Deinstitutionalization of Psychiatric Care in Latin America and the Caribbean

PAHO
Pan American Health Organization
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Deinstitutionalization of Psychiatric Care in Latin America and the Caribbean

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Acronyms

ATLAS	Mental Health Atlas
NGO	Nongovernmental organization
PAHO	Pan American Health Organization
PHC	Primary health care
WHO	World Health Organization
WHO-AIMS	WHO Assessment Instrument for Mental Health Systems

Summary

This technical document is a framework for action. Its objective is to guide the health authorities of Latin American and Caribbean (LAC) countries toward the deinstitutionalization of psychiatric care in the context of the Region.

Deinstitutionalization points psychiatric care away from the seclusion of people with mental illness in psychiatric hospitals, toward decent, quality care in the community.

Psychiatric hospitals should be replaced by beds for acute cases in general hospitals, as well as different community-supported housing solutions for people with severe mental illness. At the same time, an efficient network of community-based mental health services is needed. This involves the priority development of new practices and community services with proven effectiveness that protect the rights of people with mental illness.

The Pan American Health Organization's Plan of Action on Mental Health recognizes this priority. [1] The plan's second strategic line calls for improving the responsiveness of mental health systems and one of its goals is to reduce the role of psychiatric hospitals. Most LAC countries are currently working on the reorganization of mental health services. However, despite the progress made, psychiatric hospitals still consume the majority of the limited resources available for mental health in many countries. In addition, they continue to be closed-door institutions with poor living conditions where the human rights of hospitalized service users are systematically violated.

This document presents a summary of the facilitators and barriers that will be encountered during deinstitutionalization processes. In addition, useful and proven interventions are identified in the context of LAC countries. This document has been prepared using three sources of information:

1. Exploratory review of the literature on deinstitutionalization processes,
2. Online survey of professionals with experience in the field of mental health and deinstitutionalization processes, and
3. Results of three regional expert consultation meetings.

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1 Pan American Health Organization. Plan of Action on Mental Health. 53rd Directing Council 55th Directing Council, 66th Session of the Regional Committee of WHO for the Americas; CD53/8, Resolution CD53. R7. Washington, D.C.: PAHO; 2014. Consulted on 20 September 2020. Available at https//www.paho.org/hq/dmdocuments/2014/CD53-R7-e.pdf.

Furthermore, the current situation of mental health services in LAC has been reviewed, addressing the experiences and lessons learned that could help move away from the psychiatric hospital-based mental health service model and further fight the stigma, abuses, and discrimination suffered by people with mental illness.

Four work areas have been identified with the respective guidelines or suggestions for action. This information may provide operational guidelines for countries that are restructuring of mental health services and moving toward the deinstitutionalization of psychiatric care.

KEY MESSAGES FOR THE PSYCHIATRIC CARE DEINSTITUTIONALIZATION PROCESS

1. Community network-based mental health services are the best choice for the care of people with mental illness. However, a significant number of countries continue to allocate most of their limited financial resources to maintaining psychiatric hospitals, yielding very poor outcomes that are ineffective and inefficient.
2. Deinstitutionalization involves developing a network of community-based services before or during the process.
3. Integrating and coordinating mental health into the overall health system is crucial, especially in primary health care and general hospitals, as is developing specialized outpatient and community residential services for people with severe mental disorders who cannot or do not want to live with their families.
4. Deinstitutionalization processes can be long and complex. They therefore require planning, resources, and political decisions that continue over time. Otherwise, there is a risk that these processes will go backwards or stagnate.
5. Experience shows that there are several successful paths to deinstitutionalization.
6. Operational commitments need to be promoted across sectors, entities, and institutions in the health system and other systems.
7. The participation of users and their families ensures a basis of support for the deinstitutionalization process.
8. Raising public awareness (of community leaders, churches, police, etc.) and working with the media are essential.
9. Restructuring mental health services requires additional financial investment.
10. Political will is vital for initiating or strengthening deinstitutionalization processes, as well as for identifying and seizing windows of opportunity.

Introduction

In mental health services, a biomedical approach has prevailed that has focused more on mental illness than on the person, and on the psychiatric hospital more than the general health system. Psychiatric hospitals become asylums or shelters where people with mental illnesses are confined for long periods of time, in most cases against their will.

The Pan American Health Organization (PAHO) Plan of Action on Mental Health approved by Member States promotes the development of a community model "with new services and alternatives that offer comprehensive and continuous care that make it possible to replace psychiatric hospitals in a progressive and appropriate manner." *(1)* Thus, deinstitutionalization is a key element of the process for restructuring psychiatric services.

Three decades after the Caracas Declaration *(2)*, deinstitutionalization has not made sufficient progress in the Region, despite the fact that representatives of most Latin American and Caribbean (LAC) countries pledged to move away from the hospital/asylum-based psychiatric services model and combat the violation of human rights suffered by people with mental illness.

The World Health Organization (WHO) points out that despite efforts to develop community-based care, psychiatric hospital-based care continues to dominate the provision of services worldwide *(3)*. Some health systems have been able to deinstitutionalize people with mental illness and transition them to community care. However, most countries continue to spend most of their limited resources on managing a small number of people with mental disorders exclusively in long-stay institutions *(4)*, an alternative that is often inefficient and inhumane.

This document is the result of an endeavor that lasted a little over two years (2017-2019) and involved a large group of experts and professionals, with the objective of resuming efforts to deinstitutionalize psychiatric care in the Region.

The objectives of the document are:

1. Describe the facilitators and barriers encountered during processes to deinstitutionalize psychiatric care.
2. Identify strategies and interventions that have proven to be useful and effective in the context of LAC, in order to move forward in the deinstitutionalization of psychiatric care.
3. Suggest guidelines for moving toward the deinstitutionalization of psychiatric care in the context of the Region, based on the defined work areas.

In terms of methodology, the document was based on three sources of information. A bibliographic review of deinstitutionalization processes was conducted; the results of a deinstitutionalization survey taken by professionals with experience in the field of mental health and deinstitutionalization processes were used; and three meetings were held with international experts. During this process, the current situation of mental health services in

LAC was reviewed, and strategies to promote deinstitutionalization processes were identified. There was discussion of experiences and lessons learned that would help move away from the psychiatric hospital-based mental health services model and strengthen efforts to fight the stigma, discrimination, and abuse suffered by people with mental illness.

The final product is this technical reference document for action that guides health authorities in LAC countries in their efforts toward deinstitutionalization.

The document includes a glossary describing the operational criteria that define the different services comprising the mental health services network. Annex 1 presents the selected results of the exploratory review of the literature. Annex 2 shows the results of the close-ended multiple-choice questions in the survey given to health professionals.

I. Background

In the nineteenth century, the mental asylum was legitimized as an institution specialized in caring for the mentally ill, which had medical treatment and curative functions but limited effectiveness. The custodial model of care of these institutions continued, especially for people with long-term severe mental disorders and those who lacked the means or ability to return to their community.

A mental asylum is generally characterized by the absence of effective treatments, segregation, poor living conditions, lack of resources, and overcrowding, among other problems. This set of conditions has very negative consequences on patients, who suffer from clinical and social deterioration, depersonalization, and marginalization. In addition, the concept of a mental asylum contributes to increasing stigma and discrimination toward people with mental illness.

Starting in the 1960s, several experiences with psychiatric reform gained more strength in Europe and the United States of America, which were influential in LAC. The best known is the psychiatric reform movement in Italy, but advances also occurred in Spain, Ireland, and the United Kingdom. In some cases, psychiatric hospitals *(5)* were even closed.

Between the 1970s and 1980s, many countries in the Americas worked on initiatives to move away from centralized psychiatric care in psychiatric hospitals and developed community-based alternatives, especially local ones *(6)*. Some pioneering regional experiences occurred in South America, such as the ones in Rio Negro Province, Argentina *(7)*, and in Santos, a city in the State of Sao Paulo, in the late 1980s and early 1990s.

In November 1990, the Pan American Health Organization (PAHO) promoted the Initiative for the Restructuring of Psychiatric Care in Latin America; a regional consensus on this issue was achieved, and the Caracas Declaration, which marked a historic milestone in the Americas, was approved *(2)*. The Declaration was issued to end the hegemonic role of the psychiatric hospital and promote community, decentralized, participatory, comprehensive, continuous, and preventive care based on human rights, which was impossible to achieve in psychiatric hospitals. In addition, it promoted the development of decentralized mental health services that were close to the community and associated with primary health care (PHC) networks.

In 1997 and 2001, the PAHO Directing Council addressed the subject of mental health and issued resolutions urging Member States to include mental health in their priorities *(8, 9)*. The regional conferences on mental health held in Brasilia in 2005 and in Panama in 2010 evaluated the progress made thus far *(10, 11, 12)*.

In recent years, PAHO and WHO have approved several programmatic documents that have been relevant in the reorganization of mental health services *(3, 10, 11)*.

In addition, Article 19 of the Convention on the Rights of Persons with Disabilities (which includes psychosocial disability) recognizes "The right of persons with disabilities to choose where and with whom to live, to do so independently, and to be included in the community" *(12)*.

Community care has greater therapeutic effectiveness and is more humane. Furthermore, users of mental health services prefer to live outside of an institution and enjoy their rights as citizens.

Deinstitutionalization requires new and alternative practices and services that are more efficient, effective, and humane allowing people with mental illnesses to remain in their communities and have their rights protected. People with mental illness who have more difficulty living in the community or who do not have families that can take them in must be able to access social support programs with some degree of protection, such as halfway houses, supervised housing, assisted living apartments, or "adoptive families." Users in psychiatric hospitals should not be moved to the community unless the necessary solutions for receiving them are in place. Problem-solving and meeting the needs of people are essential parts of the deinstitutionalization process. Addressing these problems and needs will serve as guidance for developing the services and practices that will comprise the new mental health system.

Trans-institutionalization, i.e. moving people from a psychiatric hospital to another type of service that has a different name but reproduces the control dynamics and violation of rights found in mental hospitals, must be avoided.

The following are some examples of trans-institutionalization in the Region:

- Moving people from one institution in the health ministry's service network to another (such as the ministry of social protection or welfare), reproducing the problem of providing residences that are isolated from the general health network and the community.
- Renaming the institutions without substantially changing the mental hospital care model. These new names include neuropsychiatric hospital, mental health center, teaching hospital, and mental health institution, among others.
- Giving the institution an alleged community-based psychosocial rehabilitation function that it does not actually perform.

It should be noted that deinstitutionalization is not an isolated process. It is developed in the context of a national mental health plan and in conjunction with other strategies aimed at restructuring mental health services and implementing a community-based model.

II. Why process for the deinstitutionalization of psychiatric care should be repromoted in Latin America and the Caribbean

Reports evaluating the mental health systems set up over the past two decades in LAC, such as the *Atlas: Mental Health Resources in the World (13-16)* and WHO-AIMS *(17, 18)*, show that the policies, laws, programs, and community-based mental health services developed are still insufficient, which hinders deinstitutionalization. It is clear that additional efforts and resources are still needed to achieve the objectives set out in the mental health action plans adopted by governments.

The *2017 Atlas of Mental Health of the Americas (4)* report notes that the progress made in the deinstitutionalization of psychiatric care is extremely limited:

- The median number of mental health beds ranges from 16.7 per 100,000 population for psychiatric hospitals to 2.9 per 100,000 population for general hospital psychiatry services.
- More than two-thirds of users admitted to psychiatric hospitals (74%) are discharged within a year and 20% have a median stay of more than five years.
- Community residential services are present in almost half of the countries, with a median rate of 1.4 services per 100,000 population. However, they have 12 times fewer beds than psychiatric hospitals.

The speed of the deinstitutionalization process will accelerate if there are better conditions for implementing national plans aimed at strengthening a network of community-based mental health services. The persistence of infrequently updated mental health policies and insufficient human and financial resources for mental health create unfavorable conditions for deinstitutionalization. This situation is also reflected in the *2017 Mental Health Atlas of the Americas (4)*:

- By 2017, only 46% of countries had updated their mental health policies and plans.
- The median annual per capita expenditure on mental health is US$13.8, with significant differences between high-income countries (US$48 per capita) and middle- and low-income countries (US$2.5 per capita).
- Median regional public expenditure on mental health is only 2% of the health budget, and more than 60% of these funds go to psychiatric hospitals.
- The median number of mental health workers is 10.3 per 100,000 population. However, there is a wide variation between different countries and professions, ranging from less than one worker in low-income countries to 236 in the United States and Canada subgroup.
- The number of psychiatrists is low compared to the number of other mental health professionals (1.39 per 100,000 population), although it is similar to the global average.

Child psychiatrists are practically non-existent. The professionals with the greatest presence in the mental health sector are psychologists (5.4 per 100,000 population), especially in South America, followed by nursing professionals (3.87 per 100,000 population), especially in the non-Latin Caribbean.

- There are wide disparities between countries in terms of the availability of outpatient, child-youth, and social support services.

On the other hand, at the polar opposite of these unfavorable conditions for the deinstitutionalization of psychiatric care are the successful experiences with developing national plans and strengthening community mental health services in the Region, which provide sources for lessons learned *(19)*. These include the experiences of Belize, Brazil, Chile, Cuba, the Dominican Republic, Jamaica, Panama, and Peru. The National Mental Health Law enacted in Argentina in 2010 serves as an example of the legal protection of the rights of people with mental illness.

Resources are still insufficient to meet the growing burden of mental illness and their distribution is uneven and often skewed toward the hospital model, which consumes the vast majority of human and financial resources earmarked for mental health. This limits the proper development of community-based mental health services. It is urgent to accelerate processes conducive to creating the conditions needed to step up the process of deinstitutionalizing psychiatric care in LAC, and it is something that is indeed possible given the region's wealth of experiences.

Current services should be transformed or restructured to improve coverage and access to mental health care, ensuring that it is part of national universal health coverage policies.

The following four components are essential for the development of the community-based mental health model:

1. A PHC network with the capacity to handle mental health problems.
2. A network of decentralized local mental health services that are close to the population.
3. An informed and proactive community.
4. Families of people with mental illness who are committed to an attitude conducive to change, recovery, and community life.

III. Methodology used to prepare the document

This technical document is based on the following three elements: 1) an exploratory review of the literature on deinstitutionalization processes; 2) an online survey; and 3) consultation with experts.

a. Review of the literature on psychiatric care deinstitutionalization processes

The objective of the review was to improve understanding of the barriers and facilitators of deinstitutionalization processes as documented in the literature. To this end, we followed the exploratory methodology (scoping review) adopted by Arksey and O'Malley (2005), which is understood as a form of knowledge synthesis where an exploratory question is raised in order to map key concepts, sources, types of evidence, and gaps in research related to a defined field, through the systematic search, selection, and synthesis of existing knowledge *(20, 21)*.

The scoping review consisted of the systematic analysis of a wide range of materials, including published research and grey literature, in order to gain greater conceptual clarity on the subject. It specifically included:

1. Mapping the relevant literature by period and geographical location (Region of the Americas) and sources (e.g. peer-reviewed literature, grey literature, and country reports), and origin (e.g. health sciences or social sciences).

2. Identification of barriers and facilitators in psychiatric care deinstitutionalization processes.

A systematic search was conducted to answer the following question: What are the barriers and facilitators of the process of deinstitutionalizing people with severe mental illness? The international literature published up to July 2019 was included and any articles not written in Spanish, English, French, Italian, or German were excluded. Three dimensions of the research question were identified: 1) deinstitutionalization; 2) severe mental illness; and 3) barriers and facilitators.

We worked with Medline databases and performed manual searches to find other relevant articles identified in the general search. Web of Knowledge citation indexes and Scopus identified the most frequently cited literature in the area and confirmed that the key bibliography was captured. Grey literature was searched (for the purposes of this review, anything not commercially published or peer-reviewed). Searches were also conducted on relevant national institutional websites, mainly those of the ministries of health in all countries of the Region, as well as the websites of major international organizations and grey literature databases (PsycExtra, OpenGrey, and grey literature report of the New York Academy of Medicine). Finally, the results were imported into Endnote and any duplicates were removed. The following were included:

1. Research studies (experimental, quasi-experimental, observational, qualitative) and non-research studies (guides, narrative reviews, policy documents) that examined or documented deinstitutionalization processes.

2. Articles and summaries focused on deinstitutionalization. Certain documents identified in the bibliographic references of the located articles were included because they were deemed of interest using the "snowball sampling" method. Documents that addressed deinstitutionalization but only from a theoretical or conceptual point of view and opinion articles were excluded.

Two team members conducted a second review of the publications to ensure reliability among the evaluators and consistent search criteria.

b. Online survey of professionals with experience in the field of mental health and deinstitutionalization processes

The objective of the survey was to gather evidence on experiences with the deinstitutionalization of psychiatric care in the Region and identify practices that facilitate the process. It was inspired by a previous similar experience of WHO in collaboration with the Calouste Gulbenkian Foundation, which was documented in 2014 *(22)* in the Innovation in Deinstitutionalization report: a WHO expert survey (table 1).

The survey was answered by 47 professionals from 11 LAC countries who hold senior positions in the health system or academic positions and have experience in mental health and knowledge about psychiatric care deinstitutionalization processes.

The average age of the respondents was 52 (35-74 years), of whom 38% were women, 32% men, and 30% who did not indicate sex. The average number of years of experience in mental health work was 23.3 (6-40 years).

The survey consisted of a section with open-ended questions and another with closed-ended questions. Closed-ended questions were multiple choice, with statements on methods or activities related to the deinstitutionalization process and the expansion of community mental health services. Each statement asked respondents to choose from five possible preset responses: two of them corresponded to a positive assessment (very useful and quite useful), two to a negative assessment (slightly useful and not useful), and one for not applicable. Responses were grouped as either positive or useful, or negative or not very useful.

To encourage respondents to be more spontaneous in their assessment, three open-ended questions were asked. These questions covered the positive aspects (effective/achieved) and negative aspects (failed/did not produce results) of methods or activities aimed at implementing the deinstitutionalization process and expanding community mental health services.

Table 1. Innovation in deinstitutionalization: a WHO expert survey

WHO-CALOUSTE GULBENKIAN FOUNDATION JOINT REPORT (2014)

The Global Mental Health Platform was a joint initiative of the Calouste Gulbenkian Foundation and WHO to generate information for obtaining evidence-based guidance and best practices to support the countries in planning mental health services. In keeping with the key objectives of the *WHO Comprehensive Mental Health Action Plan 2013-2020*, the topic of psychiatric care deinstitutionalization was prioritized in one of its reports due to the urgent need to make a radical change in the way mental illness is managed, moving it away from long-term hospitalization and toward community-based mental health care. Despite decades of promoting deinstitutionalization, psychiatric hospital-based care still dominated in the provision of services, consuming on average more than 70% of the total mental health budget in low- and middle-income countries.

CONCLUSIONS OF THE REPORT

Long-stay psychiatric institutions tend to be inefficient and frequently inhumane. Yet they continue to consume the majority of mental health budgets in low- and middle-income countries while caring for relatively few people. The survey of 78 mental health experts from various countries provided 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 using that knowledge in strategic ways appears to be a key facilitator of deinstitutionalization.

1. Community-based mental health services must be in place before institutional residents are discharged. Specific efforts are needed to reduce the number of long-stay beds, including access to social services to get help with housing, employment, and reintegration into the community.
2. The health workforce must be committed to change. It is crucial to convince psychiatrists and other mental health leaders of the benefits of deinstitutionalization.
3. Political support at the highest levels is critical. Building support across stakeholders helps overcome resistance and foster momentum for change.
4. Timing is key. Windows of opportunity (such as emergency situations and changes in political leadership) must be seized to rally support and introduce reform.
5. Additional financial resources are needed. Although institutional care tends to be inefficient, the deinstitutionalization process requires additional funds, at least in the short term.

World Health Organization, Calouste Gulbenkian Foundation. Innovation in deinstitutionalization: a WHO expert survey. Geneva: WHO; 2014. Available at: https://www.knowledge-action-portal.com/en/content/innovation-deinstitutionalization-who-expert-survey.https://www.who.int/mental_health/publications/gulbenkian_innovation_in_deinstitutionalization/en/

c. Expert opinion

Three working meetings were held with experts and professional groups with experience in deinstitutionalization processes and the reorganization of mental health services:

- First meeting: held in Washington, D.C. (United States of America) on 5-6 December 2017. Ten experts from Brazil, Chile, Dominican Republic, Peru, and the United States participated, along with PAHO's Mental Health Unit team.
- Second meeting: held in Lima (Peru) on 12-13 September 2018. Representatives of the ministries of health of 12 countries participated: Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, Jamaica, Peru, and Trinidad and Tobago, as well as officials from the PAHO office.
- Third meeting: held in Bogota, Colombia, on 8-9 October 2019. Representatives of the ministries of health of 19 countries participated: Antigua and Barbuda, Argentina, Belize, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Panama, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago, and members of PAHO's mental health team.

The participants reviewed the current situation of mental health services in LAC. In addition, they discussed the experiences and lessons learned during deinstitutionalization processes, as well as the coordination of strategies to move away from the psychiatric hospital-based mental health service model, and eliminate the stigma, abuse, and discrimination suffered by people with mental illness.

The reports on these workshops were the basis for the first draft of this document, particularly for defining work areas and recommendations for action (see paragraph VI).

IV. Barriers and facilitators of the psychiatric care deinstitutionalization process

After analyzing the results of the exploratory review of the literature, seven categories of barriers and facilitators were identified for implementing the psychiatric care deinstitutionalization process. The selected literature finds that there are more barriers in each of the categories, although some facilitators are identified as well.

The **first category** concerns the legal framework, advocacy, and policies. The existence of mental health legislation and policies that are conducive to deinstitutionalization is a facilitator. Conversely, barriers are associated with inconsistent advocacy, institutional and legal inertia, as well as a lack of support from key political figures.

An insufficient budget for mental health is the main barrier to the **second category** on economic resources and financing. Facilitators of the deinstitutionalization of psychiatric care are having sufficient financial resources and allocating resources to support the families of mental health service users.

The **third category** includes barriers associated with the conditions of mental health provider organizations. In this category, having sufficient human resources and their level of training is key. The main barriers identified are a lack of community services and spaces for service users in general hospitals, as well as gaps in provider management processes for the coordination and provision of quality care.

The **fourth category**, which is related to the previous one, identifies another barrier to deinstitutionalization: the existence of models, paradigms, and treatment practices. Lack of participation in the treatment of mental health service users, poor adherence, and the lack of effectiveness and preparation for reintegration into the community are conditions that work against the mental health model in the community. Deinstitutionalization processes are facilitated when paradigms stimulate self-care and services are implemented appropriately.

The absence or weakness of indicators is a specific barrier to information systems, which was included in the **fifth category**. Lack of information applies not only to care providers, but to the overall process involved in deinstitutionalizing psychiatric care and developing a network of community-based mental health services.

Some publications consider the characteristics of institutionalized people as barriers. For example, antisocial traits that lead to re-institutionalization, the social deterioration of institutionalized people, or family members who support hospitalization. The **sixth category** identifies facilitators that tend to support families and support groups for users of mental health services.

Finally, the **seventh category** includes certain sociocultural factors. Stigma and safety-oriented policies are seen as a barrier to deinstitutionalization, as opposed to cultural acceptance and user advocacy movements, which are facilitators.

The barriers and facilitators for deinstitutionalization processes identified in the analyzed literature are summarized in table 2. Further information on the flowchart and the selection of results and articles can be found in annex 3.

Table 2. Barriers and facilitators for deinstitutionalization processes

Categories	Barriers	Facilitators
Legal framework, advocacy, and policies	- Inconsistent and poorly defined advocacy - Institutional and legal inertia - Lack of political support (of key authorities or decision makers) to move toward deinstitutionalization	- Approval of mental health laws - Mental health policies aimed at deinstitutionalization
Economic resources and financing	- Insufficient and non-specific mental health budget - Insufficient budget to develop community alternatives - Lack of parallel financing in the transition process - Rigid funding mechanisms - Global economic crises that influence decision-making - Wars or conflicts that affect funding priorities	- Sufficient economic resources to implement deinstitutionalization, with residency services in the community and other support needed for recovery - Support for the user's family members
Mental health care providers: human and organizational resources	- Poor working conditions in public mental health services - Lack of human resources - Lack of training - Limited community supervision - Lack of health care systems in the community - Lack of hospital units for new service users - Resistance to organizational, legal, or administrative changes - Fragmentation or lack of coordination between psychiatric hospitals and other services - Lack of quality control - Lack of predictive behavior elements	- Existence of multidisciplinary teams - Availability of modern psychopharmaceuticals
Treatment models, paradigms, and practices	- Paradigms that do not encourage the participation of users in their treatment - Treatments with poor adherence - Lack of preparation for reintegration into the community - Low effectiveness of the treatment - Poorly designed programs	- Paradigm that encourage autonomy - Appropriate implementation of services
Information systems	- Absence or weakness of indicators	
Institutionalized people	- Antisocial traits of institutionalized people which lead to re-institutionalization - Social deterioration or impairment of institutionalized users - institutionalized people with traits that complicate deinstitutionalization - Family members who support institutionalization	- Support for family members - Psychoeducation of family members - Existence of support groups
Sociocultural factors	- Stigmatization of people with mental illness - Social policies aimed at safety and behavioral control	- Favorable sociocultural conditions - User advocacy movements - Cultural acceptance

V. Measures to move forward in the psychiatric care deinstitutionalization process and development of community mental health services in the context of Latin America and the Caribbean

In the experience of different LAC professionals, it has been observed that the same measure or action will be useful both for expanding community mental health services and for reducing the institutionalization of psychiatric care. According to the 47 participants in the online survey, the methods described are useful for both processes, since they are interrelated.

The measures or actions most often deemed useful (by approximately 70% of the respondents) both to expand community mental health services and reduce institutionalization (selected from the multiple-choice answers to some of the questions) are those related to:

- The reduction of psychiatric hospitals, i.e. eliminating beds, closing the front door, reducing admissions, and moving institutionalized service users to community residences.
- Community mental health services, including self-help groups, the integration of mental health into PHC, community residential services, day services, and community mental health centers.
- Mental health legislation, policies, and plans.
- Training of health professionals and technicians.
- Advocacy and education with mental health professionals.

The measures or actions deemed of limited usefulness for both processes (approximately 40% of the respondents) are those related to:

- Advocacy and education of the government with nongovernmental organizations (NGOs) and user's family members.
- Outpatient care in general hospitals.
- Mental health telemedicine.
- Mobile clinics or extension services.

See annex 3 for details on the percentage distribution of responses to each measure or action (closed-ended multiple-choice questions).

Based on the accumulated experience of the professionals surveyed, the responses to open-ended questions tended to describe positive or synergistic factors that support the implementation of the deinstitutionalization of psychiatric care and are conducive to the implementation of community-based mental health services. They also described the unfavorable or negative factors in the implementation of both processes. The answers are summarized below, paraphrasing the surveyed professionals' own words.

The factors that support the expansion of community mental health services and reduce institutionalization are described as:

1. **Essential support:** key elements for change that make it possible to initiate and maintain the deinstitutionalization process.

    a) ***Enforcement of laws and policies:*** which translate into regulations, health plans, and treatment protocols that facilitate the implementation of community mental health services and restrict admission to psychiatric hospitals.

    b) ***Budget and economic resources:*** flexible financing mechanisms to be adapted to specific opportunities or needs. This notably includes funding for rehabilitation and social reintegration with ongoing personalized and multidisciplinary support, and long-term follow-up, which entails having new resources.

    c) ***Political will, commitment and leadership:*** Change is only achieved if there are people committed to political action in favor of deinstitutionalization. Commitment is also indispensable among the people involved in change management.

    d) ***Assimilation of the new community mental health model:*** The new paradigm must be accepted by society. Despite the benefits of the community model, traditional mental health services still persist to varying degrees. The community mental health model is defined as multisectoral and multidisciplinary. In addition, the inclusion of unconventional health professionals (such as anthropologists, sociologists, educators, and actors) is mentioned. The need for inter-level coordination and communication to build the health network is also mentioned. This model is consistent with the concept of family health.

    e) ***The new community mental health paradigm should be reflected by:*** viewing mental health as equal to other health conditions, including the community model in the training programs for health professionals, and having the support of scientific and professional societies.

    f) ***New indicators and ways of registering users of mental health services and mental health care activities.***

    g) ***Training and education in the community model (technical and attitudinal skills):*** This should be crosscutting for professionals involved in mental health work, as well as for technicians and administrative staff at the three levels of care. The family should also be educated to recognize symptoms, the early stages of crises, what to do during crises, and the use of the health care network. In addition, train key actors such as neighborhood leaders and heads of community organizations (religious leaders, teachers, etc.) on how to understand mental health and address the stigma that affects people with mental illness, and their reintegration into the community, including their duties and rights.

    h) ***Public awareness:*** Consider respect for the human rights of all citizens, creating movements to support the human rights of people with mental disorders, which includes returning their essential rights such as dignity and freedom. People with mental illness are everyone's responsibility and should not be excluded from civic life.

2. Diversity of services (active, in-person, and nearby) that respond to people's actual needs.

   a) **Community mental health center:**

      - ***Ability to address mental health problems:*** includes the availability of timely and appropriate medications, hours of service based on community demand, and the development of specific programs such as treatment programs associated with alcohol and drug use.

      - ***Field visits to identify needs and problems,*** as well as current leaders and resources in the community.

      - ***Multidisciplinary care:*** participation of professionals such as psychologists, social workers, nursing professionals and occupational therapists, among others.

      - ***Cross-sectoral and community efforts:*** coordination to build networks with key community actors such as schools, churches, neighborhood associations, and more.

   b) **General hospital with mental health and psychiatric unit:** when integrated into the service network, the general hospital coordinates the continuity of care with the community mental health center, avoiding hospitalization in the psychiatric hospital. It provides care for psychiatric emergencies, admissions, psychological and psychiatric consultations, mental health consulting services, and liaison psychiatry.

   c) **Discontinuation of new patient admissions in psychiatric hospitals:** This is a very effective action that leads to the development of other strategies without hospitalization, such as short-stay hospitalization in the general hospital. The discontinuation of new admissions must be accompanied by actions for discharging hospitalized individuals. The following steps have been described as effective:

      - Preparing institutionalized people for discharge, specifying the team responsible for the process in the psychiatric hospital and the formulation of customized rehabilitation plans (with targets, follow-up, and evaluation) for life in the community, based on the person's degree of functionality.

      - Rebuilding family connections.

      - Supporting rehabilitation and reintegration into the workforce.

      - Coordination or creation of a network of outpatient health services so that the user and his/her family know who they can turn to in the event of a crisis.

      - Availability of medicines in community mental health services.

      - Working with the community to support the user's recovery and contribute to their social integration.

   d) **Creation and support of "intermediate care" services:** half-way houses or supervised residences and day hospitals, which enable institutionalized people to live in the community if they have no family that can take them in. These services are considered very useful, although it can sometimes be difficult to implement them due to lack of funding.

The following negative elements are not conducive to the deinstitutionalization of psychiatric care and expansion of community mental health services:

1. **Political, economic, social, and environmental context of the countries**

    a) ***Laws and policies:*** the absence of laws supporting deinstitutionalization and community mental health services makes it difficult for changes to last or for stakeholders to fulfill their commitments. There is a lack of political will to create laws that support community mental health.

    b) ***Reduced and unstable budget:*** The absence or weakness of legal regulations makes it impossible to guarantee the economic and human resources needed to implement change. Also mentioned is the delay in releasing funds to be used to make changes, or that these funds were diverted for other purposes.

    c) ***Stigmatization of people with mental illness:*** The perception about people with mental disorders does not match reality. They are viewed as dangerous, which impedes their social reintegration. The media generates negative publicity by sensationalizing certain episodes of violence involving people with mental illness, labeling them a danger to society.

2. **Stagnation or obstruction in the health system:**

    a) Persistence of the biomedical model in mental health, i.e. a model focused on curative clinical care only

    b) Unrealistic expectations in terms of the complexity of deinstitutionalization.

    c) Resistance on the part of professional associations and psychiatric hospital worker unions to change established practices and incorporate new ones. They do not want to lose the financial conditions they have gained or do not want to venture out into the community.

    d) Scarcity and instability of specialized human resources in outpatient mental health care centers. There is a high turnover of trained professionals, mainly due to lack of financial resources or incentives and the rigors of the work itself.

    e) Unresponsive PHC centers that fail to meet the needs of people with mental illness. The professionals are not always supported and supervised by specialists. The supply of medicines is irregular, resulting in discontinuity of treatment. When psychiatric hospitals were closed, people with mental illness did not have anywhere to go or anyone who would care for them in the community.

3. **Factors or interventions that did not work or were implemented with limitations:**

    a) Poor monitoring and tracking of the new practices implemented.

    b) Prevention and promotion actions in different areas were limited, with a lack of intervention protocols or a definition of the roles of each actor.

c) Although the development of services in the community was observed, new service users continued to be admitted to psychiatric hospitals.

d) Coordination between different actors within the health system was insufficient.

e) Lack of funding to implement residential and intermediate care services, such as halfway houses or supervised community residences and day hospitals. These services are considered very useful for deinstitutionalization, especially when hospitalized people have lost contact with their families. There are difficulties in providing quality care in these residential services, which could become a new small-scale version of a "mental asylum."

f) People with severe mental illness or significant loss of functionality, as well as those with impaired family networks face more difficulties in their social and work reintegration. There were no specific types of support for this population profile.

g) There is a lack of evidence and scientific support. Changes and improvements have not been recorded, so there is not enough supported evidence to show the benefits of the change.

In the experience of survey participants, there was consensus that the deinstitutionalization of psychiatric care is necessary to develop a more modern, effective, and efficient mental health system in LAC. The methods deemed useful and the obstacles encountered indicate a certain degree of similarity between countries.

VI. Areas of work and suggestions for moving toward the deinstitutionalization of psychiatric care in Latin America and the Caribbean

The deinstitutionalization of psychiatric care is a complex process that involves changes at all levels of the health system. After incorporating the views of different experts, four areas of work were identified, with guidelines or suggestions for action in each area. This should provide operational guidance for countries engaged in the restructuring of mental health services.

6.1 Legislation and policies

Appropriate legislation provides a legal framework that protects and facilitates advancement of the process of deinstitutionalizing psychiatric care.

In some countries, legal instruments have been powerful catalysts. If there is no legal framework or if existing legislation is implemented on a limited basis, the risk of negative outcomes may increase. The legal framework is crucial to ensure respect for the human rights of people with mental illness. It is essential to enact a mental health law that includes a ban on institutionalization in psychiatric hospitals. However, the absence of a mental health law should not be considered an unsurmountable obstacle to deinstitutionalization, especially if there is political will on the part of government authorities. Political will is an essential element for driving reforms in the field of mental health. Educating and motivating political leaders and policy-makers is imperative.

Strategies for action

- Review current legislation, regulations, and existing policies and plans in the health and other sectors. In addition, the extent to which they legally support the expansion and restructuring of health services should be determined.
- To facilitate deinstitutionalization, international instruments and agreements should be used, especially those related to disability and human rights. These include the Caracas Declaration, the resolutions of PAHO and WHO governing bodies, WHO's QualityRights initiative, the Convention on the Rights of Persons with Disabilities, as well as other conventions and declarations of the United Nations system and the Inter-American Human Rights System.
- Promote the creation or revision of a mental health law with an inclusive strategy that incorporates all key actors and strengthens the multisectoral and inter-agency approach.
- Strengthen the human rights focus in legislation, regulations, and mental health policies and plans.

- Promote social protection policies, with the goal of ensuring access to subsidies, job offers, and other benefits for people with mental disorders and disabilities, as well for those with physical disabilities.
- Try to get the media to report appropriately, with a view to broadening the discussion on mental health and deinstitutionalization, and address stigma and discrimination.
- Inform and raise the awareness of the community and families about community-based mental health, covering specific angles that are meaningful to the population, such as institutionalized children. It is important that communicators and their messages are consistent and aligned.
- Coordinate with the judicial system to reduce the stigma and discrimination of people with mental illness.
- Provide refresher training for legal professionals such as lawyers, judges, and legal scholars.
- Promote the inclusion of community-based groups and NGOs in the deinstitutionalization process.

6.2 Funding and allocation of resources to restructure mental health services

Funding is a major challenge in the deinstitutionalization process. In most LAC countries, the budget allocated to mental health is small, in some cases less than 1% of the total health budget. Moreover, most of the funds are allocated to psychiatric hospitals. The restructuring of mental health services and deinstitutionalization require financial decisions.

Although investing in community-based mental health services produces medium- and long-term benefits, an initial investment is needed in the short term. There are sometimes financial incentives to not reduce the number of beds in psychiatric hospitals. For example, a reduction in the number of beds may be associated with a decrease in budget.

Significant barriers or limitations include:

- Difficulties in allocating funds and resources for new decentralized and community services, as well as for programs to monitor users in the community.
- Generally, transferring financial, physical, and human resources from psychiatric hospitals to community services is complicated and requires efficient planning and management.
- There are problems with relocating professionals and other workers from psychiatric hospitals, as well as difficulties in allocating resources for certain relocated positions. Conflicts with workers' unions may halt the deinstitutionalization process, but the cost of doing nothing is higher.
- The first stage of the deinstitutionalization process may entail additional costs.

Strategies for action

- Financial planning for the restructuring of mental health services should include not only a calculation of immediate, direct, and associated expenditures, but also an analysis of medium- and long-term financing and funding sources.
- Clearly identify where resources are allocated and what they are to be used for.
- Evaluate alternatives in the event of difficulties in allocating funds and resources for new decentralized and community services, as well as for monitoring users in the community. An example would be transferring entire units from the psychiatric hospital to the general hospital.
- Ensure systematic control and supervision of the use of financial resources.
- Prevent other sectors of government from appropriating resources that may be temporarily available during the process of reorganizing mental health services.
- Prioritize job relocation for health professionals and other workers from psychiatric hospitals.
- Conduct comprehensive studies that include the economic dimension of deinstitutionalization processes and include:
    - a comparative analysis of the health, social, and economic impact of the monovalent psychiatric hospital-based model versus the community model, and
    - a cost analysis per long-stay patient in the psychiatric hospital compared to in residential services in the community.

6.3 Organization and effective integration of mental health services into the health systems

The **first level of care** is responsible for the promotion and comprehensive protection of the physical and mental health of the population. PHC plays a critical role in the proper functioning of a mental health system; and developing PHC with a territorial approach is recommended. Primary care professionals should ensure that people with mild or moderate mental disorders receive: 1) a simplified but standardized assessment and diagnosis (e.g. according to the Mental Health Gap Action Programme, mhGAP), 2) listening and support, 3) treatment, and 4) continuity of care. In moderate and severe cases that require more complex interventions, PHC professionals should ensure efficient referral and counter-referral mechanisms.

Another key role of PHC is to educate the community in order to reduce stigma and discrimination. Mental illness and disability should not be associated with stigma or any form of human rights violation. The stigmatization of mental illness is a major barrier to deinstitutionalization. For example, the idea that people with mental illnesses are "violent" or pose a danger to the community is widespread and is used as justification for putting them in psychiatric or closed-door institutions.

Outpatient mental health services comprise the **secondary specialized network** closest to PHC, providing a link with general hospitals. Their position in the service network is essential for development of the community model, as they support and contribute to the building of PHC capacities. They are organized based on the structure of each health system.

General hospitals play an important role in the mental health services network. Depending on the needs of users, they handle crises or emergencies, brief hospitalizations, specialized monitoring of cases, and liaison psychiatry, and may act as a specialized support team for PHC.

There have been successful experiences with residential solutions for the recovery of people with severe long-term mental illnesses, especially those discharged from psychiatric hospitals who have disabilities and difficulties in terms of their reintegration into the community. There are various models of community residential services, as well as psychosocial rehabilitation programs and services (which in some cases were developed through public-private partnerships) and specific networks for the comprehensive care of people with long-term severe mental illness. The territorialization of mental health services and a collaborative approach with psychosocial support and rehabilitation plans are positive experiences that have been successful in some countries.

The development of an integrated network of mental health services that covers the different levels of the health system is essential. The integrated network should have mechanisms for working with users and their families and promoting self-care and the role of community actors. The network is coordinated with PHC, specialized mental health services, general hospitals, and residential services. It is important to note that experience has demonstrated that mixed models—i.e., where psychiatric hospitals and community mental health services coexist—end up preventing reform and contribute to the institutionalization of people in mental asylums (3).

Strategies for action

Deinstitutionalization

- Conduct a clinical, functional, and social evaluation of individuals admitted to psychiatric hospitals in order to develop an individualized and comprehensive therapeutic plan that includes their reintegration into the community.
- Develop a multi-stage deinstitutionalization plan. The number of beds should be reduced and services should be closed at the same time as out-of-hospital alternatives are offered, in order to meet the needs of users.
- The recommended first step is to move short-stay services, emergency services, and outpatient consultations. These services can usually be transferred to general hospitals and outpatient clinics.
- Quickly discharge those people with severe mental illness who can immediately return to the community with specialized support and monitoring.
- Determine how many people admitted to psychiatric hospitals are considered complex cases from the standpoint of community reintegration. For these people, residential services may need to be available.

Integration of mental health into primary health care

- Increase PHC's mental health treatment capacity.
- Connect mental health teams with PHC teams in an organic and functional manner. A specialized consulting strategy and the mobilization of mental health teams through regular rounds in PHC units helps expand territorial coverage, facilitates access to mental health services, and improves the relationship between users and professionals, making it more intimate and personalized.
- Establish protocols for mental health care in PHC and for referrals between the first and second levels of care.
- Ensure adequate distribution and availability of essential psychopharmaceuticals at the different levels of care, especially for the low-income population.
- Include community workers in the monitoring of people with mental disorders, the same way some chronic noncommunicable diseases are monitored on an outpatient basis.
- Ensure that specialized mental health staff supervise the most complex cases treated by PHC professionals.

Outpatient mental health care services

- Develop a decentralized network of outpatient mental health services in order to achieve broad and uniform specialized coverage in each territory. PHC network services should be as local as possible in order for the integration process to be most effective.
- Set up case management, formulating an individualized treatment plan for each user of mental health services, paying special attention to people with severe mental illness and the associated disability.
- In each territory, link outpatient mental health services both to PHC units and to general hospitals, ensuring that an integrated and functional network of mental health services connects the first and second levels of care.

Mental health units in general hospitals

- Develop mental health units with beds for stays in general hospitals, at the same administrative level as other hospital sections.
- Define the roles of mental health units in general hospitals based on national conditions (crisis or emergency care, brief stays, specialized case monitoring, liaison psychiatry, and specialized teams to support PHC).
- Use all types of incentives, including financial incentives, to encourage the use of psychiatric beds in general hospitals and discourage their use in psychiatric hospitals.
- Overcome the resistance of general hospital managers and health professionals to setting up mental health units in their facilities.
- Train general hospital staff in mental health, with a special focus on emergency care.

Residential services in the community

- Develop community residential services modalities that meet the country's needs and existing conditions. These services may be supervised homes, halfway houses, community residences, psychosocial rehabilitation centers with cross-sectoral support, and surrogate families. Other alternatives include psychosocial rehabilitation programs developed through public-private partnerships, networks for the comprehensive care of people with long-term severe mental disorders, and family care support programs, among others.
- Set up territorial networks linking outpatient mental health services at the secondary level of care, mental health units in general hospitals, and residential services, in a collaborative approach with support and psychosocial plans.

6.4 Training

Health teams at all levels should receive training in mental health. Training should address the deinstitutionalization of psychiatric care as an important part of the reform and modernization of the mental health services network.

These training processes have a dual purpose. On the one hand, they convey knowledge and build the treatment capacity of staff. On the other hand, they educate and raise awareness in health teams in order to achieve a gradual change in attitude towards mental illness.

Strategies for action

- Organize mental health training that is comprehensive, ongoing, and systematic. The initial and priority target audience should be PHC physicians, followed by other professionals and health workers, including non-clinical administrative staff.
- Provide a training program with appropriate content based on practical needs. The following content is recommended:
    - deinstitutionalization of psychiatric care with a multisectoral approach;
    - community mental health model;
    - protection of the human rights of people with mental illness.
    - empowerment of people with mental illness
    - basics concepts of emergency care.
- Develop or adapt training manuals with standard, evidence-based procedures.
- Set up an in-service monitoring and follow-up process.
- PAHO and WHO recommend using the mhGAP program as a tool for training non-specialized health professionals, especially in PHC (3).
- Health ministries and universities in the countries must continually adapt their mental health curriculum (undergraduate and postgraduate).

VII. Evaluating psychiatric care deinstitutionalization processes

The process of deinstitutionalizing psychiatric care must be evaluated. To do so, basic and reliable data is needed on psychiatric hospitals and the provision of mental health care in the context of the health services network at the different levels. This data is used to conduct a situation analysis in the country, identify priorities, and establish a baseline. The analysis should include an evaluation of the types of support available when users leave the psychiatric hospital. The status of discharged individuals must be monitored to periodically assess their psychosocial well-being *(23)*. It is recommended that the user's family members be included into the process of analyzing the available information. The main aspects of this assessment are as follows:

1. Gradual closure of psychiatric hospitals: reduction of beds and services.
2. Individualized and comprehensive evaluation of people admitted to psychiatric hospitals: a) clinical condition; b) degree of disability; and c) social functioning.
3. Identification and quantification of the types of support available to users discharged from a psychiatric hospital: (a) families who take them in; (b) community residences; (c) supervised workshops; (d) community-based psychosocial rehabilitation programs; (e) employment programs for individuals with disabilities, and (f) social protection programs, etc.
4. Strengthening PHC mental health treatment capacity: a) number and rate of cases with mental health problems treated at the PHC level; and b) referrals to the secondary level.
5. Expansion and strengthening of the mental health services network: (a) number of decentralized outpatient mental health services; b) percent coverage of the population; and c) number and rate of cases treated.
6. Capacity of general hospitals to hospitalize people with mental illness, and alternative crisis and emergency management: a) number of mental health units in general hospitals and number of beds; and b) number of people with mental illness treated by the general hospital's emergency services.
7. Alternative residential solutions capacity: for users discharged from psychiatric hospitals who are unable to reintegrate into the community *(24)*.
8. Community education and awareness-raising programs: focused on mental health and combating stigma and discrimination *(25).*
9. Regular reporting on the follow-up of service users discharged from the hospital: especially severe cases, whose well-being and health status should be frequently assessed *(26)*.
10. Operational availability of cross-sectoral collaboration: (a) multisectoral coordination agency operating on a regular basis; and b) programs currently in implementation.

WHO-AIMS *(17)* is an excellent tool that contains indicators related to the deinstitutionalization of psychiatric care. Basic indicators include the number of psychiatric beds (total and by category), the categorization of people admitted for mental illness by sex, age, diagnosis, and length of stay, as well as the number and size of the psychiatric institutions.

VIII. Models for the deinstitutionalization of psychiatric care and the development of community mental health services suggested by international references

The results of the analysis obtained from the exploratory review of the literature, the online survey of professionals with experience in mental healthcare restructuring processes in LAC, and workshops with experts all agree that psychiatric care deinstitutionalization is necessary and possible in the Region.

After completing the analysis for constructing this document, certain models for implementing the restructuring of mental health services were specifically mentioned by some of the experts. They suggested that these models could be highlighted as part of this technical document, given their high degree of consistency and agreement with the analysis conducted and because they focus specifically on deinstitutionalization. It was felt that keeping them in mind could contribute to the psychiatric care deinstitutionalization processes in LAC.

A balanced care model for mental disorders

The balanced care model is an evidence-based approach that is systematic yet flexible and is used to plan and implement care for people with mental disorders. It was primarily developed based on the work of Thornicroft and Tansella *(27-29)*, which some countries consider in their planning processes for restructuring mental health services.

The Lancet Commission on Global Mental Health and Sustainable Development (2018) presented a table describing the mental health service components relevant to environments in low-, middle-, and high-income countries based on the balanced care model *(30)*. The model has been adapted to reflect resource-based contexts, recognizing the wide inequalities within each country as well as between countries (table 3). The model has been developed with an emphasis on the need to strike a balance between the different service delivery platforms, adapted for each resource configuration.

The "increasing, decreasing, enhancing, assessing, learning" (IDEAL) model

The logic of the "increasing, decreasing, enhancing, assessing, learning" (IDEAL) model *(31)* suggests that a plan to move away from psychiatric hospitals is based not only on relevant arguments, but also on the urgent need to give policymakers, professionals, and stakeholders concrete strategies and practical suggestions on how these institutions could be scaled down so that they are ultimately abolished and replaced by a strengthened and decentralized mental health system that includes residential services for people with long-term severe mental illness, which are located in the community, as well as beds in general hospitals for acute cases, and community-based mental health services. The model is organized in three specific programs (table 4), and also includes assessment activities and learning from the good practices developed during the process.

Table 3. Lancet Commission on Global Mental Health and Sustainable Development (2018): A Balanced Care Model for Mental Disorders

This balanced care model stresses the importance of evidence-based community and cross-sectoral interventions (provided outside the medical care framework), such as employment opportunities, child protection services, measures to improve community understanding of mental illness and available services, long-term social care, and suicide prevention measures.

In low-income settings, the focus is on increasing the capacity of PHC and community health staff, as well as providers in other relevant settings such as schools and the criminal justice system. These individuals should acquire and practice the skills needed to identify and care for people with mental disorders. For children and young people, there must be better integration of mental health care into a variety of platforms that address their concerns, especially in terms of education, child protection, PHC, child health services, and social care settings.

In middle-income environments, the provision of mental health services should be strengthened across all community and PHC platforms, and a wide range of community and hospital secondary and tertiary services should be added.

In high-income settings, the balanced care model proposes that each of these four platforms (community and cross-sectoral interventions, primary, secondary, and tertiary health care) should be strengthened in terms of coverage, degree of specialization (e.g. early intervention teams for people in the first episode of psychosis), and a wider range of evidence-based interventions should be provided in an integrated manner.

This model foresees a progressive trend in the range of resource configurations for the various components of the different platforms. For example, when long-stay psychiatric institutions continue to be a major and even predominant form of service delivery, it is a priority to have a structured process for moving people from hospital rooms in psychiatric hospitals to general hospitals and community settings.

Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P et al. The Lancet Commission on Global Mental Health and Sustainable Development. Lancet. 2018 Oct;392(10157):1553-1598. Available at: https://pubmed.ncbi.nlm.nih.gov/30314863/.

Table 4. The "increasing, decreasing, enhancing, assessing, learning" (IDEAL) model

The **IDEAL** model means:

- **I**ncreasing community care for users who are able to leave psychiatric hospitals.
- **D**ecreasing new admissions in psychiatric hospitals.
- **E**nhancing the quality of care and respect for the rights of those who are still in psychiatric hospitals.
- **A**ssessing the process on a periodic basis.
- **L**earning from other experiences and best practices.

It stems from WHO's questioning of the concept and practice of psychiatric hospitals and large institutions and is based on two main fundamental arguments:

- The moral argument, i.e. the systematic and ubiquitous violation of human rights in psychiatric institutions.
- The proven profitability of developing community-based mental health care.

The model is organized around:

- The establishment of three different simultaneous programs (IDE).
- Ongoing assessment (A), and
- Peer learning and good practices (L).

The three programs (IDE) are associated with three areas of virtual action in psychiatric hospitals: the exit door, the entrance, and the inside space.

The **first program** (increased community care for those who are able to leave psychiatric hospitals) operates with a focus on the exit door and the group of users whose clinical and social conditions (severity, symptoms, family support, existing community resources) allow for a relatively easy discharge. This group of users should be identified through a careful social and clinical evaluation by a group of professionals (nursing professionals, psychologists, psychiatrists, social workers, and occupational therapists) who will be in charge of identifying potential solutions for each user within his or her community (family or independent and supervised solutions), and negotiating their discharge with local communities, families, and PHC services.

The **second program** (decreased number of new service users admitted to psychiatric hospitals) works with a focus on the entrance. It requires a limited group of well-trained staff to identify geographic catchment areas that could significantly reduce the number of new users admitted to psychiatric hospitals.

It should be noted that deinstitutionalization is all too often considered exclusively as a process aimed at discharging service users from psychiatric hospitals. However, the main factor that promotes a gradual decrease in the size of psychiatric hospitals is reducing the number of admissions rather than increasing the number of discharged users.

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Paradoxically, if a psychiatric hospital stops admitting new service users, it will disappear in 25 years as a result of the natural death of its hospitalized population. Conversely, even if a psychiatric hospital discharges a significant number of users (e.g. 50%) yet continues to admit new users, it will continue to exist forever due to turnover from having a new population of young chronic users.

In other words, when the health authorities find it difficult to discharge a large number of chronic hospitalized individuals, a successful strategy is to slowly but systematically reduce new admissions. The main objective of this program will be to establish connections with health and mental health services located in geographic areas where the organization of mental health care is relatively rich in human and logistical resources. These areas could be the first to commit to reducing admissions to a psychiatric hospital. The presence and availability of beds for people with acute episodes of mental illness in the general hospital would logically be a key factor in facilitating the progressive reduction of hospital admissions in psychiatric hospitals. In other words, those geographic catchment areas that have a community mental health service or team and the potential to admit acute cases to the general hospital will be best positioned to halt new admissions to the old psychiatric hospitals.

The **third program** (enhancing the quality of care and rights of those who remain in psychiatric hospitals) operates within the hospital setting and requires a broader group of workers (mainly nurses, occupational therapists, and psychologists) who can significantly improve the living conditions of users who are not candidates for rapid discharge due to the severity of their disability, their age, or social abandonment. This means significantly enhancing the protection and respect of human rights, improving various issues such as individual space, privacy, and more generally, the humanization of hospital facilities (bathrooms, bedrooms, living environments). In addition, significant entertainment activities and regular opportunities for individuals or groups to get out should be systematically developed and implemented.

Of course, the three programs must be continuously assessed (periodic assessment of the process) which should be done by an independent group of individuals (mental health and justice system professionals, human rights defenders, members of family and user associations), according to a set of pre-established indicators and quality criteria (including the regular use of the WHO *QualityRights* tool.

Staff participating in the IDEAL program should also participate in learning experiences (L) based on local trainings offered by their peers (professionals who have already gone through similar successful experiences) and, if possible, by visiting places where good deinstitutionalization practices have been implemented.

Saraceno B. Lisbon International Learning Program on Mental Health Policy and Services Organization. Module on Disability-Rehabilitation-Deinstitutionalization. Lisbon: Lisbon Institute of Global Mental Health; 2018.

IX. Key messages for action

1. Community network-based mental health services are the best option to care for people with mental illness. However, a significant number of countries continue to spend most of their limited financial resources on maintaining psychiatric hospitals. These hospitals consume large amounts of financial resources, with very poor results. They are therefore ineffective and inefficient.

2. Deinstitutionalization involves developing a network of community-based services before or at the same time as the process is being implemented.

3. It is crucial to integrate and coordinate mental health in the general health system, especially in primary care (PHC) and general hospitals. In addition, specialized outpatient services and community residential services must be developed for people with severe mental illness who cannot or do not want to live with their families.

4. Deinstitutionalization processes may be long and complex. For this reason, they require planning, resources, and political decisions that continue over time. Otherwise, there is a risk that they will stagnate or reverse.

5. Experience shows that there are several successful paths to deinstitutionalization.

6. Operational commitments need to be promoted across different sectors, agencies, and institutions within and outside health systems.

7. The participation of users and their families ensures a base to support the deinstitutionalization process.

8. It is essential to raise public awareness (of community leaders, churches, police, etc.) and work with the media.

9. Restructuring mental health services requires additional financial investment.

10. Political will is essential in order to initiate or strengthen deinstitutionalization processes, and to identify and take advantage of windows of opportunity.

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Glossary

The following working definitions should be used in the context of this technical document and should not be construed as official definitions of the World Health Organization. The terms have been adapted from those in the WHO-AIMS tool and refer to the different services that comprise the mental health services network.

Community residential facility: A community-based, non-hospital mental health facility that provides full-time accommodations for people with mental illness. They usually serve users with relatively stable mental disorders who do not require intensive medical interventions. Includes: Group residences, supervised homes, accommodations with varying degrees of supervision (no staff, with resident or visiting staff, with day staff, with day and night staff, and homes with 24-hour nursing staff), transitional or halfway houses, and therapeutic communities. Public and private for-profit or non-profit institutions are included. Community residential services for children and adolescents only, and for other specific groups such as the elderly, are also included.

Mental health day treatment facility or unit: A service that offers care to users during the day. These facilities generally: 1) are available to groups of users at the same time (rather than delivering services to individuals one at a time); 2) expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on users coming in for appointments with staff and leaving immediately after the appointment); and 3) involve attendances that last at least half a day. Includes: Day hospitals, day care centers, training workshops for people with mental illness, clubhouses, social assistance centers, employment or rehabilitation workshops, and social firms. Public and for-profit or non-profit private institutions and mental health day treatment facilities or services for children and adolescents only and other specific groups, such as the elderly, are also included.

Mental health or psychiatric unit or service in a general hospital: A mental health/psychiatric unit in a general hospital that provides care to users admitted for mental disorders. These units serve users with acute problems and the hospitalization period is limited to the shortest time possible (days or weeks). They usually also offer emergency services, external consultation, and liaison with other services or specialties. They may be part of the territorial mental health network and support primary care units. When these types of units do not admit cases but only offer external consultation and liaison or inter-consultation services, they should be considered outpatient mental health facilities. Includes: Public and for-profit or non-profit private establishments or services, crisis intervention units, psychiatric hospitalization units for children and adolescents only, which may be located in general or pediatric hospitals, inpatient psychiatric units in other community-based services for specific groups, such as the elderly. Excludes: Psychiatric hospitals and community residential services.

Outpatient mental health facility or service: Outpatient service for users that focuses on the clinical and social aspects of mental illness. They may be separate units or part of a health facility. Includes: Community mental health centers, psychosocial care centers, outpatient mental health clinics, specific outpatient services or services for specialized treatments of people with mental illnesses, external mental health consultation departments in general hospitals, mental health polyclinics, specialized NGO centers that provide outpatient mental health care (e.g. for rape survivors or homeless people). Public and for-profit or non-profit private institutions and mental health day treatment facilities or services for children and adolescents only, and for other specific groups such as the elderly, are also included.

PHC Center or Unit: A service that acts as the community's first point of contact with the health system. Primary care centers or units generally provide the initial evaluation and treatment of the most common health problems and refer those that require more specialized diagnoses and treatments to services with more highly qualified professionals (second level of care). Includes: Health centers, rural health posts, and family medicine units. Some small rural or local hospitals operate as a primary care service.

Psychiatric hospital: Specialized hospital-based (monovalent) facility or establishment that offers inpatient and residential services for people with mental disorders. The functional structure and level of medical specialization varies considerably. In some cases, long-stay custodial services are offered. Other services are also available for short and medium stays, emergency care, external consultations, specialized care, and other services such as rehabilitation, specialized units for children and the elderly, and others. Public and private for-profit or non-profit institutions, and psychiatric hospitals for children and adolescents only and for other specific groups such as the elderly, are included. Forensic psychiatric hospitals are also included. Excludes: inpatient psychiatric units in general hospitals.

Annex 1.
Selected results of the exploratory literature review

In 2019, a scoping literature review was conducted to create a synthesis of the literature regarding the barriers and facilitators of the deinstitutionalization process.

Figure A1 shows the decision flowchart for selecting articles, and table A1 lists the articles selected.

The findings of the preliminary and systematic review of the selected articles are described in paragraph 5.1.

Figure A1. Decision flowchart for selecting articles

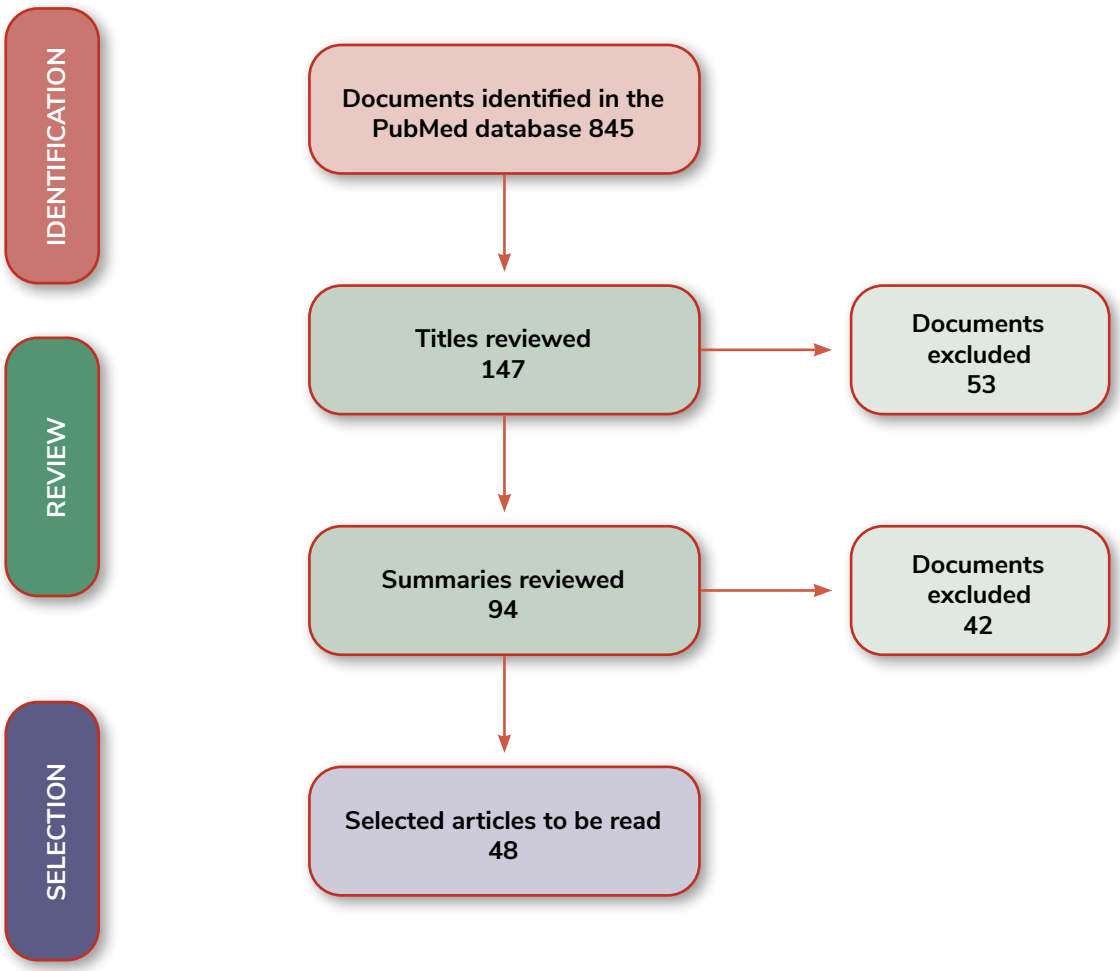

Table A1. Articles selected from the literature review

Authors, year, and country	Type	Sample	Sample Characteristics	Topics Addressed	Complete Reference
Fakhoury and Priebe (2002); United Kingdom	Literature review	–	–	Deinstitutionalization as an international process	Fakhoury W, Priebe S. The process of deinstitutionalization: an international overview. Current Opinion in Psychiatry 2002 March 15(2):187-192.
Shen and Snowden (2014); United States of America	Literature review	193	Countries	Factors associated with the adoption of public mental health policies	Shen GC and Snowden LR. Institutionalization of deinstitutionalization: a cross-national analysis of mental health system reform. International Journal of Mental Health Systems 2014 8(1):47.
Larrobla and Botega (2000); Brazil	Quantitative empirical study	10	Ministries of health, psychiatry societies, and key informants	Deinstitutionalization in Latin America	Larrobla C and Botega NJ. Las políticas de asistencia psiquiátrica y desinstitucionalización en América del Sur. Actas Esp Psiquiatr 2000 28(1):22-30.
Barbui, Papola, and Saraceno (2018); Italy	Literature review	8	Countries	Effects of mental health reforms	Barbui C, Papola D, and Saraceno B. Forty years without mental hospitals in Italy. International Journal of Mental Health Systems 2018 12(1):43.
Westman, Gissler, and Wahlbeck (2018); Sweden	Quantitative empirical study	341 630	People hospitalized or in early retirement due to mental disorders between 1981 and 2003 in Finland	Effects of mental policies	Westman J, Gissler M, and Wahlbeck K. Successful deinstitutionalization of mental health care: increased life expectancy among people with mental disorders in Finland. The European Journal of Public Health 2011 22(4):604-606
Bigby (2008); Australia	Mixed empirical study	24	Sample of 24 participants randomly selected from a group of 55 residents who moved to the community	Changes in residents in community settings	Bigby C. Known well by no-one: Trends in the informal social networks of middle-aged and older people with intellectual disability five years after moving to the community. Journal of Intellectual and Developmental Disability 2008 33(2):148-157.
Burrell and Trip (2011); New Zealand	Literature review	–	–	Post-structural analysis	Burrell B and Trip H. Reform and community care: has deinstitutionalisation delivered for people with intellectual disability? Nursing inquiry 2011 18(2):174-183.

Authors, year, and country	Type	Sample	Sample Characteristics	Topics Addressed	Complete Reference
Nolan, Bradley and Brimble-combe (2011); United Kingdom	Qualitative empirical study	44	Users of acute hospital care and users dis-charged from the clinic	User experiences	Nolan P, Bradley E, and Brimblecombe N. Disengaging from acute inpatient psychiatric care: a description of service users' experiences and views. Journal of psychiatric and mental health nursing 2011 18(4):359-367.
Anderson, Lakin, Mangan, and Prouty (1998); United States of America	Literature review	–	–	Changes in residents in community settings	Anderson LL, Lakin KC, Mangan TW, and Prouty RW. State institutions: Thirty years of depopulation and closure. Mental Retardation 1998 36(6):431-443.
Nøttestad and Linaker (2001); Norway	Quantitative empirical study	53	People with no previous self-in-jurious behaviors who developed them after deins-titutionalization	Changes in residents in community settings	Nøttestad JA and Linaker OM. Self-injurious behaviour before and after deinstitutionalization. Journal of Intellectual Disability Research 2001 45(2):121-129.
Spreat and Conroy (2002); United States of America	Quantitative empirical study	N1:33 N2:56 N3:38 N4:50	People discharged from the Hissom Memorial Center	User families	Spreat S and Conroy JW. The impact of deinstitutionalization on family contact. Research in Developmental Disabilities 2002 23(3):202-210.
Beadle-Brown and Forres-ter-Jones (2003); United Kingdom	Quantitative empirical/ cohort study	250	People dischar-ged and set up in community settings	Changes in residents in community settings	Beadle-Brown J and Forrester-Jones R. Social impairment in the “Care in the Community” cohort: The effect of deinstitutionalization and changes over time in the community. Research in Developmental Disabilities 2003 24(1):33-43.
Nøttestad and Linaker (1999); Norway	Quantitative empirical / prospecti-ve cohort study	109	People between the ages of 16 and 65	Changes in residents in community settings	Nøttestad JA and Linaker OM. Psychiatric health needs and services before and after complete deinstitutionalization of people with intellectual disability. Journal of Intellectual Disability Research 1999 43(6):523-530.
Conroy, Spreat, Yuskauskas, and Elks (2003); United States of America	Quantitative empirical study	254	Persons with developmental disabilities who moved from a large state institu-tion to community settings	Changes in residents in community settings, quality of life	Conroy J, Spreat S, Yuskauskas A , and Elks, M. The Hissom closure outcomes study: A report on six years of movement to supported living. Mental Retardation 2003 41(4):263-275.

Authors, year, and country	Type	Sample	Sample Characteristics	Topics Addressed	Complete Reference
Yazbeck, McVilly and Parmenter (2004); United States of America	Quantitative empirical study	492	Disability service students and professionals	Stigma	Yazbeck M, McVilly K, and Parmenter TR. Attitudes toward people with intellectual disabilities: An Australian perspective. Journal of Disability Policy Studies 2004 15(2):97-111.
Duhig, Gunasekara and Patterson (2015); Australia	Qualitative empirical study	13	People readmitted to hospital within 28 days of discharge	Readmission to psychiatric services	Duhig M, Gunasekara I, and Patterson S. Understanding readmission to psychiatric hospital in Australia from the service users' perspective: a qualitative study. Health and social care in the community 2017 25(1):75-82.
Hamelin et al. (2011); United States of America -Canada	Quantitative empirical study	23	Study of the effects of deinstitutionalization on intellectual with intellectual disabilities	Effects of deinstitutionalization	Hamelin JP, Frijters J, Griffiths D, Condillac, and Owen F. Meta-analysis of deinstitutionalisation adaptive behaviour outcomes: Research and clinical implications. Journal of Intellectual and Developmental Disability 2011 36(1):61-72.
Gostin (2008); United States of America	Literature review	–	–	Human rights	Gostin LO. 'Old' and 'new' institutions for persons with mental illness: Treatment, punishment or preventive confinement? 2008 Public Health, 122(9):906-913.
Friedlander (2006); United States of America	Literature review	–	–	Changes in residents in community settings, quality of life	Friedlander R. Mental health for persons with intellectual disability in the post-deinstitutionalization era: experiences from British Columbia. Israel Journal of Psychiatry and Related Sciences 2006 43(4):275.
Vandevooren, Miller, and Reilly (2007); Canada	Quantitative empirical study	25	Individuals with severe psychiatric disabilities who completed a 1-year follow-up period after discharge from the program	Assessment of the outcomes of a community intervention	Vandevooren J, Miller L y O'Reilly R. Outcomes in community-based residential treatment and rehabilitation for individuals with psychiatric disabilities: a retrospective study. Psychiatric rehabilitation journal 2007 30(3):215.

Authors, year, and country	Type	Sample	Sample Characteristics	Topics Addressed	Complete Reference
Yanos (2007); United States of America	Literature review	–	–	Urban environment	Yanos PT. Beyond "Landscapes of Despair:" the need for new research on the urban environment, sprawl, and the community integration of persons with severe mental illness. Health Place 2007 13(3):672-676.
Krieg (2003); United States of America	Literature review	–	–	Philosophy of the law	Krieg RG. A social contract for deinstitutionalization. Journal of social philosophy 2003 34(3):475-486.
Arvidsson and Ericson (2005); Sweden	Literature review	–	–	Effects of mental health reforms	Arvidsson H and Ericson BG. (The development of psychiatric care after the mental health care reform in Sweden. A case register study. Nordic Journal of Psychiatry 2005 59(3):186-192.
Thesen (2001); Norway	Quantitative empirical study	Nonspecific	Mental health users and health care providers	Stigma	Thesen J. Being a psychiatric patient in the community-reclassified as the stigmatized "other". Scandinavian Journal of Public Health 2001 29(4):248-255.
Kormann and Petronko (2004); United States of America	Literature review	–	–	Training of health care providers	Kormann RJ and Petronko MR. Community inclusion of individuals with behavioral challenges: Who supports the careproviders? Mental retardation 2004 42(3):223-228.
O'Doherty et al. (2016); Ireland	Quantitative empirical/ focus group study	40	Family members of mental health service users	Families of users	O'Doherty S, Linehan C, Tatlow-Golden M, Craig S, Kerr M, Lynch C, and Staines A. Perspectives of family members of people with an intellectual disability to a major reconfiguration of living arrangements for people with intellectual disability in Ireland. Journal of Intellectual Disabilities 2016 20(2):137-151.
Simpson et al. (2014); United Kingdom	Quantitative empirical/ comparative study	46	46 service users were recruited for the study; 23 received peer support and 23 received the usual care	Assessment of intervention results	Simpson A, Flood C, Rowe J, Quigley J, Henry S, Hall C et al. Results of a pilot randomised controlled trial to measure the clinical and cost effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK. BMC psychiatry 2014 14(1):30.

Authors, year, and country	Type	Sample	Sample Characteristics	Topics Addressed	Complete Reference
Fisher, Haagen, and Orkin (2005); United States of America	Qualitative empirical study	13	Health care center directors	Experience of health care center directors	Fisher K, Haagen B, and Orkin, F. Acquiring medical services for individuals with mental retardation in community-based housing facilities. Applied Nursing Research 2005 18(3):155-159.
Stark, MacLeod, Hall, O'Brien, and Pelosi (2003); Scotland	Quantitative empirical study	6776	People discharged from long-term psychiatric care in Scotland between 1977 and 1994	Study of cause of mortality	Stark C, MacLeod M, Hall D, O'Brien F, and Pelosi A. Mortality after discharge from long-term psychiatric care in Scotland, 1977-94: a retrospective cohort study. BMC Public Health 2003 3(1):30.
Stein (2002); United Kingdom	Mixed empirical study	58	Health teams	Risk assessment	Stein WM. The use of discharge risk assessment tools in general psychiatric services in the UK. Journal of Psychiatric and Mental Health Nursing 2002 9(6):713-724
Goel and Keefe (2003); United States of America	Literature review	–	–	Critical analysis of public policy	Goel NL, Keefe RH. Medicaid managed care meets developmental disabilities: proceed with caution. J Health Soc Policy. 2003;16(3):75-90.

Annex 2.
Results of multiple-choice questions in the survey given to mental health professionals

Method or action for deinstitutionalization	Very useful or quite useful		Slightly useful or not useful		Not applicable	
	EC (%)	RI (%)	EC (%)	RI (%)	EC (%)	RI (%)
Mental health legislation	70.6	70.6	23.5	26.5	5.9	2.9
National or regional mental health policies or plans	91.2	76.5	8.8	23.5		
Advocacy and public education						
• Government	55.9	50.0	41.2	47.1	2.9	2.9
• Nongovernmental organizations	47.1	38.2	44.1	52.9	8.8	8.8
• Mental health professionals	85.3	70.6	11.8	26.5	2.9	2.9
• Family	52.9	41.2	41.2	52.9	5.9	5.9
• Users of health services	64.7	55.9	29.4	41.2	5.9	2.9
Outpatient care in general hospitals	52.9	50.0	41.2	47.1	5.9	2.9
Community mental health centers	76.5	73.5	20.6	23.5	2.9	2.9
Integration of mental health into PHC	85.3	76.5	14.7	23.5		
Emergency rooms	64.7	55.9	29.4	41.2	5.9	2.9
Other outpatient services	61.8	55.9	29.4	32.4	8.8	11.8
Psychiatric hospitals or mental asylums						
• Closed doors	79.4	79.4	8.8	8.8	11.8	11.8
• Protocols to reduce admissions	70.6	67.6	17.6	17.6	11.8	14.7
• Elimination of beds	88.2	85.3	5.9	8.8	5.9	5.9
• Transfer from psychiatric hospital to community residence	73.5	79.4	14.7	8.8	11.8	11.8
Improvement of information system	50.0	50.0	32.4	32.4	17.6	17.6
Professional training	91.2	82.4	8.8	17.6		
Assisted employment	64.7	58.8	20.6	26.5	14.7	14.7

Method or action for deinstitutionalization	Very useful or quite useful		Slightly useful or not useful		Not applicable	
	EC (%)	RI (%)	EC (%)	RI (%)	EC (%)	RI (%)
Family-member psychoeducation	67.6	67.6	20.6	17.6	11.8	14.7
Mental health beds outside of psychiatric hospitals	91.2	85.3	5.9	8.8	2.9	5.9
Day services	79.4	76.5	11.8	14.7	8.8	8.8
Residential care in the community	79.4	73.5	11.8	14.7	8.8	11.8
Mobile clinics or extension services	47.1	41.2	23.5	29.4	29.4	29.4
Self-help and user groups	73.5	61.8	20.6	29.4	5.9	8.8
Mental eHealth	47.1	41.2	38.2	41.2	14.7	17.6

EC: Expansion of community services. RI: Reduction of institutionalization.

This technical document is a framework for action. Its objective is to guide the psychiatric care deinstitutionalization process in the context of Latin America and the Caribbean.

The essential purpose of deinstitutionalization is to limit the role of psychiatric hospitals by incorporating acute care hospital beds into general hospitals and replace those psychiatric facilities with community-supported housing solutions for people with severe mental illness. At the same time, there must be an efficient network of community-based mental health services. This involves the priority development of effective new community practices and services that protect the rights of people with mental illness.

This publication summarizes the facilitators and barriers that will be encountered in the deinstitutionalization process and identifies useful and proven interventions in Latin American and Caribbean countries.

Four areas of work are identified with the respective guidelines or suggestions for action, which should provide an operational guide for countries that are restructuring mental health services and moving toward the deinstitutionalization of psychiatric care.

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