated by fewer than 50% of respondents as quite useful or very useful.

Table 4. Methods for downsizing institution-based services rated by fewer than 50% of respondents as '*quite useful*' or '*very useful*'.

RANK ORDER (CONTINUING FROM TABLE 3)	METHOD FOR DOWNSIZING INSTITUTION-BASED SERVICES	NUMBER OF RESPONDENTS REPORTING USE OF METHOD	PERCENTAGE OF RESPONDENTS RATING METHOD AS 'QUITE USEFUL' OR 'VERY USEFUL'
11	Advocacy and public education by health-care professionals	57	49.1%
12	Community mental health centres	54	48.1%
13	Physically removing unused beds / reducing the number of psychiatric beds	42	47.6%
14	Mental health legislation	49	44.8%
15	Outpatient care at general hospitals	59	44.1%
16	Integration of mental health in primary care	60	43.3%
17	Vocational training	48	41.7%
18	Day care services	46	41.3%
19	Advocacy and public education by service users	49	40.8%
20	Advocacy and public education by NGOs	57	36.8%

RANK ORDER (CONTINUING FROM TABLE 3)	METHOD FOR DOWNSIZING INSTITUTION-BASED SERVICES	NUMBER OF RESPONDENTS REPORTING USE OF METHOD	PERCENTAGE OF RESPONDENTS RATING METHOD AS 'QUITE USEFUL' OR 'VERY USEFUL'
21	Advocacy and public education by government	50	36.0%
22	Improving mental hospital information systems	48	35.4%
23	E-mental health (use of IT for self-help, strengthening mental health care delivery, or support of caregivers)	27	29.6%
24	Advocacy and public education by family members	51	29.4%

The relatively low ratings given to advocacy and public education bear further consideration. Some respondents cited low levels of advocacy activity in their country, while others commented on the relatively weak impact of advocacy even when present. For example, Dainius Puras from Lithuania noted that, "*Among major stakeholders, the forces that advocate for mental health reform according to recommendations of WHO and other international organizations are much weaker than those who support status quo.*" Nonetheless and reporting on the same country, Karile Levickaite noted that, "*Invoking foreign experts was among the valuable methods of advocacy. Experts from old European Union countries or representatives of international institutions get more attention.*"

Advocacy by family members tended to be judged neutrally, negatively, or with ambivalence. Important exceptions existed, in which respondents were enthusiastic about the contribution of family members to overall advocacy. However, other respondents noted challenges and issues. Exemplifying the ambivalence noted by several participants, Hwang Tae-Yeon commented that, "*Many mental health professionals thought the family association [would be] very important for the advocacy of consumers that tried to collaborate and support it, but that kind of approach did not go well in Korea.*" Family groups and service user organizations share the same platform in many countries.

Mental health legislation was viewed as quite or very useful by only 45% of respondents. Albert Maramis' views on Indonesia might help clarify this assessment, "*Mental health legislation at national and sub-national level is a very strategic option, although it is difficult and may take years to develop.*" In some cases, mental health legislation was outdated and therefore counterproductive, as reported in Zambia. "*The current mental health law of 1951 (Mental Disorders Act) advocates for the removal of persons with mental health problems from the community and institutionalizing them in mental hospitals...*" stated C. Sylvester Katontoka.

The integration of mental health services into primary health care was not rated as highly as other methods for facilitating deinstitutionalization. Nonetheless, several other respondents noted the importance of mental health services in primary care in their own right. For example, Jafar Bolhari from the Islamic Republic of Iran wrote about the success of this country's primary care integration strategy. "*Some of the main effective methods were integrating mental health programmes into the primary health services in all levels, integrating health services with health personnel training, establishing*

primary health worker high school in remote areas …" This thought was echoed by an anonymous respondent, "*The most effective and appropriate method for Yemen is to integrate mental health into primary health care services.*"

The relatively low rating of e-mental health (including electronic medical records, tele-psychiatry, and other interventions enabled by electronic devices) may reflect that this relatively new method of supporting people with severe mental disorders has not yet expanded beyond few countries. In the Netherlands, where it is in use, Douwe Jippes reported that, "*E-Health or E-mental Health has been a game changer … it has been proven to be as effective as traditional personal intervention.*" In India, "*Tele-psychiatry services, especially mobile tele-psychiatry services, have helped take the [mental health] service to almost the door step of the patient, using easily available technology. This also helps to optimize the scarce mental health [human] resources by saving time and travel of the professionals,*" according to R. Thara. Peter Yaro Badimak noted that in Ghana, "*The growing use of information technology has potential in helping many families.*"

QUALITATIVE RESULTS

Respondents were provided with opportunities to write freely about other important factors in downsizing institution - based care. Additional themes emerged, which were: managing the workforce, including reorganizations, training and supervision, and optimizing motivation and morale; aligning financing; rallying support; and capitalizing on timing and sequencing. In addition, most emphasized - directly or indirectly - the importance of political skill in moving towards deinstitutionalization.

MANAGING THE WORKFORCE

Respondents wrote about the health workforce repeatedly and at length. More than one quarter of respondents identified the shortage of qualified staff as a barrier to expanding community-based services and deinstitutionalizing care. Chantharavady Choulamany wrote of Lao PDR that, "*The task of building efficient district mental health teams from scratch proved to be extremely challenging due especially to the local difficulties and constraints: limited number of health staff and financial resources, lack of knowledge and skills on mental health, low level of motivation and commitment, and poor administration and management of the health sector.*"

On the other hand, qualified health workers were cited as an essential prerequisite for successful scale-up of community-based services and eventual deinstitutionalization. Discussing mental health services in refugee camps in Ethiopia, Inka Weissbecker noted that, "*The main factor contributing to success of mental health integration was the availability of already qualified human resources (e.g. nurses with MsC in Clinical and Community Mental Health and national mhGAP master trainer).*"

NEW CADRES, TASK SHIFTING, AND OTHER REORGANIZATIONS

Many countries have a shortage of mental health workers to at least some degree. In many low- and middle-income countries, the migration of health workers from rural to urban areas and from poorer to wealthier countries creates considerable obstacles for health systems striving to respond to the mental health needs of their populations. If deinstitutionalization is to be successful, mental health workers must be available in the communities where people with mental disorders live. Respondents took note of these challenges and reported on the use of innovative methods to strengthen the mental health workforce.

One of the methods they reported was the creation of new cadres of mental health workers. Concerning Sri Lanka, John Mahoney reported that, "*In areas with a shortage of staff (particularly nurses) full-time psychosocial workers have been trained who have identified and supported almost 70% of new cases of serious mental illness. An evaluation of their role showed them to be extremely effective at managing people in the community and keeping people in contact with services.*" In Niger, "*Senior mental health technicians [were trained] to overcome the lack of psychiatrists,*" according to Houdou Seyni.

Task shifting (or task sharing) is the process of moving mental health-care functions from more to less specialized health workers. This enables more efficient use of available human resources. Task shifting also promotes multidisciplinary team care and community-based services, both of which are vital for effective management of mental disorders. M. Ganesan wrote about his work in Eastern Sri Lanka that, "*Task shifting was necessary and very useful. Doctors with some training and nurses did most of the clinical work. The consultant was involved only when the help was needed … With support from administrators we trained cleaning staff in the health sector to provide community services … They are the backbone of our services now. They maintain a database of all the clients and visit their houses. As they are from the community they serve they are accepted well by the clients and their families.*"

Nurses were cited in several examples as crucial to expanding community-based mental health services, as they constitute a larger, more flexible pool with wider geographic distribution. For example, Atalay Alem of Ethiopia shared that, "*We started recruiting nurses from the regional hospitals and training them as psychiatric nurses … by so doing the service was made available closer to homes of service users and in this method we were able to open around 60 clinics in the country which were run by these nurses.*"

Several participants noted other workforce reorganizations, including restructuring towards multidisciplinary team care. According to Andrew Mohanraj concerning Indonesia, "*The lesson here was the need to recognize the importance of focusing on primary care nursing and village volunteer capacity building rather than training doctors while recognizing the need for complementary roles of doctors and nurses and village volunteers for optimal community care.*" Budi Anna Keliat, Professor of Nursing in Indonesia, echoed this view. Cheng Lee added that in Singapore, "*Deployment of multidisciplinary teams within [community-based mental health centres] allowed for a comprehensive approach to the management of mental illness.*"

TRAINING AND SUPERVISION

Many respondents discussed the training of primary and general health workers as a method for expanding community-based care. For example, according to Thi Mai Hien Nguyen of Vietnam, "*Building the community-supported mental health care network through a series of training courses on a wide range of skills for the collaborative team to develop skills in different tasks, including regularly supportive supervision and coaching for primary health care workers by the mobile team of specialists from provincial hospitals and the provision of favorable working conditions [was a successful approach].*"

For countries transferring health workers from hospitals to community-based settings, in-service training and support are essential. In Belgium, this has included initiating a programme of knowledge exchange between services within the country, and establishing links and visits to service settings in other countries.

However, numerous respondents noted that training had failed in their country, for one or two main reasons: 1) lack of ongoing supervision, and/or 2) increased workload without commensurately increased resources. As noted by Marjolein van Duijl concerning Uganda, "*Training without supervision and follow-up is not useful ... Flying in specialists from western countries who conduct a short training and leave again [has not been successful]. Only with continuous follow-through, e.g. supervision, in the place of work of the trainees, is it possible for the local trainees to implement what they have learned on a durable basis.*"

Several respondents mentioned pre-service health worker curricula as another area for training reform. Implying the need for change, M. Ganesan noted that, "*Most psychiatrists in Sri Lanka feel community mental health means giving medication in the community... Developing skills necessary for community mental health is not part of the training of psychiatrists here.*" However, noting some positive changes in curricula from a university in the same country, Daya Somasundaram wrote that, "*At the primary health level, all medical students, nurses and primary health workers (or family health workers) underwent training in basic mental health as part of their regular curricula each year.*"

MOTIVATION AND MORALE

Numerous respondents noted the importance of managing health worker motivation and morale throughout the process of deinstitutionalization. Blagoje Vucinic of Serbia reported, "*The hardest thing in the process was battling very rigid attitudes of the professionals and their reluctance for any changes in the way of their work.*" Discussing Nicaragua, Pau Perez-Sales stated that, "*There is a need to develop special policies and plans to involve mental health professionals and introduce reform as a challenge.*"

Motivation and morale were diminished in some cases by unrealistic work demands or poor working conditions. In Vietnam, for example, Thi Mai Hien Nguyen noted that, "*More work was added to the primary health staff who was assigned to do everything related to health care for their population, while incentives were not used enough. Thus, they did not always have enough motivation to perform, which lead to undesired results.*"

In other cases, psychiatrists and other health workers need to be convinced of the need for change. According to Angelo Barbato of Italy, "*The closure of mental hospitals will be thwarted by professionals,*

especially doctors, if they will see the closure as a process in which their prestige and/or remuneration will be damaged. Therefore a high status must be bestowed on community-based work." Mauricio Gómez-Chamorro of Chile echoed these challenges, "*Local and medical authorities of health services and catchment areas where a psychiatric institution is located often have common interests according to mental health attention, they share what I define as an unconscious collusion, both act in order to keep things the same, general health [workers don't] want psychiatric patients inside their hospitals, institutional psychiatrists want to stay inside their institutions.*" Other respondents made similar comments concerning deinstitutionalization efforts in Ghana, Pakistan, and Sweden.

Some respondents nonetheless reported the beneficial effects of health workers' support. In Italy, strong commitment for change was found among a professional leadership as well as administrative and political support. In Spain, dedicated professionals pressured institutions through strikes, and formed professional societies to counter the resistance of unions and other detractors. Many other respondents cited the participation of enthusiastic, committed professionals and administrators, and emphasized the necessity of building a network of such like-minded professionals to maintain momentum for change.

ALIGNING FINANCING

Policies and legislation cannot be enforced, and strategies and plans cannot be implemented without budgetary support, as stated by numerous respondents. For example, Wolfgang Rutz writes of Sweden that, "*Political decisions and verbal intentions proclaimed by political decisions makers [carry little or no weight] as long as they are not financed.*"

Important financing-related concepts emerged from respondents.

First, respondents noted that successful deinstitutionalization requires financial support and in some cases, double funding. According to Angelo Barbato of Italy, "*The move from an institutional-based to a community-based model of care cannot be conceived as a cost-saving process, because good quality community services are not cheap. Therefore, any plan aimed at saving money through downsizing or closing mental hospitals will produce poor services.*" Harvey Whiteford of Australia added that, "*Establish[ing] the community services before closing the beds…needs 'double funding' for at least two budget cycles (two years). It takes at least that long to get the money out of the institutions.*" John Jenkins of the United Kingdom expressed similar views.

In resource-constrained systems where double funding is not possible, an alternative solution is to provide bridging finance while funding is transferred progressively from institutions to service users' home health districts. This was done in the United Kingdom, according to John Mahoney, where the total hospital cost was divided by the number of beds to arrive at a 'unit cost' per service user. When service users were discharged, the home health district was allocated the full unit cost and the bed had to close. Occasionally, institutions were given additional bridging finance for short periods to cover residual building costs such as heating, lighting, and fuel.

Second, budgets for community-based mental health services need to be ring-fenced. In New Zealand, for example, Barbara Disley said that following deinstitutionalization, "*There was close monitoring of mental health expenditure [for community-based mental health services] to ensure that the money did not fall back into physical health services.*"

Third, financing can be used as a lever for change. In Belgium, for example, "*The hospital law reform provided for psychiatric hospitals to reorient a minimum 10% of their budget to develop community services,*" according to John Mahoney. In Chile, "*Public insurance stopped paying mental hospitals for newly admitted patients to chronic wards,*" wrote Alberto Minoletti. Similarly in Georgia, "*Changing the funding method of hospitals encouraged them to discharge patients,*" wrote Nino Makhashvili. Angelo Barbato noted that in Italy, "*Financial incentives for mental health professionals to move from mental hospitals to community services [were a successful method].*"

Fourth, incentives can be used to foster innovation. "*The creation of financial incentives for good innovative projects made possible the implementation of more than 50 new projects that could be used as demonstration projects. Some of these projects were evaluated and their results were very important to prove the effectiveness of community-based care [in Portugal],*" according to Jose Miguel Caldas de Almeida.

RALLYING SUPPORT

Respondents wrote at length about the importance of broad-based support to facilitate deinstitutionalization. "*Decisions must be supported at the highest possible level, involving most levels possible, and with the enough political and budgetary support,*" according to Mauricio Gómez-Chamorro of Chile. Robert van Voren reported that in Georgia, "*NGOs are pivotal to push for change, while the government is essential as a partner to make the newly established services sustainable.*"

National committees or task forces are one method for rallying support across diverse stakeholder groups. In Jordan, for example, "*The National Steering Committee included a high number of stakeholders, a choice that revealed to be successful. In fact, it made the process longer and the mediation and negotiation more difficult, yet it built a very strong and broad consensus and it helped building nationally a momentum for mental health,*" according to Anita Marini. Dévora Kestel added that in Albania, "*The … National Steering Committee of Mental Health (NSC) [included] stakeholders belonging to different realities and chaired by Deputy Minister of Health … some of these members (from different sectors within the Ministry of Health, for instance) played a key role in facilitating the project implementation, creating needed conditions, etc.*"

Support from senior leaders can be challenging to obtain, but is worth every effort. Anita Marini explained how this worked in Jordan. "*The very strong investment in developing, building capacity, mentoring and constantly motivating a number of young psychosocial professionals as members of multidisciplinary teams working in community services was also fundamental to the success of the project. It attracted the attention, admiration and then support of the high level politicians, of the donors and of the strong personalities in the country such as some members of the Royal Family.*"

Community engagement is also important. Writing about the development of community-based services in Ethiopia, Abebaw Fekadu noted that, "*Repeated meetings with the community leaders helped us to learn from the community, be accountable to the community, and gain legitimacy.*" By addressing community concerns in a proactive manner, the support of different stakeholders might be easier to obtain. "*Developing awareness [through] publishing articles in newspapers, publishing newsletters,*" was cited as a facilitating factor by Anil Vartak of India.

CAPITALIZING ON TIMING AND SEQUENCING

Several respondents wrote about the importance of timing in mental health reform. In some cases, this timing related to an emergency situation, which was followed by an influx of aid and increased attention to mental health issues. In other cases, timing referred to a change in political leadership.

Wolfgang Rutz wrote, "*Emergency situations, whether it was war or tsunami, helped us to educate the importance of mental health and psychosocial need to all the people and agencies on the ground. There was also less control from the central mechanisms, and as such it was easy to convince the locals and develop community mental health services.*" Similarly, Giuseppe Raviola of Partners In Health shared that, "Soon after the 2010 earthquake in Haiti, [we] recognized the earthquake as a catalyst to expand [our] mental health services in Haiti and to support the government's capacity to develop a sustainable, community-based mental health system." These sentiments are consistent with data reported in the recent WHO publication, *Building back better: sustainable mental health care after emergencies*.[15] This report concludes that global progress on mental health reform would happen much more quickly if, in every crisis, efforts were made to convert short-term interest in mental health issues into momentum for mental health reform.

Echoing this theme, Dévora Kestel wrote of Albania that, "*The crisis in Kosovo brought attention from the international community to other countries of the region, including Albania. The condition of the country's mental health services (consisting primarily of psychiatric hospitals) was seen as potentially benefiting from external support. This interest, created in an emergency context, continued for several years, with health authorities and some international actors committed to support the improvement of the mental health system. Thanks to this support and commitment, it was possible to initiate the deinstitutionalization of some mental hospitals through the development of a variety of services at community level.*" In Afghanistan, "*After the fall of the Taliban, the rebuilding of the Afghan health care system, from scratch, provided opportunities to integrate mental health into basic health services through the use of funds that became available during this complex humanitarian emergency,*" according to Peter Ventevogel.

Political changes also can create openings for reform. "*In the 1970s, a new generation of professionals grew up fighting against the lack of freedom…*" wrote Francisco Torres-Gonzalez of Spain. "*When democracy was restored in 1978, groups of leaders were ready to take over the direction of some psychiatric institutions and some became public officers under the health administration. The main result was the new General Health Law (1986), in which community-based care principles were fully integrated.*"

With regard to sequencing, many respondents emphasized the importance of establishing community-based services prior to discharging institutional residents. This is also implicit in the high correlations between methods deemed as successful for deinstitutionalization and those for expanding community-based services. Without this forward planning, adverse consequences can occur. As stated by an anonymous respondent, "*Reducing beds without proper community support structures does lead to a 'revolving door' into psychiatric facilities and added stigma and discrimination as people tend to cause disruptions in their communities.*" In Japan, "*Sudden closure [of psychiatric hospitals] shifted patients to prison,*" according to Tsuyoshi Akiyama. Budi Anna Keliat of Indonesia noted that, "*Forty percent of patients in the mental hospital are able to live in the community, but the problem is there is no community mental health service that can help and support these patients.*"

A broad range of community-based services is needed prior to deinstitutionalization. Harvey Whiteford of Australia made the point that, "*Community services are a tripod of clinical services, disability support, and stable accommodation; not just clinical services. All three are interdependent. If one fails, the tripod fails.*" Barbara Disley of New Zealand added that, "*It is imperative that the whole of people's needs are met and that social welfare/income needs, housing, employment and clinical follow up needs are all considered when deinstitutionalizing.*"

POLITICAL SKILL

Many respondents emphasized, to a greater or lesser degree, the importance of political skill in moving towards deinstitutionalization. They spoke at length about the need to have "will," "vision," "commitment," and "ownership" of developing community-based mental health services and downsizing institution-based services. "*With no political will, things don´t go ahead,*" wrote Mauricio Gómez-Chamorro of Chile.

Political skill was considered important because of the rigid attitudes and resistance to change among several groups, including health workers (especially those working in the institutions subject to downsizing), government officials, community members, and families and patients themselves. Writing about challenges with family members, Gurudatt Kundapurkar of India stated that, "*[In rural areas], if the affected person is not able to contribute to family income/household chores they may admit her to the government hospital, invariably located at far off district headquarters, even with fictitious residential address so that the hospital will not be able to send her back home later. Fear of stigma is also one other reason for not taking recovered persons back home. Hundreds of such stable persons with mental illness are stuck in these institutions for years.*"

John Mahoney offered several practical tips for overcoming resistance and rallying support. "*Know key players and remember most people are scared of change. Do not try and tackle institutional change head-on as problems are rarely solved in institutions that created them. Adopt an approach where you slowly change the service, which will change people's thinking and attitudes … Build relationships with senior staff and Ministers and this takes time. Be prepared … Do not take no for an answer and never give up! Ministers and senior staff rarely agree straight away.*"

Pau Perez-Sales echoed the importance of working politically to foster change. "*Nicaragua is a perfect example of the relationship between politics and health and that a stakeholder interested in expanding services and help in a reform must begin by having a strong and proactive action at governmental level, being involved not only as potential consultant, but as active actors in fostering change.*"

DISCUSSION

This survey of 78 mental health experts was designed to identify approaches associated with successful deinstitutionalization. To achieve this aim, respondents rated the usefulness of 24 pre-defined methods to expand community-based mental health services and/or downsize long-term institution-based care. In addition, they were provided with space to write about other methods or factors that they felt were particularly useful or unhelpful.

Several limitations should be noted. Potential respondents were identified and invited to participate by WHO's Director of Mental Health and Substance Abuse. Some respondents have close affiliations with WHO; thus they might share the same general vision for mental health service delivery. In addition, respondents might have been biased by the fact that the survey was initiated by WHO. An effort was made to include a wide range of mental health experts. In particular, focused efforts were made to enrol service users as part of the overall sample. Nonetheless, several groups were under-represented, including women, service users, and those from the Regions of the Americas and the Eastern Mediterranean. Results might be poorly representative of these perspectives as a result. Finally, normative definitions of 'deinstitutionalization' and 'innovation' were not explicitly provided in the survey, in order to minimize conceptual constraints. It is possible therefore that respondents held differing views of these concepts as they answered the survey questions.

In aggregate, results revealed that that there is no single 'formula' for fostering deinstitutionalization. Some respondents described deinstitutionalization processes that were decisive and immediate, whereas others pointed to examples that were gradual and phased over time. National-level policies drove deinstitutionalization in some countries, whereas others started from pilot projects that later gained support and momentum for spread.

Overall, respondents pointed to the establishment of various community-based services as imperative for successful deinstitutionalization. These included both mental health services, including access to evidence-based clinical care, and support for housing, employment, and community reintegration. Respondents made the point that long-term institutional residents need to be involved in decision-making concerning their discharge, and prepared and supported for reintegration into the community. Families and communities also require education and support when institutional residents return to the community. Ongoing communication and coordination are essential throughout the process, which should focus on outreach, proactive case management, and taking care not to lose people from care.

Relatively few mental health systems reported upon in this survey entirely closed their institutional facilities. More commonly, institutions were transformed to reduce long-stay beds and to provide new and better-quality services, including mobile outreach, short-stay admissions, and rehabilitation. Transformation—versus outright closure—might be particularly relevant in lower-income countries where the total number of inpatient mental health beds is limited and mental health resources are especially scarce.

In various countries, nongovernmental organizations played central roles in providing community-based mental health services, especially in some settings with weak public health infrastructures. In these contexts, it was important to ensure adequate coordination and regulatory oversight of these services within the public mental health system.

Numerous respondents commented that deinstitutionalization implied new ways of working for mental health professionals; and many reported considerable challenge in facilitating this transition. Many professionals were trained in an exclusively biomedical model of care and without any practical experience working as part of a community-based, multidisciplinary team. In addition, psychiatrists and other mental health professionals working in institutions were sometimes skeptical about the usefulness of community-based mental health care.

Respondents who reported successful deinstitutionalization often referred to early engagement and involvement of hospital health workers, as well as implicit or explicit modifications to their monetary and professional incentives. In other cases, appropriate regulatory review and alignment were cited, for example to support task shifting to nursing staff. Longer-term, structural changes to pre-service and in-service training would presumably strengthen these efforts.

Most respondents referred to the importance of political skill in introducing mental health reform. Respondents wrote that political skill can be—and was—directed towards managing the health workforce, aligning financing mechanisms, rallying support, and capitalizing on timing and sequencing. Key aspects of political skill include social astuteness, interpersonal influence, networking ability, and communication of sincerity.[16] Another feature is the ability to establish alliances, involving as many actors as possible. These 'soft' political skills are likely vital for deinstitutionalization because of the entrenched positions of many stakeholders in continuing to use institutions as the main setting for mental health service delivery.

Can the kind of political skill needed to overcome these challenges be learned? Experts in the field say "yes," and strategies have been developed[17] to assist people in this endeavor. Several programmes[18 19 20 21 22] have been established that train current and future mental health leaders in these skills. This type of training may prove to be an important method for accelerating deinstitutionalization in the countries where these students live and work.

PRINCIPLES AND ACTIONS

Based on quantitative and qualitative responses, five overarching principles for deinstitutionalization were identified.

1.COMMUNITY-BASED SERVICES MUST BE IN PLACE

Community-based services must be in place before long-term institutional residents are discharged. Former residents need access to mental health services, including evidence-based clinical care, and also access to social services for help with housing, employment, and community reintegration.

Community-based services can be initiated by institutions, through the reallocation of resources towards mobile teams, outpatient and day care facilities, group homes, and rehabilitation programmes. Initial efforts made by institutions to strengthen community-based services can encourage additional funding and reduction of long-stay beds and reallocations in successive waves.
Deinstitutionalization is unlikely to be successful without a well-functioning secondary level of mental health care. Secondary care (e.g. mental health specialists working at general hospitals or community mental health centres) can provide essential supervision and support to primary health care, conduct a range of other community-based services, and prevent (re)institutionalization through the provision of acute psychiatric care.[4]

Although community-based services are essential, it is nonetheless important to note that their existence does not necessarily lead to deinstitutionalization. Targeted efforts at reducing long-stay beds are needed.

2.THE HEALTH WORKFORCE MUST BE COMMITTED TO CHANGE

The health workforce has dual potential: to be either a great asset or a great liability to deinstitutionalization. In particular, it is crucial to convince psychiatrists and other mental health leaders about the benefits of deinstitutionalization. General health workers who will be assuming mental health functions also must be persuaded.

Health workers (and their professional associations) need to be consulted widely and involved in the planning and implementation of deinstitutionalization and community-based care. Those employed currently in institutions deserve special attention. They usually have valuable views concerning discharge and care planning for institutional residents, and moreover, their involvement in the process helps mitigate any concerns they might have about losing employment, professional status, or familiar ways of working.

3. POLITICAL SUPPORT AT THE HIGHEST AND BROADEST LEVELS IS CRUCIAL

Building support across broad groups of stakeholders helps overcome resistance and foster momentum for change. Support is needed not only from government officials and political leaders, but also from academic leaders, health professionals, communities, and service users and their families.

The process of building support involves more than simply informing people about the need for deinstitutionalization and what it entails. It also is the process of using information in deliberate and strategic ways to change perceptions and to sway decision-making. In part, mobilizing people means asking them to become part of the solution. This creates commitment. Generating this type of political support is a skill, and it can be taught.

4. TIMING IS KEY

Moments of openness, such as emergency situations and changes in political leadership, provide opportunities to rally support and introduce reform. During emergencies, attention and resources are turned towards the psychological welfare of broad groups of affected people, while decision-makers become willing to consider options beyond the status quo. Similarly, changes in political leadership are opportunities for deinstitutionalization because new administrations often welcome signature issues to define their tenure. Success is not invariably ensured in these moments, however. Political skill is required to recognize these and other openings, and to act effectively upon them.

5.ADDITIONAL FINANCIAL RESOURCES ARE NEEDED

Deinstitutionalization should not be seen as a cost-saving process. Comprehensive community-based services that are accessible to an entire population are usually more expensive than institutional care provided to a relative few. Although it is important to direct savings from deinstitutionalization to community-based mental health services, these 'ring fenced' funds do not typically match the operational costs of providing community-based mental care across an entire district or country. Additional funds are needed in most cases.

In addition to ongoing operating costs, time-limited expenditures on training, supervision, and infrastructure are often needed to support the establishment of community-based mental health care. A period of double funding for both institutions and community-based services enables community-based care to be established before institutions are downsized or closed.

If resources are limited, it is useful to start work within available funds while strongly advocating for more support.

CONCLUSION

Long-stay psychiatric institutions tend to be inefficient and too frequently inhumane, yet continue to consume the majority of mental health budgets in many low- and middle-income countries while managing relatively few people. This survey provided insight into the innovations that led to successful deinstitutionalization in selected mental health systems around the world.

Results indicate that there are several paths to deinstitutionalization. Some deinstitutionalization processes were immediate and decisive; others took more than a decade to reach full scale. Changes to national-level policies precipitated action in some countries, whereas pilot projects were the starting point for change in other countries.

Despite these variations, it was possible to identify five principles for deinstitutionalization based on survey responses. Community-based services must be in place so that deinstitutionalization does not result in homelessness, incarceration, or neglect of former residents; nor does it leave families to fend for themselves. Second, health workers and health professional bodies should be actively involved in the planning, implementation, and monitoring of reform; otherwise their resistance could thwart any attempts at changing mental health systems. Third, a range of government sectors, academic leaders, nongovernmental organizations, and service users and their families have important roles to play. Each of these groups has unique perspectives that can help strengthen the transformation of mental health service delivery. Fourth, contextual transformations such as emergency situations and changes in political leadership should be considered for their ability to create openings for deinstitutionalization. Finally, additional financing is needed to support the transition from institutional to community-based care.

The path to deinstitutionalization is not linear: change tends to be complex. Survey respondents emphasized the importance of political skill, or the ability to understand the motivation of stakeholders and changing situational demands and to use that knowledge in strategic ways, as a key success factor. Looking to the future, it is possible that the most important 'innovation in deinstitutionalization' will be to equip current and future mental health leaders in a systematic way with the strategic, political skills that will enable them to stimulate and sustain reform.

ANNEX 1: SELECTED COUNTRIES' EXPERIENCES WITH DEINSTITUTIONALIZATION

BELIZE

Traditionally, mental health services in Belize were concentrated in its sole mental hospital outside the capital city. People with psychotic disorders tended to stay for long periods and care was custodial in nature. The only mental health outpatient clinic in the country was located in Belize City, within the general hospital compound. Since 1992, Belize has made important progress toward creating alternatives to its psychiatric hospital and strengthening the network of community-based services. The introduction of psychiatric nurse practitioners has facilitated numerous improvements: admissions to the psychiatric hospital have been reduced; outpatient services have increased; and community-based prevention and promotion programmes are now in place. Gradually, this process led to the closure of the mental hospital in November 2008 and a consequent strengthening of community-based mental health services: outpatient services (nine mental health clinics across the country); inpatient services (six of seven general hospitals in the country now admit psychiatric acute patients); community outreach services; and a community treatment programme. Around 30 patients from the former psychiatric hospital are currently living in an assisted residence. Overall, Belize's reform has not yet resulted in complete deinstitutionalization or fully realized community-based service networks, but many people are being treated in the community rather than in hospitals, and many who previously would not have received care are now able and willing to access services.

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BRAZIL

Large public mental hospitals were the cornerstone of mental health services in Brazil until the 1980s, when mental health reform began. Deinstitutionalization has been progressing since that time. Action was accelerated by a 2001 federal law that defined hospitalization as the last recourse in the treatment of mental disorders and ensured people's right to be treated through community-based services. From 1995 to 2011, the portion of the total mental health budget allocated to psychiatric hospitals decreased from 95% to 28.9%, while the allocation to community-based services increased from 0.8% to 71.1%. The number of beds in mental hospitals declined by around 18 500 (35%) from 2001 to 2009.

Psychosocial Community Centres (CAPS) are now the foundation for mental health care in Brazil: they offer a range of services for people with severe mental disorders and liaise with primary health care settings. In 2002, CAPS registered around 40 000 consultations; by 2010, this number had risen to 20 million annually. As of 2012, 1803 CAPS are functioning in the country. The process of distributing them more equally across the country's regions is still ongoing.

For more information:

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CHILE

Over the last 20 years, Chile has taken important steps towards deinstitutionalization and the development of a comprehensive network of community-based services as an alternative form of treatment. A series of two national policies and plans (1993-1999; 2000-2010) guided reform, and commensurate changes to funding reinforced action. From 1999 to 2009, public sector funds for mental health increased from 1.3% to 3.1%; while the allocation of funds for mental hospitals decreased from 74% of the mental health budget in 1990 to 19% in 2009. The number of beds in mental hospitals declined by two thirds over the same time period. Overall, the deinstitutionalization process in Chile has been gradual though non-linear, and uneven between sub-regions. Those involved with the process have noted the importance of timing, political skill, commitment of professionals and authorities at local levels, and international cooperation in making progress.

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GEORGIA

In Georgia, the process of deinstitutionalization is still in progress. Until recently, people with mental disorders were housed in institutions with inhumane living conditions. Advocacy to policy-makers on human rights violations in these facilities became the impetus for mental health reform. A doubling of the mental health budget in 2004 enabled the introduction of some new services and quality improvement of others. Subsequent reforms in 2008 to the way in which mental hospitals were funded led to a gradual reduction in the number of inpatients. However, many community-based services were still not available at scale despite ongoing efforts by nongovernmental organizations to pilot and expand community-based programmes. In 2011, one of the largest psychiatric hospitals in the country was closed and replaced by psychiatric units in general hospitals and new community-based services. Planned next steps include the further development of community centres, which will offer multifaceted services to people in need. Ongoing challenges to deinstitutionalization in Georgia include the lack of a comprehensive mental health plan, societal stigma and discrimination, and resistance from health workers.

For more information:

Makhashvili N, van Voren R. Balancing community and hospital care: a case study of reforming mental health services in Georgia. *PLoS Medicine*, 2013, 10(1):e1001366.

ITALY

Deinstitutionalization started in Italy 35 years ago with the passage of a federal law that prohibited the building of new psychiatric hospitals, restricted hospital admissions, and ordered the creation of new community-based mental health services. Rather than trying to create a community-based mental health system as a parallel structure to hospital-based care, the law called for the swift dismantling of institutional care. A comprehensive network of community-based services was built over time. The deinstitutionalization process started in the mid-1970s and was completed in 2000, when the last group of long-term patients was discharged. Today, a wide range of community-based mental health services is available throughout the country.

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KOSOVO

Kosovo's conflict and violence culminated in international intervention and transition of governance to the United Nations in 1999. This rapid change and interest in mental health created an opportunity to reform Kosovo's mental health system, which until that time had been hospital-focused and biologically oriented. A new strategic plan emphasized the strengthening of community-based mental health services at the same time as closing Kosovo's notorious institution, which housed people with mental and developmental disorders in very poor conditions. The institution was subsequently transformed into the Centre for Integration and Rehabilitation. It is now part of the community-based mental health service; it offers secondary-level services to all seven regions. Each region now has a range of complementary community-based mental health services.

For more information:

Building back better: sustainable mental health care after emergencies. Geneva, World Health Organization, 2013.

PORTUGAL

In its most recent mental health plan (2007-2016), the government of Portugal acknowledged that mental health services suffered serious deficiencies in terms of accessibility, equity, and quality of care. In particular, it noted that hospitalization continued to consume the majority of mental health resources (83%), thereby inhibiting development of community-based services. Deinstitutionalization in Portugal was planned around three guiding principles: changes should facilitate the creation of local mental health services based in the community and of inpatient units in general hospitals, as well as the psychosocial integration of people with mental health problems; no service can be closed until another has been created to replace it; and patients and family members should be involved in the changes to be made from the outset.

In the first four years of the plan's implementation, the number of institutionalized patients in psychiatric hospitals decreased by 40%, and two psychiatric hospitals were closed and replaced by community-based services and mental health units in general hospitals. A national initiative aimed at developing residential facilities and day centres for people with mental disorders was another key facilitator for downsizing institution-based services. Other drivers of change included: financial incentives for innovative, community-based pilot projects; health worker training on the management of severe mental illnesses; and the involvement of service users and families in the reform. The large majority of mental health care is now provided by local mental health services integrated into the general health system..

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INNOVATION IN DEINSTITUTIONALIZATION: A WHO EXPERT SURVEY

Although community-based services are widely regarded as the best approach for providing mental health treatment and care, most low- and middle-income countries continue to spend the vast majority of their scarce mental health resources managing people with mental disorders in mental hospitals. To better understand this vexing issue, 78 mental health experts representing 42 countries were surveyed on the relative usefulness of different methods to expand community-based mental health services, and/or to downsize institution-based care. Results indicate that there are several successful paths to deinstitutionalization. Most respondents emphasized—directly or indirectly—the importance of political skill and timing. Based on the survey, five principles for deinstitutionalization were identified: community-based services must be in place; the health workforce must be committed to change; political support at the highest and broadest levels is crucial; timing is key; and additional financial resources are needed.

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