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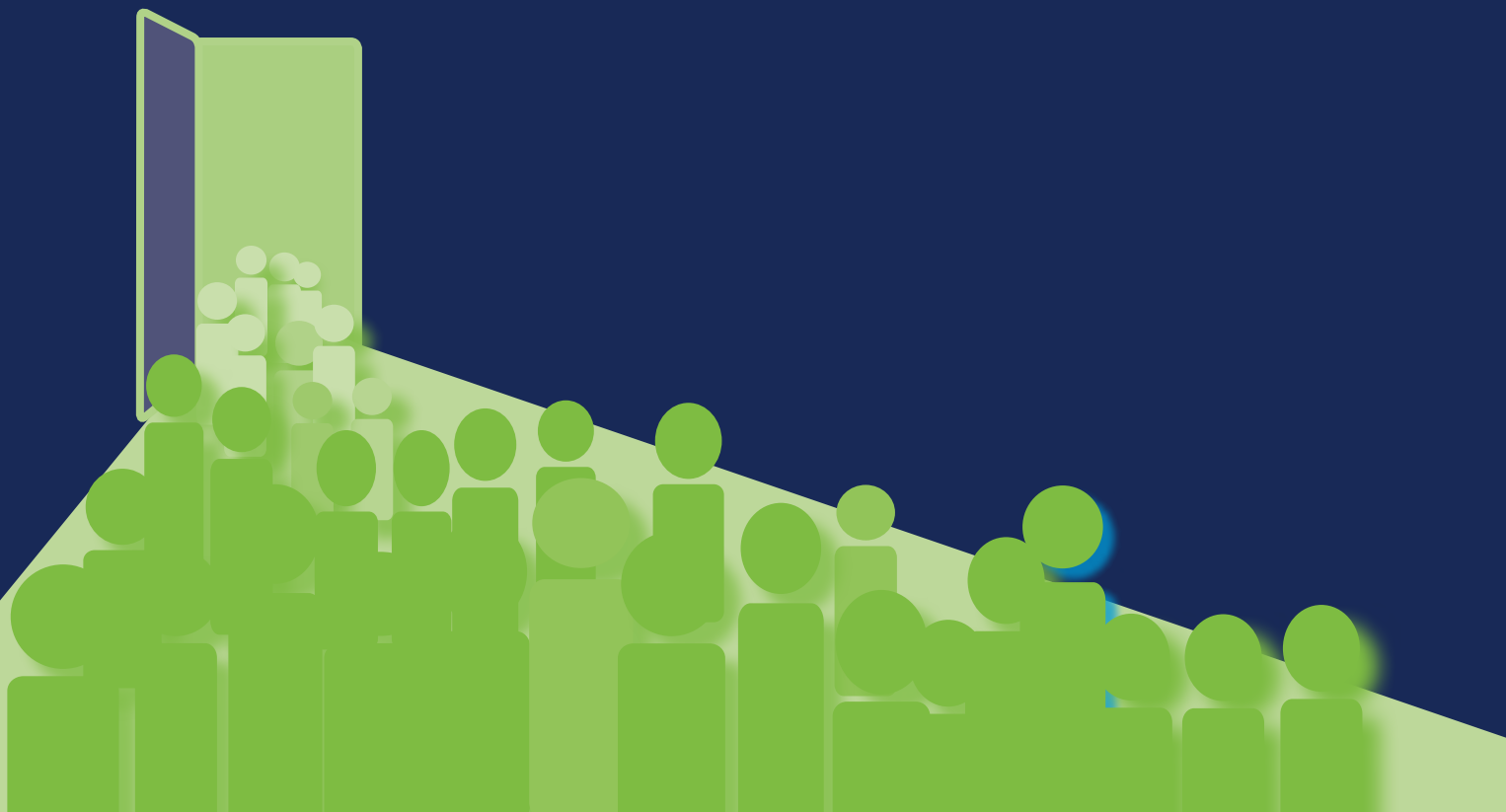
World Health  
Organization

South-East Asia

# Deinstitutionalization of people with mental health conditions

in the

WHO South-East Asia Region







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# Foreword

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The impact of mental health conditions is pervasive, touching individuals and societies alike, regardless of age, gender, geography, income and social status. Despite the enormous progress made in understanding of public mental health, long-stay institutions still exist in the South-East Asia Region as well in other parts of the world.

Within such institutions, people with mental health conditions are at high risk of isolation and social exclusion, and often experience different types of abuse and violations. By confining people with mental health conditions to institutions, the cycle of stigma and exclusion is perpetrated.

Transitioning from long-stay psychiatric institutions to community-based care is beneficial for both individuals and societies at large. This paradigm shift allows for greater personal autonomy, improved quality of life, and personalized care options. In community-based settings, individuals have opportunities to regain a sense of independence and engage in social and vocational activities, which can significantly improve their overall well-being.

From a societal perspective, deinstitutionalization is more cost-effective than maintaining large psychiatric institutions. Community-based care is often less expensive and more efficient, as it allows for the allocation of resources where they are most needed, reducing the financial burden on governments and health care systems.

As people transition from institutional settings to community care, the demand for accessible and effective mental health services in the community increases. Therefore, sustained efforts to strengthen community-based mental health care should continue in parallel. The Paro Declaration on universal access to people-centred mental health care and services, adopted by all Member States in 2022, and the Regional Action Plan for Mental Health for the WHO South-East Asia Region 2023–2030 provide impetus and pathways for establishing both deinstitutionalization and strengthening of community-based services and support systems.

There are no one-size-fits-all solutions to deinstitutionalization. Deinstitutionalization must be a context-driven, culturally attuned process. This report acknowledges the complexities and unique contexts of each country within the South-East Asia Region, offering guidance and recommendations that can be adapted to local realities. It is my hope that this report will serve as a catalyst for change, igniting a process that results in every person, regardless of their mental health condition, leading a life of dignity, purpose, and fulfilment.



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# Abbreviations

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CSO	civil society organization
HMIS	health management information system
MNSS	mental, neurological and substance-use disorders and self-harm
NGO	nongovernmental organization
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNHCR	United Nations Commission on Human Rights

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# Executive summary

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Deinstitutionalization of mental health care is the process of shifting mental health care and support from long-stay psychiatric institutions to community mental health services. For centuries, psychiatric hospitals have been the primary model for delivering mental health services. Human rights violations and poor treatment have been extensively documented in such institutions. Over the past few decades, deinstitutionalization has gained global attention, with the growing push towards community-based mental health care. The “Trieste Model” in Italy has been an exemplar, paving the way for the adoption of deinstitutionalization practices across different contexts and settings.

The Convention on the Rights of Persons with Disabilities, adopted by the United Nations in 2006, recognizes, among other rights, that of people with psychosocial disabilities to live independently in their communities.

The adoption of the Paro Declaration by the Member States of the WHO South-East Asia Region in 2022 was a major development in the Region. The Paro Declaration commits Member States to achieving universal access to people-centred mental health care and services, and to systematically planning for deinstitutionalization through a series of actions that include strengthening the capacity of primary care services to deliver mental health support, and developing community mental health networks. The declaration was followed by the Mental health action plan for the WHO South-East Asia Region 2023–2030, which aims to provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

## Methodology

To develop a comprehensive understanding of deinstitutionalization in the Region, a multi-pronged approach was used to collect and synthesize data from Member States. This included developing an overview of deinstitutionalization in the region, conducting formative research on existing datasets, literature and other government documents, conducting interviews with key stakeholders, and synthesizing the information based on the conceptual framework.

## Findings

The findings from the data collection and synthesis are presented in three sections.

Section 3 provides insights into the prevalence of mental health conditions across Member States, the current context for deinstitutionalization (including the historical and contemporary factors that have supported the deinstitutionalization processes) and the policy and legislative landscape in the Member States that consists of legal provisions that safeguard the rights of people with mental health conditions to live in the community and shift away from institutional care. This section further explores formal mental health service delivery models across the region, namely the mix of psychiatric institutions, community-based residential care services, psychiatric units in general

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hospitals and community mental health services. Other aspects of mental health are covered in this section, including mental health tele-services, mental health financing, and monitoring and evaluations.

Section 4 explores the concerted and coordinated efforts needed by key actors within mental health systems to deinstitutionalize. Government stakeholders are responsible for planning and implementing mental health plans and services, including laws and regulations that shift the focus from institutional services to community care. Civil society is also a major agent of change in relation to human rights in mental health services.

Section 5 illustrates the challenges and barriers confronting Member States in their goals towards deinstitutionalization.

## Strategies and recommendations

Section 6 highlights strategies that can be employed to prevent a return to institutionalization practices and the establishment of new institutions, and discusses strategies for prevention of institutionalization.

Section 7 presents recommendations to catalyse deinstitutionalization efforts across four main areas:

1. Policies and governance
2. Stakeholder engagement
3. Service delivery
4. Monitoring and research.



This report provides an overview of the process of deinstitutionalization of mental health care undertaken in the countries of the WHO South-East Asia Region, identifying the challenges and barriers faced by Member States, and good practices that enable recovery-oriented and rights-based deinstitutionalization efforts. It also contains regional recommendations to inform and support policy-makers on the deinstitutionalization process.

## 1.1 Background

Psychiatric institutions are specialized hospital-based facilities dedicated to the treatment of persons with mental health conditions, providing inpatient care and long-term residential services (1). For centuries, they have been the mainstay of mental health service delivery across the world. Historically, such institutions or “asylums” were custodial institutions for people with severe mental health conditions who were perceived to be a threat to society (2). Reforms to psychiatric care were triggered by poor and inhumane living conditions, segregation, social exclusion and human rights abuses faced by people living in such institutions. The global recognition of these harmful practices, the high cost of maintaining psychiatric institutions, and the introduction of effective psychotropic drugs that enabled individuals with mental health conditions to receive services closer to their communities drew attention in the mid-20th century to the need for deinstitutionalization (3).

Deinstitutionalization is the process of shifting mental health care and support from long-stay psychiatric institutions to community mental health services. There are two crucial aspects of deinstitutionalization. The first involves reforming the conditions and service delivery within psychiatric institutions and downsizing the number of long-stay beds. This is accompanied, in parallel, by the strengthening of community-based mental health facilities to ensure that those with mental health conditions receive the psychosocial support required for their recovery and integration into society within their communities (4).

The “Trieste Model” developed in Trieste, Italy shifted the mental health care paradigm from the biomedical model to one focused on recovery and psychosocial support. It was in Trieste that smaller community mental health centres, with fewer beds and the capacity to support people with severe mental health conditions, were first conceptualized. Trieste’s “whole system” approach relied on a strong network of crisis management centres, housing services and social enterprises to facilitate access to care in communities.

Following the success of the Trieste Model, good practices of deinstitutionalization have emerged in other countries and regions. For example, in Brazil, at the start of the new millennium, legislation was introduced to ban the construction of new psychiatric institutions. Simultaneously, deinstitutionalization was planned involving investment in integrated-care beds in the community, psychosocial

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care centres and residential services in the community (5). More recently, Peru, in a similar manner, legislated that mental health care move from psychiatric hospitals to a network of community mental health facilities ranging from halfway houses to mental health centres in the community (6).

In the WHO South-East Asia Region, Sri Lanka has progressed towards deinstitutionalization, which is discussed in Section 3.4.1.

## 1.2 International conventions and plans

Decades of advocacy in the protection and promotion of human rights led to the adoption of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) by the United Nations General Assembly in December 2006.

Article 12 of the UNCRPD focuses on equal recognition before the law, emphasizing the right of persons with disabilities to exercise legal capacity on an equal basis with others. Article 14 addresses the right to liberty and security of persons with disabilities, emphasizing the need to safeguard against arbitrary deprivation of liberty. Article 19 of the Convention recognizes the right of persons with disabilities to live independently, participate in their communities and have access to a range of psychosocial support services, including housing and other supported-living services (7).

In September 2022, the Committee on the Rights of Persons with Disabilities of the United Nations Commission on Human Rights (UNCHR) adopted guidelines on deinstitutionalization, including in emergencies. The guidelines firmly call on States parties to “abolish all forms of institutionalization, end new placements in institutions and refrain from investing in institutions” (8).

The adoption in 2022 of the Paro Declaration by the Member States of WHO South-East Asia Region was a major development. The declaration expresses the commitment of the Member States to achieve universal access to people-centred mental health care and services, through a series of actions that include strengthening the capacity of primary care services to deliver mental health support, developing community mental health networks and systematically planning for deinstitutionalization of care for people with severe mental illnesses (9).

More recently, the *Mental health action plan for the WHO South-East Asia Region 2023–2030* (10) provides an extensive menu of options to expand and strengthen community mental health services in WHO South-East Asia Region Member States under objective 2: Provide comprehensive, integrated and responsive mental health and social care services in community-based settings. It contains a specific indicator (the number of beds in tertiary care psychiatric hospitals) to monitor deinstitutionalization. *Mental health, human rights and legislation: guidance and practice*, jointly released by the WHO and the United Nations (11), and Section 7.1.3 of the *World mental health report: transforming mental health for all* (12) provide comprehensive guidance on reframing mental health legislation. This includes legal provisions and strategic action plans necessary for the processes involved in sustainable deinstitutionalization, such as restricting the establishment of new institutions, promoting multi-sectoral coordination for implementing deinstitutionalization actions, establishing mechanisms and bodies to repatriate survivors of forced institutionalization, and improving monitoring and evaluation of deinstitutionalization.

### 2.1 Data collection and synthesis

To understand the process of deinstitutionalization and the existing mental health system within the 11 Member States of the WHO South-East Asia Region, a multi-pronged methodology was used to collect and synthesize data from each country. The steps were as follows.

1. A framework was developed that included topics and issues relevant to the deinstitutionalization processes: the policy–legislative landscape, service delivery models, stakeholder engagement, monitoring and evaluation and sustainability of the deinstitutionalization processes. This framework formed the basis for data collection and research (Annex 1).
2. A formative review of existing datasets and documents that were available in the public domain was conducted. This included a detailed review of international reports, country-level policies and plans, other government documentation, and country-specific academic literature on deinstitutionalization and community-based care. The data from this formative review was put into country profiles (Annex 2).
3. Following the synthesis of the existing data, data-request sheets were developed and shared with WHO key focal points from the 11 Member States. To contextualize the data, key informant interviews were conducted through WHO focal points. Using a snowballing approach, relevant country-level stakeholders involved in deinstitutionalization (16 in all), including representatives from civil society organizations (CSOs), were interviewed. The interviews were conducted online for a duration of 45 minutes to 1 hour. Detailed notes were recorded by two members of the research team, who shared this with the interview participants for their verification.

The qualitative data gathered during the interviews was, as per the framework (Annex 1), to supplement the data gathered in the review stage. The findings are presented in the subsequent sections of the report.

### 2.2 Limitations

The findings in the following sections are limited by gaps in data across the different countries. Informants from the Democratic People’s Republic of Korea, Thailand and the Timor-Leste were not available for interviews. As data quality and reporting systems are limited and vary markedly across countries in the Region, it has not been possible to draw comparisons across countries.

## 3.1 Prevalence of mental health conditions

The WHO South-East Asia Region comprises 11 Member States: Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste. These countries are home to over a quarter of the world's population, with India accounting for over 60% of the region's population. In terms of economic development, Indonesia and Thailand are categorized as upper-middle income, the Democratic People's Republic of Korea is considered low-income, and the remaining eight countries in the region are categorized as lower-middle income.

In 2019, the prevalence of mental, neurological and substance-use disorders and self-harm (MNSS) in the Region was 13.2%, a marginal increase from 12.9% in 2000 (13). The prevalence of such conditions ranged from 7.1% to 18.7% (Table 1). The disability-adjusted life years (DALYs) attributed to MNSS conditions saw an increase in almost all Member States from 2000 to 2019, except in Sri Lanka (Fig. 1).

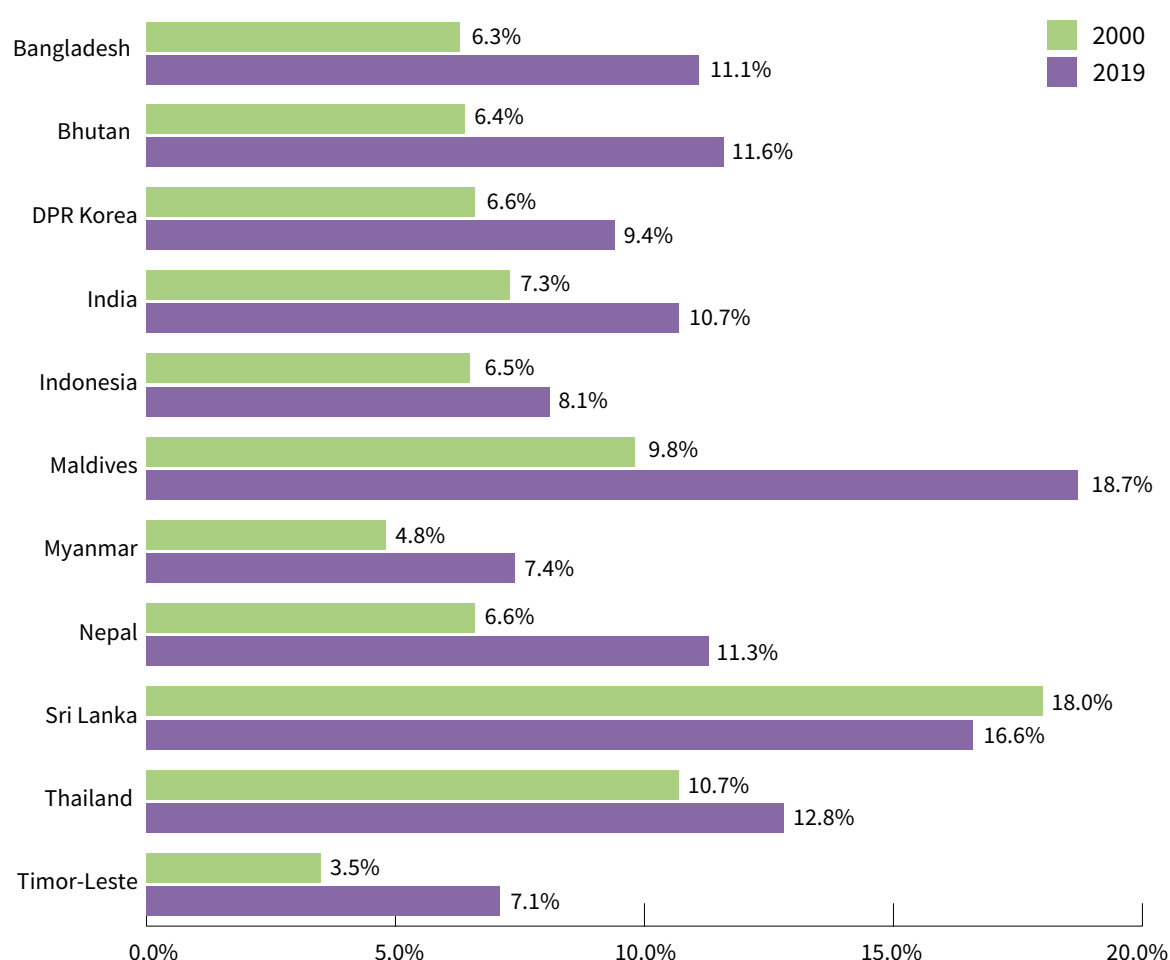
Table 1. Prevalence of MNSS conditions in the WHO South-East Asia Region

Member State	Population (millions)	DALYs due to MNSS as % of total DALYs
	2022	2019
Bangladesh	169.4	11.1%
Bhutan	0.8	11.6%
DPR Korea	25.9	9.4%
India	1407.6	10.7%
Indonesia	273.8	8.1%
Maldives	0.52	18.7%
Myanmar	53.8	7.4%
Nepal	30.0	11.3%
Sri Lanka	21.8	16.6%
Thailand	71.6	12.8%
Timor-Leste	1.3	7.1%

Sources: col. 1: *World Population Prospects (14)*; col. 2: *Mental health conditions in the WHO South-East Asia Region (13)*.



Fig. 1. Comparison of DALYs due to MNSS conditions in the WHO South-East Asia Region 2000–2019



Source: *Mental health conditions in the WHO South-East Asia Region* (13).

### 3.2 Context of deinstitutionalization

Historically, in Bangladesh, India, Indonesia, Myanmar, Sri Lanka and Thailand asylums or mental hospitals were the primary service-delivery models for mental health care. Asylums were established in the late 19th and early 20th centuries and were mainly situated in towns or cities, which led to the expansion of beds and facilities in and around the institutions (15, 16, 17, 18). In other countries, such as Bhutan and Nepal, long-stay psychiatric facilities were not the norm; decentralized psychiatric care in general hospitals was the practice. For instance, in Nepal, formal mental health services were first initiated with the establishment of a psychiatric out-patient department (OPD) at Bir Hospital in 1961 (19).

As in other parts of the world, institutional reform and, by extension, deinstitutionalization was triggered by several external factors. In Indonesia, the loss of lives and livelihoods and widespread devastation that the 2004 tsunami left in its aftermath led to an increase in mental health conditions among the population, which expedited the adoption of community mental health (20, 21).

Simultaneously, in many countries, community mental health care gained prominence in

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government policies and plans in response to a high burden of mental disability and its impact on overall health. In Thailand, community mental health services were recognized as a priority in 1976 under the Monitoring Mental Health Needs project (a collaboration with WHO). As a result, services began to extend from psychiatric institutions into general health care services (22). In Sri Lanka, the aim to establish a comprehensive and community-based mental health service to optimize the mental well-being of the population featured in the first mental health policy launched in 2005 (23).

At present, Member States are shifting their focus from institutional care to community-based services. This transition involves developing a range of community-based interventions, including residential facilities, psychiatric wards in general hospitals, primary health care services, crisis-intervention teams and psychosocial rehabilitation programmes.

While such initiatives are primarily undertaken by the government, several non-profit organizations have contributed to the expansion of community-based mental health services and safeguarding the rights and well-being of individuals with mental health conditions, particularly long-stay service users in psychiatric institutions.

### 3.3 Policy and legislative landscape

Several countries have mental health policies that prioritize community mental health and contain human rights components for people with mental health conditions to live independently with social and economic supports (Box 1).

All WHO South-East Asia Region Member States have ratified the UNCRPD. Bangladesh, India and Thailand have enacted mental health legislation with provisions for the rights of people with mental health conditions, standards for mental health establishments and admission procedures in cases where people require hospital-based support (24, 25, 26).

For instance, Bangladesh has specific directives whereby a person admitted involuntarily can only be subject to emergency admission for up to 72 hours on the recommendation of the medical officer-in-charge. This period can be extended on the recommendation of a psychiatrist, but the case is reviewed every 28 days. Admission can last a maximum of 180 days, with careful review by the Mental Health Review and Monitoring Committee (27).

Eight countries in the region have action plans supporting their national policies on mental health (28, 29, 30, 31). Several action plans lay down specific activities which are in line with deinstitutionalization objectives.

Government expenditure on mental health is indicative of a country's funding priorities. The *Mental health atlas 2020* reported that in 2017 the global median government outlay on mental health per capita was US\$7.49. The WHO South-East Asia Region reported subminimal expenditure on mental health per capita at US\$0.10 (1).

In the Region, government expenditure on mental health as a proportion of total health expenditure ranged from 0.2% in Bhutan and Nepal to 2% in Indonesia (32, 33, 34). Myanmar reported the largest expenditure on psychiatric institutions at 85% of mental health expenditure (35), closely followed

by Thailand at 81% and Indonesia at 66% (32, 36). Nepal reported 20% of mental health expenditure on mental hospitals (34) (Table 2).

Table 2. Government expenditure on mental health

Member State	Total government expenditure on mental health as % of total government health expenditure	Total government expenditure on mental hospitals as % of total government mental health expenditure
Bangladesh	0.5%	–
Bhutan	0.2%	–
India *	1.3%	–
Indonesia	2.0%	66.1%
Maldives **	–	–
Myanmar	1.4%	85.2%
Nepal	0.2%	20.0%
Sri Lanka	–	–
Thailand	2.3%	81.2%
Timor-Leste*	–	–

Sources: *Mental health atlas 2020* (32, 33, 34, 35, 36, 37, 38, 39); \* *Mental health atlas 2017* (40, 41). \*\*There are no psychiatric hospitals in Maldives. Tertiary care is provided in the Indira Gandhi Memorial Hospital (IGMH).

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### **Box 1: Protection of the rights of persons with mental health conditions to live independently in the community**

Sri Lanka released its updated National Mental Health Policy in 2021. The new policy explicitly states that “Persons who have been treated for serious mental disorders and have residual disability and who do not have family or carers for support shall be provided dignified homely living facilities in the community. There shall be a minimum of one such unit per province, with the necessary supportive staff. The necessary clinical care will be provided by the Medical Officer/Mental Health (MOMH) or Medical Officer/Psychiatry in the locality under the supervision of Consultant Psychiatrist of the area.” (42)

In India, the recently enacted Mental Healthcare Act 2017 has a similar provision that guarantees the right of every person with mental illness to live in their community and not be segregated or isolated from society. The Act also calls upon the government to “provide for or support the establishment of less restrictive community-based establishments including half-way homes, group homes and the like for persons who no longer require treatment in more restrictive mental health establishments such as long stay mental hospitals” (24).

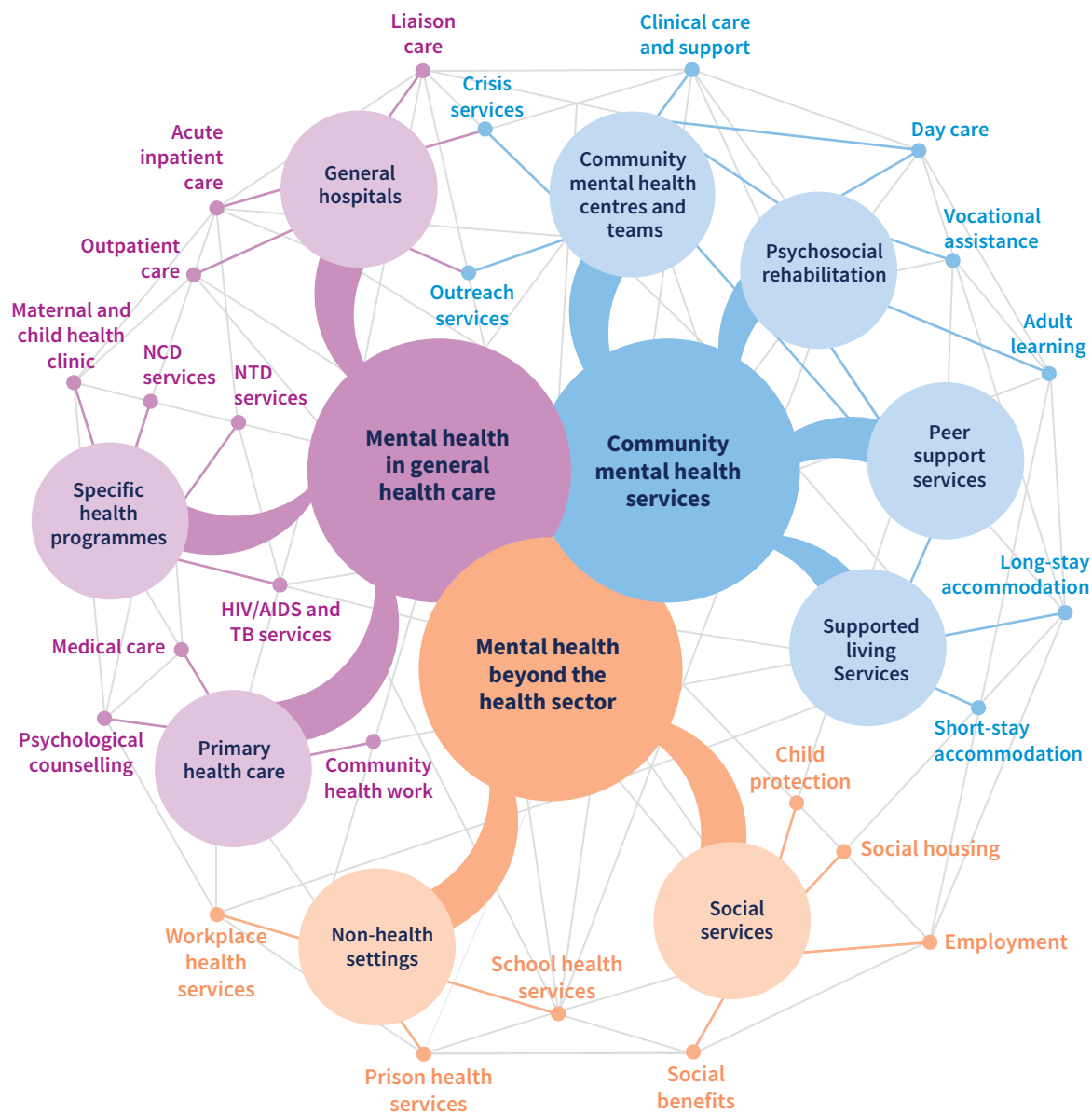
Similarly, Thailand’s Five-Year Government Action Plan (2018–2022) by the Department of Mental Health includes a provision on supporting families and communities in providing opportunities for individuals with mental health conditions to actively participate in daily life and activities according to their potential (28).

Mental health laws and regulations in Indonesia emphasize social rehabilitation and reintegration by empowering persons with mental health conditions to live independently in society (43).

### 3.4 Service delivery models

The WHO recommends that the optimal combination of formal mental health services consists of a network of community mental health care which encompasses all mental health services provided outside psychiatric institutions (Fig. 2). Such services include mental health care in primary health care settings, district or regional general hospitals with psychiatric units, community residential facilities, community-based outpatient services and other social services (44).

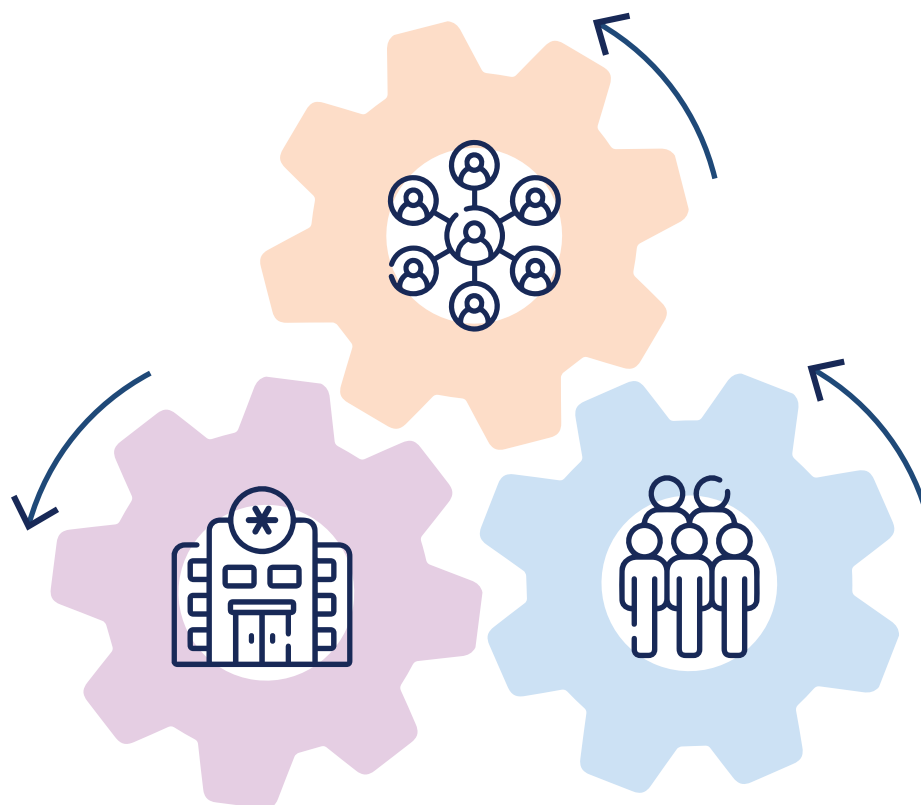
Fig. 2. Model network of community-based mental health services



Source: World mental health report 2022 (12).

Fig. 3. Approach to deinstitutionalization

**Deinstitutionalization involves simultaneously increasing discharges, reducing admissions, and scaling up care in the community**



### **Reduce admissions**

Systematically reduce new psychiatric hospital admissions and enhance the quality of care and rights of people in all inpatient or residential care.

### **Scale up services**

Build up a network of coordinated and linked community-based mental health services and social care to support anyone living with a mental health condition.

### **Increase discharges**

Progressively discharge residents of psychiatric hospitals as community-based solutions to meet their health and social needs become available.

Source: *World mental health report 2022* (12).

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The process of deinstitutionalization involves restructuring and strengthening different tiers of services available in the community (Fig. 3). For many countries, deinstitutionalization is a gradual and parallel process and cannot be immediately implemented owing to several social, economic and political considerations. In such circumstances, the IDEA approach to mental health service delivery (Annex 1) provides an additional framework to implementing deinstitutionalization processes. In this section, we discuss the service delivery models among the Member States of the WHO South-East Asia Region, categorized as follows:

- psychiatric institutions
- community-based residential care facilities
- psychiatric services in general hospitals
- community-based mental health services
- monitoring and evaluation.

### 3.4.1 Psychiatric institutions

#### ■ **Number of institutions**

Psychiatric institutions are standalone facilities providing long-term inpatient and residential services to persons with mental health conditions. Globally, there are 0.5 psychiatric institutions per 100 000 population according to the *Mental health atlas 2020*. The six South-East Asian Region countries that provided data reported fewer facilities at 0.1 per 100 000 population (1).

In 2020, eight countries in the Region reported a total of 220 psychiatric institutions. India had 136 (40) (46 of the facilities are government-run while the remaining are privately managed (44)), followed by 49 in Indonesia and 20 in Thailand (32, 36). The three countries accounted for 93% of all such facilities in the Region. In Bhutan, Maldives and Timor-Leste, there are no long-stay mental health institutions as specialized services are delivered through general hospitals with psychiatric wards (33, 37, 45).

Sri Lanka has one government-run mental health hospital (38), while Bangladesh and Myanmar have two each (35, 39). According to the *Mental health atlas 2020*, Nepal has 10 such hospitals (34). It should be noted that only one facility out of the 10 is government-run and that it has 50 beds (46).

One of the largest government-run facilities in the region is in India: the Regional Mental Hospital Yerwada with over 2540 beds (47).

#### ■ **Number of beds in psychiatric institutions**

There are 3.6 beds per 100 000 population in the Region, one-third of the global rate of 10.8 per 100 000 population (1). The highest ratios are reported in Sri Lanka (6.61) and Thailand (6.26), followed closely by Indonesia (4.19) (32, 36, 38). While India has a significantly higher number of mental hospitals, the number of beds available across the country is 1.43 per 100 000 population, which is relatively low (40). Bangladesh has a substantially lower number of beds at 0.43 per 100 000 population, while Nepal reports 0.52 beds per 100 000 population (34, 39).

The *Mental health action plan for the WHO South-East Asia Region 2023–2030* has set a regional target to reduce beds in specialized psychiatric hospitals by 30% by 2030. In the process of setting baselines, 9087 beds were reported across five Member States, namely Bangladesh, Myanmar, Nepal, Sri Lanka and Thailand, with over 60% of beds located in Thailand (48).

## Admissions

The WHO South-East Asia Region reported 34.5 admissions in psychiatric institutions per 100 000 population, which was nearly half the global rate of 71.8 per 100 000 population (1). Among the eight countries that reported data on admissions, Thailand had the highest admission rate in 2020 of 126.27 per 100 000 population (36). Indonesia was second highest with 71.99 per 100 000 population (32). The reported admission rate was lowest in Bangladesh at 3.73 per 100 000 population (39). Admission rates are subject to data-reporting inaccuracies and reporting biases whereby countries with mature and well-functioning health management information systems will report higher rates.

Interviews with key informants revealed limited information on critical deinstitutionalization practices to avoid readmission, such as discharge planning for those who are ready to transition into the community (Box 2).

Table 3. Number of facilities, beds, admissions in psychiatric institutions

Member State	No. of specialized psychiatric institutions	No. of beds/100 000 population	No. of admissions/100 000 population
Bangladesh	2	0.43	3.73
Bhutan	0	0	0
India*	136	1.43	6.95
Indonesia	49	4.19	71.99
Maldives	0	0	0
Myanmar	2	2.93	34.48
Nepal	10**	0.52	-
Sri Lanka	1	6.61	31.68
Thailand	20	6.26	126.27
Timor-Leste*	-	-	-

Sources: *Mental health atlas 2020* country profiles (32, 33, 34, 35, 36, 37, 38, 39);

\* *Mental health atlas 2017* country profiles (40, 41);

\*\* *WHO Special Initiative for Mental Health situation assessment – Nepal, 2021* (49).



## Box 2: Sri Lanka downsizes largest psychiatric institution

Historically, Sri Lanka's mental health system relied on an asylum-based model, primarily centred on a few psychiatric hospitals such as Angoda Mental Hospital and Mulleriyawa Unit 2. These institutions faced severe criticism due to archaic treatment practices, administrative inefficiencies, overcrowding and inhumane conditions.

In 2001, the newly appointed director of the institution commenced changing the attitudes of the medical and nursing staff to phase out outdated and coercive practices. Steps were taken to address mistrust among the hospital staff toward the health administration to ensure their support and cooperation. An agreement was signed with the National Institute of Mental Health and Neurosciences in 2007 to train nurses, social workers, doctors and occupational therapists.

The staff categorized people within the hospital based on the kind of rehabilitation required and their readiness to be discharged: acute, intermediate and long-term. The Community Placement Questionnaire was introduced for intermediate and long-term residents, and individual plans were developed for people to make a successful transition into the community based on their specific needs (50).

Non-profit organizations such as BasicNeeds and Volunteer Services Overseas extended their services to people within the hospital for their psychosocial recovery. BasicNeeds introduced horticulture therapy, which allowed people residing in the hospital to earn money for their activities. The staff helped individuals create bank accounts, deposit the money they earned and build their savings. When the families realized they now had savings and could independently support themselves, they were more eager to take them back.

Efforts were made to empower people within institutions to access their essential civil rights, such as the right to vote and possess national identity cards. This has also played a pivotal role in eliciting political interest.

In 2008, Mulleriyawa Hospital, Unit 2, which housed over a thousand women with mental health conditions, became the focus of the initiative. Small houses were rented for residents of Unit 2, which served as care homes. Employment opportunities were provided, leading to increased self-reliance.

The number of beds in Mulleriyawa Hospital, Unit 2 was reduced from 900 to 300. It now mostly houses people who do not have any family support, but in more pleasant and community-like environment. In parallel, community social workers and medical officers were trained in psychiatric care through short courses so they could operate in remote areas. Efforts were made to train volunteers from the community in mental health care.

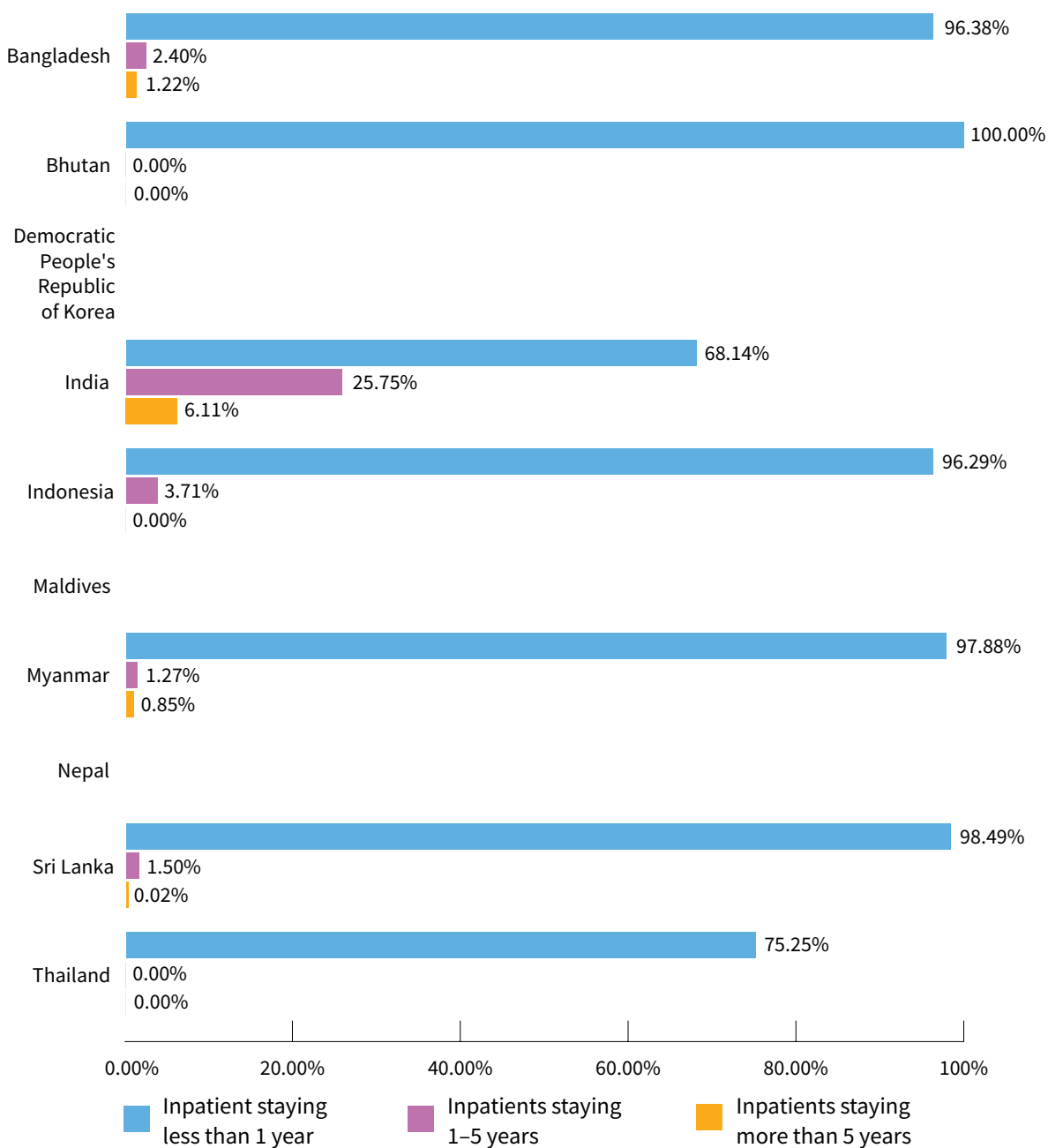
The Mental Health Policy (2005–2015) outlined a vision for the transformation of the mental health landscape, emphasizing the need for a comprehensive, community-based and decentralized service structure. It contained provisions for relocating residents of Angoda, Mulleriyawa and Hendala Hospitals to newly established district facilities or other community-based provisions (23).

## Involuntary admissions

Data on involuntary admissions in the WHO South-East Asia Region is limited. Therefore, due to data discrepancies it is difficult to draw conclusions on involuntary admissions.

### Duration of stay

Fig. 4. Percentage duration of stay of inpatients in the WHO South-East Asia Region



Sources: *Mental health atlas 2020* country profiles (32, 33, 34, 35, 36, 37, 38, 39, 45); \*[India] *Mental health atlas 2017* country profiles (40).

In Bangladesh, Indonesia and Myanmar, 96% of all inpatients are admitted for less than a year (32, 35, 39). In India, 68% of all inpatients stayed for less than a year, which means over one quarter of all admissions reside in institutions for over a year (36). In 2023, the National Human Rights Commission in India conducted an inspection of the 46 government-run institutions. The findings indicate that more than 2000 people remained in these institutions, despite having recovered from their mental health conditions, accounting for 12% of all admissions during the period of the survey (51).

### Community-based residential care facilities

Residential facilities provide non-hospital-based services that include accommodation for persons with mental health conditions (e.g. halfway homes, group homes or hostels) within the community. In 2020, five countries reported the presence of these facilities, namely India, Indonesia, Sri Lanka, Thailand and Timor-Leste (40, 44). Maldives has no such facilities (37). India has 223 residential facilities (40), Indonesia 150 (32) and Thailand 13 (36). Disaggregated data on public and privately run facilities is unavailable.

In 2023, the Government of India, launched an online dashboard to provide details on halfway homes and rehabilitation facilities across the country. Based on these recent figures, there are 330 facilities across the 33 states and union territories (Box 3).

#### Box 3: Manoashraya: an online dashboard

In India, Manoashraya is an initiative by the Ministry of Social Justice and Empowerment, launched in 2023. It is a dashboard that records data on rehabilitation homes/halfway homes throughout the country, requiring states and union territories to provide real-time updates.

This data encompasses details such as the total number of homes, their capacity, current occupancy rates and the number of individuals still residing in mental health institutions despite being cured.

The dashboard has been integrated with online psychiatric consultations offered through the National Tele Mental Health Programme (52, 53).

### ■ Number of beds

India had 5.18 residential care beds per 100 000 population (40). While Indonesia had the highest number of facilities after India, the number of beds was 0.74 per 100 000 population (Table 4) (32).

Table 4. Number of community residential facilities, beds, admissions rate

Member State	Community residential facilities		
	No. of community residential facilities	No. of beds/100 000 population	No. of admissions/100 000 population
Bangladesh	–	–	–
Bhutan	–	–	–
India*	223	5.18	0.69
Indonesia	150	0.74	2.01
Maldives	–	–	–
Myanmar	–	–	–
Nepal	–	–	–
Sri Lanka	26	2.13	5.36
Thailand	116	1.67	–
Timor-Leste*	2	1.93	0.08

Source: *Mental health atlas 2020* country profiles (32, 33, 34, 35, 36, 37, 38, 39)

\* Data from *Mental health atlas 2017* country profiles (40, 41)

As a part of the *Mental health action plan for 2023–2030* for the *WHO South-East Asia Region*, the 11 Member States have agreed to increase the number of supported-living facilities by 50%, by 2030. In reported baseline data for 2023, 485 facilities were reported across the region, with India reporting the highest number at 407 (48).

### Admissions

According to the *Mental health atlas 2020*, the global admission rate to residential care facilities is 4.0 per 100 000 population. In comparison, two countries in the South-East Asian Region reported an admission rate of 3.7 per 100 000 population (54). Of the countries that reported admissions, Sri Lanka had the highest rate at 5.36 per 100 000 population and Timor-Leste the lowest at 0.08 per 100 000 population (38, 41). It is difficult to draw inferences from the small sample of countries that have reported on residential care data in the Region.

Few experiences of community-based residential facilities are documented in the Region. The Kudil intermediary facility in Sri Lanka (Box 4) serves as a promising example of a government-run facility. In Bangladesh, several non-profit organizations are providing residential services (Box 5).

#### **Box 4: Kudil intermediary care facility in Sri Lanka**

Kudil, a pioneering community-based psychiatric rehabilitation centre in Jaffna, Northern Sri Lanka, has played a crucial role in filling a significant gap in mental health care services in the region. Historically, mental health care in Sri Lanka has been delivered primarily through psychiatric units and outpatient clinics, but their services were limited in scope, with little emphasis on psychosocial support and rehabilitative services.

In 2007, the Kudil facility was established with the aim of providing a supported-living and structured environment for those recovering from mental health conditions. Initially operating in rented homes within local communities, Kudil has now been relocated near the Base Hospital Tellipalai, which facilitates better access to medical care for its residents.

The rehabilitation centre spans two floors, providing space for psychological services and a shrine area that respects and integrates religious practices. Kudil can accommodate a maximum of 18 residents, and their family members are encouraged to participate in the rehabilitation process during their stays.

With the motto, “Gateway to Life”, this facility has helped over 400 individuals and families in the past decade. Unlike psychiatric institutions, this facility treats persons with mental health conditions as equals, while also facilitating an environment where they can regain or enhance their capabilities (55).

#### **Box 5: Community-based supported group homes in Bangladesh for people transitioning from psychiatric institutions**

Sajida Foundation is a non-profit organization in Bangladesh. One of the mental health interventions implemented by this organization is to provide supported-living and livelihood services for persons living with long-term mental illnesses.

In Bangladesh, often, even after being discharged from psychiatric institutions, those with severe mental health conditions are abandoned by their families and do not have anywhere to go. Through this initiative, they will be transitioned to homes within the community where they can reside with others with similar mental health conditions. They will be offered psychosocial support with a focus on improving self-reliance, functionality and livelihood options. The aim is to help them live independently within the community and earn their living.

This model was adapted from Banyan’s Home Again but tailored to fit the context of Bangladesh (56). They plan to establish 10 such homes in 2023 with a total capacity of 60 residents. If this initiative proves to be successful, they have plans to scale up their efforts (57).

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### 3.4.2 Psychiatric services in general hospitals

This category of services refers to psychiatric wards established in general hospitals based in the community that deliver inpatient treatment to people with acute mental health conditions. This approach aims to deliver specialized care to people with high support needs closer to the community, and entails shorter admissions for treatment.

Globally, there are 0.17 general hospital facilities with psychiatric units per 100 000 population. The rate for the Region is 0.13 (54). Ten Member States report a total of 918 psychiatric units in general hospitals. India and Indonesia account for 83% of all such units, with 389 and 370 facilities respectively (Table 5) (32, 40). Maldives, Timor-Leste and Bhutan, the smallest Member States by population and geographic size, have at least one such psychiatric unit (33, 37, 41).

Recent validated baseline data from the *Mental health action plan for the WHO South-East Asia Region 2023–2030* indicates that five countries have met the target to establish a mental health unit in 80% of general hospitals by 2030: Bhutan (100%), Maldives (100%), Sri Lanka (96%), India (93%) and Thailand (92%) (48).

#### ■ **Number of beds**

Although India and Indonesia have the greatest number of facilities, Sri Lanka has the highest number of inpatient beds in psychiatric units of general hospitals at 3.5 per 100 000 population, which is above the global rate of 2.5 (38). This is followed by Bhutan (2.6), Indonesia (1.4) and Nepal (1.3) (32, 33, 40).

#### ■ **Admissions**

Globally, the admission rate to psychiatric units is 43 per 100 000 population. In the WHO South-East Asia Region, it is 30.1 per 100 000 population (54). Sri Lanka has an exceptionally high admission rate (over six times the global rate) in its psychiatric unit facilities (271.83 per 100 000 population) followed by Bhutan (76.77 per 100 000 population) (33, 38). Sri Lanka's history of providing acute mental health care in general hospitals dates to 1949, with the first 24-bed units set up at the General Hospital Colombo. Since then, the sustained efforts of the country to develop these services is reflected in the data (58).

Few beds and low admission rates in countries such as India and Indonesia could indicate that services delivered in such units are primarily limited to out-patient services (Table 5).

Table 5. Number of psychiatric units and beds in general hospitals

Member State	Psychiatric units in general hospitals		
	No. of psychiatric units in general hospitals	No. of beds/ 100 000 population	No. of admissions/ 100 000 population
Bangladesh	60	0.10	–
Bhutan	1	2.62	76.27
India*	389	0.56	4.38
Indonesia	370	1.41	22.75
Maldives	1	0.75	30.13
Myanmar	17	0.41	6.22
Nepal	25	1.26	–
Sri Lanka	36	3.50	271.83
Thailand	18	–	–
Timor-Leste*	1	–	–

Sources: *Mental health atlas 2020* country profiles (32, 33, 34, 35, 36, 37, 38, 39); \* *Mental health atlas 2017* country profiles (40, 41).

### 3.5 Community-based mental health services

Development of community-based mental health services is a priority across the world, particularly in low- and middle-income countries. This includes providing out-patient mental health services at local health centres, ensuring the availability of medication and establishing referral pathways to specialized mental health services. In Thailand, mental health services are available through a strong network of community health volunteers who provide support to people with lived experience and their caregivers (Box 6). A network of community health workers has been activated across the region, from Accredited Social Health Activists in India to more recent projects with Female Community Health Volunteers in Nepal (59, 60).

Globally, there are 0.55 community-based facilities per 100 000 population. In the WHO South-East Asia Region the rate is 1.03 facilities per 100 000 population (54). This dispersed approach to providing mental health care at the primary health system level has gained traction in the Region owing to the scarcity of specialist services and a leveraging of the concept of “task-shifting” (61). India reports 167 000 community-based mental health services (Government of India, Ministry of Health (Mental Health Division), communication, 1 March 2024). Thailand had the second-highest number at 3183, followed by Sri Lanka at 49 and Timor-Leste at 5. Bangladesh, Bhutan, Maldives, Myanmar and Nepal have reported no community-based services (48) (Table 6).

India launched the Ayushman Arogya Mandirs in 2018 to deliver a range of health services, including mental health care at sub-district level health centres, called Health and Wellness Centres. Capacity building is underway for primary health care workers in these centres to detect mental health conditions, provide brief interventions and refer patients to specialists at the district hospitals (62).

Table 6. Number of community-based mental health services

Member State	Community-based mental health services (no. of services)
Bangladesh	0
Bhutan	0
India	167 000
Indonesia	no data
Maldives	0
Myanmar	0
Nepal	0
Sri Lanka	49
Thailand	3183
Timor-Leste	5

Source: *Validated baselines for the Mental health action plan for the WHO South-East Asia Region 2023–2030 (48)*; Government of India, Ministry of Health (Mental Health Division), communication, 1 March 2024.

In addition to out-patient services, there were 720 reported facilities providing day-care services (i.e. facilities that provide psychological and social services to people with mental health conditions outside hospital settings). One third of these facilities were located in India. One such centre that operates on a public–private partnership model is highlighted in Box 7.

Another example of a community-based practice that provides emergency services to people with mental health conditions is Aung Clinic in Yangon, Myanmar (Box 8).

### Box 6: Community mental health services in Thailand through village health volunteers

In 1978, Thailand included mental health as a component in the primary health care service model. Since then, the country has invested in building a cadre of village health volunteers that are up to 1 million strong (63). These volunteers have been on the front-line of educating community members on mental health, early detection of mental health conditions such as psychosis, autism, depression and suicide, provision of psychological support, and the facilitation of continued care or community rehabilitation.

For people living with schizophrenia, community volunteers have carried out regular home visits to ensure medication compliance and in the cases of emergencies, where an individual may be at harm to themselves or others, volunteers have facilitated safe transfer to hospital.

Given the paucity of trained mental health professionals in the country, village health volunteers have been a crucial link between the community and formal mental health services, enabling access to care (64).



### **Box 7: Manasadhara: a day-care centre in India for those with severe mental illnesses**

Manasadhara is a community mental health day-care centre programme operating in Karnataka, India. The programme is a public–private partnership whereby the centres are operated by a non-profit organization (65). The centres provide group therapy, social skills training, basic computer skills preparing individuals to transition into the community. The state government provides support services which include transportation to the centres.

While the day-care centre model is still nascent in India, these services could provide opportunities for individuals with severe mental health conditions to improve their recovery outcomes, particularly their social and occupational skills (66). The centres are now functioning in 13 districts, with efforts being made to expand them across the state.

### **Box 8: Aung Clinic: Emergency drop-in services and long-term therapy in Myanmar**

Aung Clinic in Yangon, Myanmar provides a range of services to people with mental health conditions, regardless of their diagnosis, including those individuals who may be homeless. Their objective is to provide holistic treatment, end institutionalization and provide community-based care.

At the clinic, day-care services from clinical treatment to art therapy are offered along with emergency services that are available on weekends.

The clinic is equipped to manage crisis situations, which reduces the incidence of hospitalization among service-users. There are also outreach services to people with lived experience and their families that are carried out over telephone or online.

In addition, several activities are organized at the clinic to promote independence among service users, from cookery classes to financial literacy training sessions. Aung Clinic has been recognized by the WHO as a good practice community mental health care centre.

## **3.6 Monitoring and evaluation**

Monitoring and evaluation of service implementation and high-quality reliable data are vital to efficiently allocate resources and assess the effectiveness of services. Among the 11 Member States, seven have health management information systems (HMIS) or web-based platforms through which mental health data on patient diagnoses, outpatient visits, inpatient admissions and outreach services is collected at a health facility level. Bhutan, India, Sri Lanka, Bangladesh, Timor-Leste and Thailand have reporting mechanisms whereby data is consolidated at a national and sub-national level by relevant authorities (45, 69, 70, 71, 72, 73). In Indonesia, while mental

health data is collected in health facilities, there are no systematic government reporting structures to consolidate this data (74). In Nepal and Maldives, efforts are ongoing to integrate mental health data with the HMIS (Table 8) (75, 76). In all countries, there is no coordinated plan to integrate indicators for deinstitutionalization in data collection and reporting.

Table 7. Mental health data collection and reporting through HMIS

Member State	Mental health data collection through HMIS
Bangladesh	Web-based data collection on mental health data is carried out, no mental health-specific indicators
Bhutan	Data is collected through an HMIS and published in the annual health bulletin
India	Data is collected at health centres and shared with the state.
Indonesia	Data is collected at a facility level but is limited as there is no systematic government reporting structure for mental health data.
Maldives	No
Myanmar	No
Nepal	Ongoing integration with HMIS
Sri Lanka	Inpatient, outpatient and outreach-related data is collected through the HMIS.
Thailand	Facility level data is collected systematically through the HMIS.
Timor-Leste	Yes

Sources: *Addressing mental health*, country profiles, 2022 (45, 69, 70, 71, 72, 73, 74, 75, 76,); Aung Clinic (69); Mental health check in (78).

Thailand has a comprehensive mental health data collection and reporting system. Managed by the Ministry of Public Health, mental health data is consolidated in a dashboard, which provides the status on mental health in the country. This data, available in real-time, is useful in planning mental health services, particularly at a district and community level (78).

# 4

## Key stakeholders in deinstitutionalization

Stakeholders and actors from government, NGOs and the private sector play a pivotal role in shaping policy, providing services and driving the overall transformation of mental health care systems. As deinstitutionalization aims to enhance individual autonomy, well-being and social integration, the involvement of these key actors, particularly mental health professionals, family members, caregivers, communities and people with lived experience is crucial in ensuring the success and sustainability of these endeavours.

The stakeholders identified are:

- government stakeholders
- civil society organizations
- private sector organizations
- mental health workforce
- family members, caregivers and communities
- persons with lived experience.

### 4.1 Government stakeholders

Ministries of health are responsible for formulating and implementing policies that guide the deinstitutionalization process, as part of their mandate to oversee the government's mental health system. Addressing mental health holistically, however, requires a multisectoral approach and the active involvement of ministries and departments beyond health, such as those responsible for social welfare, criminal justice, education and employment. At present, such coordination efforts are limited across countries in the region.

In the WHO South-East Asia Region, the countries are significantly diverse in terms of their geography, existing health care systems, service-delivery models and government structures. Subnational government bodies, including provincial, state, district and township-level governments, play a crucial role in executing and coordinating mental health efforts.

In Indonesia, while the Ministry of Health provides guidelines, policies and regulations for mental health efforts, the implementation of mental health programmes falls under the purview of the subnational provincial health offices (74). In India, the District Mental Health Programme, a flagship community mental health initiative, is implemented through the collaboration between the central and the state governments (79). The decisions of the government stakeholders influence funding allocation, legal frameworks and the creation of community-based care models.

Table 8. Government authorities responsible for mental health care in the Member States

Member State	Main governing bodies
Bangladesh	Main governing bodies: Ministry of Health and Family Welfare, Directorate General of Health Services (DGHS)
Bhutan	The Pema Secretariat
India	Ministry of Health and Family Welfare, State Departments of Health and Family Welfare
Indonesia	Ministry of Health, provincial and district governments
Maldives	Ministry of Health, Health Protection Agency (HPA)
Myanmar	Ministry of Health
Nepal	Ministry of Health and Population
Sri Lanka	Directorate of Mental Health under the Ministry of Health
Thailand	Department of Mental Health at the Ministry of Public Health
Timor-Leste	Mental Health Section under the Ministry of Health

Statutory bodies, appointed by the government or set up through legislative power, supervise and monitor mental health services as well as investigate and intervene in cases where the rights of persons living with mental health conditions are infringed. In Bangladesh, the Mental Health Act 2018 calls for the establishment of a Mental Health Review and Monitoring Committee in all districts to ensure the proper implementation of the legislation (27). Other statutory bodies, such as those concerned with human rights, the rights of women and children, narcotics and substance abuse, licensing of NGOs and private institutions for providing mental health care, also play a key role in deinstitutionalization and in promoting the rights of people with lived experience of mental health conditions.

For instance, the National Human Rights Commission of India regularly reviews the implementation of the Mental Healthcare Act 2017 and carries out audits of mental health institutions in the country (44). Likewise, in Nepal the National Human Rights Commission's Strategic Plan 2015–2020 places emphasis on the rights of people with psychosocial disabilities to access good-quality mental health services in their communities (80).

Criminal justice systems, which include law enforcement agencies and the courts, are critical actors in referring individuals to appropriate services to prevent “trans-institutionalization” for those living with mental health conditions within prisons. A systematic review of studies from 13 low- and middle-income countries (LMICs), which included India and Sri Lanka, found that persons with mental health conditions are overrepresented in the prison population. Underdeveloped community mental health care systems and poor linkages between the criminal justice systems and mental health care could be a significant factor contributing to the high incarceration rates of those with mental health conditions (81). It is imperative for law enforcement agents, notably the police, to be actively trained and equipped to recognize signs of mental distress, de-escalate crises and facilitate appropriate referrals for individuals in need of mental health support, particularly for those who are homeless or abandoned. The mental health laws of India, Bangladesh and Thailand

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delineate the responsibilities of various of these duty bearers within the criminal justice systems (24, 26, 27).

The most important element in deinstitutionalization is political will and leadership to mobilize resources for building community mental health services and promoting intersectoral coordination. In the Region, the prioritization of mental health has been gradual. In countries where key political leaders have championed mental health initiatives, significant strides have been taken to enhance mental health care.

## 4.2 Civil society organizations

Civil society organizations (CSOs) and NGOs are essential stakeholders in the processes of deinstitutionalization. They provide critical support services, such as counselling, rehabilitation, occupational training and housing assistance, to facilitate successful community integration, often filling the vacuum for such psychosocial services in communities.

Organizations in Bangladesh such as ADD Bangladesh, Sajida Foundation, Innovation for Well-being Foundation and Schizophrenia Research Foundation (SCARF) are actively involved in promoting and implementing community-based mental health services. Their work includes facilitating community engagement, coordinating with local governments and psychiatric institutions, providing training for health care providers and the general population, and more (57, 82, 83).

Residential services have also been delivered by non-profit and faith-based organizations in the region. The Banyan in India has gained global recognition for its Home Again programme, providing group residential services for women with psychosocial disabilities. Their approach is to provide a home-like environment, which fosters autonomy, recovery and growth for its residents. Each home run by Banyan accommodates four or five residents who are offered support through personal assistants (67). Furthermore, organizations such as Sajida Foundation in Bangladesh, Nest and National Council for Mental Health in Sri Lanka also provide rehabilitative and residential services for persons with mental illnesses (57, 84, 85).

The work of such organizations can significantly aid deinstitutionalization efforts by developing and testing models of community-based care which can later be implemented by the government on a larger scale.

Civil society organizations also play a significant role in advocating for the rights of persons with mental health conditions, particularly their right to live with dignity within the community. Organizations such as Koshish, a mental health NGO in Nepal led by people with lived experiences, target their advocacy efforts towards the elimination of discriminatory laws affecting those with psychosocial disabilities (86).

## 4.3 Private sector organizations

The private sector, consisting of for-profit entities, supports deinstitutionalization by investing in community-based services and employment opportunities for individuals transitioning out of

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institutions. Private sector stakeholders collaborate with NGOs and government entities to develop sustainable models of community-based care. Manasadhara, a day-care centre in Karnataka, India is an example of a promising private–public partnership model for psychiatric rehabilitation (65).

Pann Nann Ein, a social enterprise in Myanmar, supports those with mental and physical disabilities to attain sustainable livelihoods (87). According to a key informant in Indonesia, in some provinces NGOs and business owners work with the government to facilitate the reintegration of persons with mental health conditions into the community. On discharge from psychiatric institutions, they are offered on-the-job training by local businesses to develop their skills.

In countries such as India, Nepal, Sri Lanka, Maldives, Bangladesh and Myanmar, the private sector also delivers mental health services, including long-term rehabilitative care. It is worth noting that often there is an intrinsic risk of some private organizations basing their income on high rates of institutionalization and long periods of hospital stay.

#### 4.4 Mental health workforce

The mental health workforce, including psychiatrists, psychologists, occupational therapists, social workers and mental health nurses, is essential in ensuring a continuum of mental health care.

The mental health workforce may require significant re-training to support the deinstitutionalization process and shift towards a community-based and rights-oriented approach.

In Bhutan, India, Myanmar and Sri Lanka, mental health services are integrated into the primary health care system, with doctors and nurses being trained on the delivery of basic mental health services. Non-specialized community health volunteers, such as those in India, Sri Lanka and Thailand, have also been instrumental in ensuring last-mile service delivery by reaching individuals at a household level. Given the paucity of specialized mental health professionals in the region, engaging a multi-disciplinary workforce through a “task-shifting” model is essential to strengthen community care and reduce the reliance on psychiatric institutions.

#### 4.5 Family members, caregivers and the community

Family members are often the primary caregivers of people with mental health conditions and are therefore actively involved in the recovery and prevention of relapse. In some ways they may be the most important stakeholders to consider in the deinstitutionalization process. In the context of the WHO South-East Asia Region, understanding and awareness of mental health conditions is low and stigma is rampant. Consequently, those with mental health conditions may not be accepted back by families. This is observed in many countries in the Region. As per the key informants from Sri Lanka and from reports from India, this is a key factor in the continued institutionalization of those with mental health conditions.

In the Region, communities are key actors in the process of deinstitutionalization. By empowering and sensitizing communities, the burden on families can be reduced and community resources can be mobilized (Box 9). Key informants from Bhutan and Indonesia strongly emphasized the

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important role communities and community leaders play in facilitating access to mental health care and other supports for both the family and the person living with a mental health condition. In some countries, such as Bangladesh and Sri Lanka, family members often accompany persons with a mental health condition throughout their stay in inpatient care.

In some countries, caregivers are often involved in in-patient care of persons with mental health conditions and are required to accompany them for the duration of their stay in institutions. In Sri Lanka, family members of persons being admitted to psychiatric units of general hospitals are required to stay with the service user during their inpatient treatment. Similarly, in the National Institute of Mental Health in Bangladesh, the caregivers accompany the patient throughout their stay. Involving caregivers in such care can aid in the effective implementation of the supported decision-making process. However, this may also result in additional costs, both financial and emotional, to the caregiver.

### **Box 9: Mobilizing community members to support people with mental health conditions in Indonesia**

Tim Pembina, Pengarah, dan Pelaksana Kesehatan Jiwa Masyarakat and Community Mental Health Advisory and Implementation Teams in Indonesia are a good example of mobilizing the community to provide support to those with mental conditions. These teams work at the provincial, district or village level and may consist of cross-sectoral stakeholders, including village council officials, community leaders, community mental health workers, members of community associations, members of law-enforcement agencies and social welfare workers. They essentially provide integrated and intersectoral primary mental health care, including psychoeducation, administrative support for identification documentation and health insurance, screening and referrals to specialized services and handling of mental health emergencies in the village (88).

## **4.6 Persons with lived experience**

Person-centred mental health care considers the experiences, needs and perspectives of persons with mental health conditions. This is central to the success of deinstitutionalization and community-based mental health care.

There are several examples of people with lived experience offering peer support.

In Nepal, Koshish has been active in advocating for abolishing discrimination faced by people with psychosocial disabilities and integrating mental health in health care, education and other sectors (86). Another example is Banyan's Home Again Programme, which promotes the inclusion of women with psychosocial disabilities in the community. Home Again has significant representation of people with lived experience – amongst the founders, the senior management and the personal assistants delivering the programme and providing support. Moreover, women who are part of the programme are encouraged to attend and lead meetings to provide and review feedback on their programmes with the ultimate aim of improving services (67).

The following factors were identified as needing to be addressed if deinstitutionalization of mental health services is to occur throughout the WHO South-East Asia Region.

### 5.1 Policies, governance and funding

While policies in most countries emphasize the expansion of community mental health care, national policies have limited directives to downsize and/or close larger mental health institutions.

In some countries, the regulatory processes for monitoring mental health establishments require updating, in particular the monitoring of those institutions that may be registered as for-profit or philanthropic entities.

#### **Decentralization of health care within countries**

In all countries, mental health care is within the purview of the ministries of health. In some countries with federal structures, the health ministry provides guidelines for mental health policies and programmes. However, ultimately, the decision to plan and implement such programmes is taken at the level of the state or province. Decentralization can also act as a barrier due to the fragmentation of authorities and accountability.

#### **Intersectoral coordination**

Essential elements for deinstitutionalization, such as community residential care, rehabilitation and employment, are under the purview of ministries such as social justice/social welfare, labour and employment. Coordination and collaboration between these ministries and departments needs to be strengthened, with the ministry of health taking the lead and shaping subnational policies and programmes.

#### **Funding**

Funding for mental health services is insufficient in most countries of the Region. Current funding is also mostly spent on mental health institutions. The skewed funding is a significant barrier to scaling community-based services. In some countries, it is a challenge to ascertain the budget earmarked for community mental health services, as the spending on mental health is included in the spending for overall health services, which makes it difficult to track progress and budgetary planning.



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### ■ **Data collection and monitoring mechanisms**

In many countries, data collection and reporting structures need further development, including the use of country-level indicators to assess deinstitutionalization processes.

### ■ **Addressing human rights violations**

Apart from rights violations such as forced admissions, tonsuring and shackling, psychiatric institutions are often plagued by reports of sexual abuse (89). Such incidents are mainly perpetrated against women, with little support available to them to seek legal recourse or actions to prevent abuse from occurring within institutions (90).

## 5.2 Services

The delivery of community mental health services is key to deinstitutionalization, but a number of barriers to the provision of such services currently exist across the Region.

### ■ **Accessibility to mental health services**

Geographic barriers, particularly in remote and rural areas, limit access to mental health services, making it difficult to implement community-based alternatives effectively. Lack of mental health wards in general hospitals is also a common challenge.

### ■ **Community-based infrastructure**

All countries reported that infrastructure and systems (training and supervision, data collection and reporting, medicines procurement) at the community level, including mental health services, residential facilities and crisis-management centres, were insufficient and impeded the transition from psychiatric institutions to community-based care. Further, the lack of specialized psychosocial services in the community for the elderly and for certain vulnerable groups such as children and adolescents was reported as a challenge.

### ■ **Transitional and housing support**

The dearth of alternative housing or residential services was reported as a major challenge across the region. For many people living in psychiatric institutions, the lack of quality housing and support services in the community was the reason they continued to be in institutions. Dedicated facilities for people living with mental health conditions were scarce. In some countries, halfway homes and rehabilitation services were overcrowded, and spaces were shared with people living with other physical disabilities.

### ■ **Vocational and other integration services**

Across all countries in the Region, there was a paucity of psychosocial support services necessary for social recovery of people living with mental health conditions, such as housing, employment opportunities and opportunities for community engagement and acceptance. Further, linkages between health systems and such services were poor.

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### ■ **Workforce capacity and training**

For many countries in the Region, the shortage of trained mental health staff presents a challenge to the scaling up of community-based mental services. According to the *Mental health atlas 2020*, the median number of mental health workers per 100 000 population in the WHO South-East Asia Region was as low as 2.8. The global median number of mental health workers per 100 000 population was 13 (1). Further, training is restricted to the delivery of psychiatric services, with limited focus on upholding the rights laid out in the UNCRPD and promoting social recovery as prescribed by the WHO QualityRights framework (91).

### ■ **Individualized planning for transition**

There is a lack of evidence in the Region of individualized planning for people living in psychiatric institutions, and for subsequent outreach and follow-up with people with mental health conditions and their families.

### ■ **Re-institutionalization**

The lack of individual plans and frequent follow-up are likely to lead to readmissions, especially in the absence of strong well-resourced community mental health services and infrastructure and the involvement of families and communities in the reintegration process.

## 5.3 Other factors

Several other factors adversely impact the process of deinstitutionalization.

- **Persistent stigma and discrimination.** Negative attitudes and social stigma towards mental health conditions create barriers to community integration and acceptance of individuals transitioning from institutions in most countries.
- **Resistance to the deinstitutionalization processes.** Mental health practitioners and caregivers may be hesitant to support deinstitutionalization processes due to job insecurity, paternalistic mindsets and perceived negative outcomes for people with mental health conditions.
- **The need to strengthen the rights of those living with mental health conditions.** Steps are required to prevent rights violations in mental health establishments, such as restraints, forced admissions and lack of access to legal representation (Box 10).

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## Box 10: Deinstitutionalization of children

Children in institutional care are more likely to develop mental health conditions. Institutions are often unregulated and in poor condition, and they neglect both the children's mental and their physical health.

It is estimated that between five and six million children live in institutions across the world, owing to several factors. Children with disabilities, particularly those with psychosocial disabilities, are disproportionately represented in institutions. The longer children are institutionalized, the worse their developmental and socio-economic outcomes are likely to be.

Children in institutions are often malnourished, receive far fewer health check-ups and develop attachment issues in the long run. Institutions that house children are under-resourced, resulting in crowded quarters and insanitary facilities. In several cases, institutions are unregulated, and violence and abuse are pervasive (12).

In 2019, over 250 NGOs and UNICEF developed key recommendations for the United Nations General Assembly Resolution on the Rights of the Child, December 2019. This included recognizing the harm caused by institutional care to children, and ensuring institutionalization is prevented (92). They called for the prevention of family-child separation, ensuring adequate social and welfare support is provided to families and their children. In cases where family care is not possible, community-based care should be prioritized in the form of kinship care or foster care (93).

In the WHO South-East Asia Region, mental health conditions accounted for 25% of all years of healthy life lost to disability among children aged 5–14 years (94). Children in institutions are predisposed towards developing mental health conditions that impact their wellbeing in adulthood.

It is essential that deinstitutionalization of children is prioritized in the Region, and investment is made in strengthening alternative care in the community for children, particularly for those who may be orphaned or abandoned by their families.

Several factors can contribute to continued institutionalization or construction of psychiatric hospitals in countries where currently none exist. One significant factor is the perceived ease of managing hospitals compared to establishing comprehensive community-based services. The initial challenges associated with the latter, which include training various cadres of health care staff, non-specialist professionals and workforces in other relevant sectors, setting up accessible support structures, integrated across different levels of complexity to provide continuity of care, and incorporating technology for enhanced accessibility, can appear daunting.

Another critical driver is the prevalence of stigma and discrimination against individuals with mental health conditions, coupled with limited understanding of these conditions in communities. In such cases, societal pressures may lead to the isolation of affected individuals, as communities may be hesitant to accommodate them, even when reasonable and feasible alternatives exist. It is crucial to address these factors proactively to maintain the progress achieved in shifting away from institutionalization and to ensure that mental health care remains community-centred and integrated into the public health care system.

The following are strategies to prevent institutionalization.

### Informed engagement of decision-makers

Decision-makers in the institutionalization process include persons with mental health conditions, families and caregivers, community members, policy-makers, health care professionals and mental health practitioners. Such stakeholders should be made aware of viable alternatives available, involving the expansion of mental health services within the community. Active engagement through awareness campaigns, psychoeducation and associations or self-help groups can help them grasp the challenges and risks associated with institutionalization. Such factors include the inadequacy of institutions when addressing the treatment gap, the short- and long-term psychosocial impacts on people in institutions and the limitations on providing comprehensive care through psychiatric institutions. This knowledge equips decision-makers with the understanding that comprehensive community-based mental health services not only address the immediate needs of individuals but also offer a sustainable, integrated approach.

### Developing and implementing effective policies and legislation

To prevent the re-emergence of institutionalization, it is paramount that the principles of deinstitutionalization are woven into policy and legislative frameworks. It is also vital to have comprehensive mechanisms in place to actively ensure their effective implementation.

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### ■ **Downsizing psychiatric institutions**

Downsizing of psychiatric institutions or the number of beds for long-stay service users is an essential component of deinstitutionalization. One of the most influential laws pertaining to downsizing of psychiatric institutions was Italy's Law 180 or Basaglia Law, passed in 1978, which called for the decentralization of mental health services and prohibited the construction of new psychiatric hospitals and new admissions to existing institutions. It has been particularly influential in Latin American countries such as Argentina, Brazil, Chile, Paraguay and Uruguay, in the development of mental health legislation (11). However, while shutting down psychiatric institutions, it is crucial to ensure a strong network of community-based mental health services and other alternatives, the absence of which can lead to negative consequences.

### ■ **Ensuring adequate funding**

The development of community-based mental health facilities requires significant funding, especially in the initial stages. According to the *Mental health atlas 2020*, mental health expenditure as a percentage of domestic general government health expenditure amounts to only 2.13% globally (data was reported by 67 countries). To move towards, and sustain, deinstitutionalization efforts, significant strides must be made to increase funding directed to community-based services. The WHO Special Initiative for Mental Health, a programme aimed at promoting universal access to mental health care by working closely with national governments and advocating for policy and funding changes, has been successful in increasing the mental health budget of Ghana's Ministry of Health from 1.0% to 1.4% of its annual health budget. Moreover, in 2023, through the efforts of this initiative, the mental health budget in the Philippines is projected to increase to 1 billion pesos from 57 million pesos (95).

It is also vital to ensure that a significant amount of the budget is directed towards community-based mental health facilities rather than psychiatric hospitals. As indicated by the *Mental health atlas 2020*, over 70% of governments' total expenditure on mental health in lower-middle and upper-middle income countries was allocated to psychiatric hospitals, while in high-income countries it was 35%. To strengthen and expand community care, a temporary stream of "double funding" will be required to invest in new infrastructure and services within the community that may be derived from public, private and philanthropic investors (12).

## **Collaboration and stakeholder engagement**

Effective decentralization of mental health services demands active cross-sectoral collaboration, where various stakeholders, including governmental bodies, NGOs, health care providers, communities, caregivers and persons with lived experiences work together to ensure that mental health services are accessible, comprehensive and integrated into broader public health and social welfare systems. Some of the major ways this can be achieved are integrating mental health into general health and disability laws and other relevant legislation, developing and implementing mental health policies and laws through multisectoral collaboration and building strong linkages between sectors.

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## ■ **Reducing stigma and discrimination**

Stigma and discrimination are major issues in the WHO South-East Asia Region. These factors have been associated with a myriad of negative consequences, including social exclusion, reduced self-esteem, reduced autonomy, isolation and, in extreme cases, the perpetuation of violence (96, 97). Moreover, people with mental illness may be subjected to coercive or segregated treatment, such as forced medication, involuntary hospitalization, or confinement in institutions, which may violate their human rights and dignity. Thus, fostering an accepting environment that is conducive to deinstitutionalization requires tackling prejudices and harmful stereotypes and spreading awareness about rights-based approaches within the community.

Enhancing mental health awareness is a powerful and proactive strategy to confront and mitigate the harmful effects of these misconceptions. This involves disseminating accurate information about mental health, fostering open conversations and challenging stereotypes. It educates individuals about the realities of mental health conditions, dispels myths and promotes empathy and understanding. An accepting and informed community makes seeking help easier, and when people understand mental health challenges they are more likely to support community-based treatment, thus preventing unnecessary institutionalization.

## Strengthening community-based mental health services

Ensuring the success of the process of deinstitutionalization necessitates the development of well-established and well-coordinated community-based mental health facilities. For this, there must be active engagement of multiple stakeholders, with emphasis on the involvement of lay health workers or community volunteers who will serve as the frontline mental health care providers.

## ■ **Task-shifting**

Task-shifting, which involves delegating mental health care to non-specialist health care providers, is vital in preventing institutionalization. Primary health care workers can offer different types of mental health services, and make appropriate referrals to secondary and tertiary care when necessary. Regulatory and institutional provisions are required to integrate non-professional workers into the mental health workforce on equal standing with others in other sectors, in terms of rights and payment. Thailand has been successful in task-shifting by integrating mental health care at the primary-care level and training village-level community volunteers (64).

Crisis interventions in mental health are essential services designed to provide immediate support to individuals with acute mental health needs. Typically offered through community mental health centres and teams, these interventions encompass various forms of support, including helpline services, overnight stays at facilities and day-care emergency services

## ■ **Mobile mental health teams**

To ensure equitable access to mental health care, it is essential to extend mental health services beyond urban centres and into remote populations. Mobile mental health services, which generally involve community mental health teams composed of primary care workers and mental health

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professionals, make such expansion possible. Such teams may travel to remote or rural areas at regular intervals to provide care within the community. Their multifaceted roles encompass training, supervising and supporting non-specialist primary health care providers, administering clinical interventions for complex mental health cases that do not require hospitalization, and conducting preventive and promotive initiatives in their locality.

### ■ ***Psychiatric wards in general hospitals***

Establishing psychiatric wards in general hospitals can reduce the dependence on psychiatric institutions. They can provide outpatient and inpatient psychiatric services within the community, ensuring continuity of care and avoiding long-term hospitalization in psychiatric hospitals. Those in need of urgent inpatient care can be referred to hospitals in their communities rather than being dependent on a handful of tertiary care facilities. Persons with mental health conditions can be admitted for a short period of time, then discharged into the community or referred to intermediate care facilities. Several countries in the Region have expanded psychiatric services in secondary care settings.

### ■ ***Supported-living facilities***

Supported-living facilities are vital for the reintegration of people with mental health conditions into society. Instead of being isolated for long periods, these facilities ensure that the individual can receive supported-living services based on their needs while continuing to interact with the larger community. They are especially important for those who have no homes to return to.

The Banyan Home Again initiative in India serves as an example of how individuals with severe mental health conditions can coexist with the rest of the community while being actively engaged with it. Through this initiative, women with mental health conditions are provided with supported-living options where they can exist in a home-like environment while exercising autonomy and getting necessary support through personal assistants (56).

## **Empowering families and caregivers**

In the context of deinstitutionalization, families and community caregivers play a pivotal role as key decision-makers. Their active engagement in the care and support of individuals with mental health conditions is crucial. Equally important is the provision of robust support systems tailored to their needs within the community.

To achieve this, comprehensive support systems and resources must be in place to provide guidance, education and emotional assistance to families and caregivers. This approach can bolster successful reintegration of individuals into the community, foster a network of support essential for their well-being and prevent the likelihood of institutionalization.

### ■ ***Education and caregiver support programmes***

Caregiving for persons with mental health conditions is an emotionally, mentally and physically challenging endeavour, and without adequate support it can lead to caregiver burnout. A study conducted in Tamil Nadu in India aimed to examine the effects of caregiving for persons with

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mental health conditions. It identified themes of social exclusion, stigma and lost opportunities experienced by caregivers of those with mental illnesses (98). Psychoeducation and caregiver support programmes can be effective in reducing the toll of these challenges.

The Dementia Home Care Project in Goa, India serves as a cost-effective home-based intervention for supporting dementia caregivers. It trained lay workers to provide non-pharmacological interventions, including dementia education, guidance on daily support and management of behavioural issues. This project successfully reduced caregiver burden, mental stress and distress related to dementia symptoms, demonstrating the benefits of community-based initiatives in enhancing mental health awareness and supporting caregivers (99).

### ■ **Caregiver allowances and respite care**

High out-of-pocket expenditure is incurred for treatment, as well as indirect costs such as loss of income due to unpaid time off work for extended periods of hospitalization and sometimes resultant unemployment, leading to financial insecurity and in some cases poverty (100, 101). Caregiver subsidies and allowances can be highly effective in reducing the financial burden on caregivers, providing a much-needed safety net and ultimately enhancing their overall quality of life and mental well-being. It is crucial that these subsidies or allowances are sufficient to compensate for the challenges faced by caregivers, ensuring their effectiveness.

Respite care is a critical support for caregivers, offering them the opportunity to take a break from their caregiving responsibilities. It provides much-needed flexibility in managing their caring duties, enabling them to recuperate and have peace of mind, knowing they can seek help when needed. Respite care may include day-care facilities, short-term residential centres and in-home respite care. The quality and dependability of the care are essential components of respite care.

In Spain, caregivers who received home-care support and disability allowances through the programme for Promotion of Personal Autonomy and Care for Dependent Persons were found to have reduced symptoms of depression and increased life satisfaction, supporting them to provide continued care, reducing their reliance on formal health care systems (102).



## Policies and governance

- Leverage priority provided to mental health and health systems reforms by the political leadership in Member States to establish policies and mobilize financial and administrative measures that support deinstitutionalization and expansion of community mental health services.
- Establish a high-level committee that includes representatives from the health, social, financial, administrative and judicial sectors, the NGO sector and representatives of those with lived experience and caregivers to plan and implement the process of deinstitutionalization.
- Develop and implement comprehensive national and subnational deinstitutionalization action plans that also include measures to prevent re-institutionalization or trans-institutionalization, that include time-bound outcome-focused measures and roles and responsibilities of different stakeholders and sectors.
- Update mental health policy and laws to include human rights, deinstitutionalization, the scaling up of community-based care, the prevention of the construction of new psychiatric institutions, a reduction in admissions to such institutions, and ensuring that involuntary admission is a last resort and is conducted with appropriate legal safeguards.
- Strengthen regulations governing quality of mental health establishments and standardize registration of government and private, for-profit and non-profit mental health facilities.
- Increase budgetary allocations and expenditure for community-based mental health services, while correspondingly repurposing funds for mental institutions to support deinstitutionalization through temporary parallel funding for both institutions and community care (12).
- Increase literacy of professionals and policy-makers on the UN Convention on the Rights of Persons with Disability (UNCRPD).

## Stakeholder engagement and advocacy

- Partner with NGOs and civil society groups to expand mental health services and advocacy efforts.
- Establish caregiver education, support and respite programmes in collaboration with the social and nongovernmental sectors.
- Collaborate with the social services sector and institutions to create an enabling environment for recovery in communities by generating employment opportunities, fostering social integration and providing adequate support, such as supported-living facilities, insurance and disability allowances for people with lived experience and their families.
- Establish vocational training programmes in collaboration with the education sector that enable individuals with mental health conditions to integrate into society.

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- Engage individuals in the community, including people with lived experience, their families and diverse community members (e.g. local council members, faith leaders, law enforcement, health workers) to support deinstitutionalization interventions in communities.
  - Sustain capacity building in relation to the rights of those with mental health conditions, for all relevant stakeholders (including decision-makers, planners, etc.), including the WHO QualityRights tools and materials (103).
  - Document, publish and circulate good practices leading to successful deinstitutionalization and shift towards community-based mental health services.
  - Develop information and communication packages on deinstitutionalization, the prevention of further institutionalization and sustaining policies.

## Service delivery

- Develop and expand community mental health services and networks, including outpatient clinics, crisis-intervention teams, supported-living facilities, day-care centres, social enterprises and home-based care programmes, as specified in the *Mental health action plan for WHO South-East Asia Region 2023–2030*.
- Improve access to and acceptability of mental health services by expanding primary mental health care services specifically in remote areas through community health workers and mental health tele-services.
- Establish referral pathways and operational guidelines for using individual plans at psychiatric in-patient units, involving both those with mental health conditions and their families to facilitate the transition into the community, prevent relapse and support independent living and social recovery.
- Establish mobile crisis-intervention teams that can respond to mental health emergencies in the community, reducing the need for hospitalization.
- Shift the focus of mental health training for health care and social care professionals, including general practitioners, nurses and community health and social workers, from mental institutions to community-based mental health networks. Adopt a competency-based approach to training and capacity building.
- Strengthen medicine procurement, distribution and storage systems to ensure access to essential psychotropic medications.
- Promote peer-support programmes in which individuals with lived experience provide guidance and support to others.

## Monitoring and research

- Incorporate data related to deinstitutionalization (admissions, discharges, readmissions and facility-based data) into existing HMIS data collection, reporting and evaluation.
- Invest in research to evaluate the effectiveness of innovative community-based mental health services and interventions in the WHO South-East Asia Region, and document the financial implications of transitioning towards community services.

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# Annex 1: Framework used for the report

## Context

- Background and history on long-stay psychiatric institutions;
- Demographic characteristics and population trends relevant to long-stay psychiatric institutions;
- Global trends and evidence supporting the shift towards deinstitutionalization;
- Cultural, social and economic factors in the region necessitating deinstitutionalization; and
- Specific contextual factors in the region that need to be considered when developing recommendations for deinstitutionalization.

## Policy legal framework

- Existing policies and regulations governing long-stay psychiatric institutions (e.g. guidelines on admission criteria, discharge planning and quality standards);
- Adherence to international human rights conventions that advocate for deinstitutionalization in mental health;
- Alignment of country-level policies with international best practices in deinstitutionalization and community-based care;
- Presence of deinstitutionalization processes and principles and right to live in the community in mental health policies and legal framework of each country; and
- Policy changes and updates needed to support the deinstitutionalization process in the region.

## Service-delivery models

- Long-stay psychiatric institutions in each country (facilities, beds, admissions);
- General hospital with psychiatric wards and community residential facilities (facilities, beds, admissions);
- Types of community-based services that promote recovery, independence and social inclusion for individuals with mental health conditions;
- Challengers and barriers to adapting, implementing and scaling up community based mental health services; and
- Recommended service-delivery models and approaches for effective deinstitutionalization in the region.

## Stakeholder engagement

- Governmental and nongovernmental organizations (NGOs) involved in the provision of mental health services in each country;
- Roles and responsibilities of various stakeholders (e.g. government agencies, NGOs, health care

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- professionals, people with lived experience, caregivers etc.);
  - Collaboration and coordination between stakeholders to ensure person-centred care in community-based settings;
  - Challenges faced in effective stakeholder engagement in deinstitutionalization;
  - Recommendations for involvement of stakeholders, including policy-makers, health care professionals, service users and their families in deinstitutionalization processes; and
  - Strategies that can be employed to promote collaboration and engagement among stakeholders.

## Monitoring and evaluation

- Mechanisms for monitoring and evaluating the performance and quality of mental health services in the region; and
- Strategies to strengthen data collection and analysis systems and ensure reliable and valid measurements of deinstitutionalization outcomes.

## Sustainability

- Overview on challenges and opportunities for deinstitutionalization in the long-run, considering financial, political, social and cultural drivers; and
- Recommendations to improve sustainability of deinstitutionalization efforts.

## IDEA approach to service delivery

The IDEA approach to service delivery stems from circumstances and contexts wherein implementing deinstitutionalization is not an immediate possibility. This may be due to a range of social, political and economic conditions such as private control of psychiatric institutions, over-reliance on such hospitals for mental health service delivery, and poor public funding for community mental health.

Therefore, the IDEA approach allows for a parallel process to address some of these challenges while scaling up community care (1).

IDEA is based on the establishment of three different and simultaneous programmes and their constant assessment. The three programmes are associated with three virtual spaces of action within the psychiatric hospital: i) the exit door; ii) the entrance door; and iii) the inner space.

The acronym IDEA stands for:

**I**ncreasing community care for those who can leave the psychiatric hospital;

**D**ecreasing admissions in psychiatric hospital;

**E**nhancing quality of care and rights of those who stay in psychiatric hospital; and

**A**ssessing periodically the process.

Programme 1 – Increasing community care for those who can leave the psychiatric hospital) works on the *exit door* and puts its focus on a group of users who present clinical and social conditions (severity of symptoms, family support, existing community resources) allowing a relatively easy

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discharge from hospital. This group of users should be identified through a careful social and clinical assessment by a group of professionals (nurses, psychologists, psychiatrists and social workers), put together to identify potential solutions within their own communities (family or independent protected facility accommodation) and negotiate the discharge with local communities, families, primary health care services and other specialist services, if they exist.

Programme 2 – **Decreasing admissions in psychiatric hospital** – works on the *entrance door* and requires a limited group of senior staff to identify the catchment areas that could potentially be able to significantly decrease the admissions in psychiatric hospitals.

Too often, deinstitutionalization is seen exclusively as a process aimed at discharging patients from psychiatric hospitals, while the significant and core factor promoting the progressive decreasing of the size of psychiatric hospitals is the reduction in admissions more than the increase in discharges.

If a psychiatric hospital were to stop new admissions, leaving untouched its existing population, it would disappear in 20 to 25 years by the natural death of its population. However, a psychiatric hospital able to discharge a significant number of patients (such as 50%) but without stopping new admissions, will continue to exist forever because of the arrival of a new population of young chronic patients.

In other words, when health authorities find difficulty in discharging many chronic patients, a successful strategy is to slowly and systematically decrease new admissions.

The main objective of the programme is to establish connections with health and mental health services located in different catchment areas where the organization of care is relatively rich in terms of human and logistic resources.

These areas could be the first to commit to a reduction of admissions in psychiatric hospital. The presence and availability of beds for acute psychiatric patients in General Hospital would, of course, be a fundamental factor in facilitating the progressive decrease of psychiatric hospital admissions. In other words, catchment areas equipped with a community mental health service or team plus the possibility of admitting acute cases to the general hospital will be in the best position to stop new admissions to old asylums.

Programme 3 – **(Enhancing quality of care and rights of those who stay in psychiatric hospital)** works on the *inner space* of the psychiatric hospital and requires a larger group of staff (essentially, nurses, occupational therapists and psychologists) able to significantly improve the living conditions of those patients who are not candidates for rapid discharge from hospital due to severity of disability, age or social abandonment.

This means significantly enhancing human rights protection and respect, improving a variety of elements such as individual space, privacy and a general humanizing of the hospital facilities (toilets, sleeping rooms, living spaces).

In addition, meaningful activities of entertainment and periodic experiences of individual or group opportunities to go out on trips, should be systematically developed and implemented.

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The three programmes (**I, D, E**) should be constantly assessed and evaluated (Assessing periodically the process) by an independent group of people (mental health professionals, professionals from the justice system, human rights advocates, family and user association members) according to a set of pre-established indicators and criteria of quality (including the periodical application of the WHO QualityRights assessment process) (2).

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## Annex 1 references

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## Annex 2: Member state profiles

### Bangladesh

- population: **171 186 372** (1)
- DALYs (per 100 000 population): **1650.8** (2)
- income group: **lower-middle** (3)

#### Context

Bangladesh has been working towards the deinstitutionalization of mental health care by shifting from a centralized institutional model to community-based care.

The National Mental Health Strategic Plan (2020–2030) specifies provisions for the development of community-based facilities, the strengthening of rehabilitation services, and improving intersectoral linkages (4).

Governmental, nongovernmental, academic and international stakeholders work together in a network to improve mental health services and mental health literacy in Bangladesh.

#### Relevant data

- psychiatric institutions: **2**
- psychiatric units in general hospitals: **60**
- intermediate care/community residential facilities: –
- community-based mental health facilities: **0** (5)

#### Admissions

- beds in psychiatric institutions: **900** (5)
- total number of admissions in psychiatric institutions: **6076**
- involuntary admissions: –

#### Length of stay

- inpatients staying < 1 year: **5856**
- 1–5 years: **146**
- > 5 years: **74** (2)

#### Challenges and barriers

- Although the majority of Bangladesh's residents reside in rural regions, specialized mental health services are predominantly clustered in the capital city and a handful of urban areas (6).

- There is a severe shortage of mental health professionals, especially in rural areas. There are only 0.2 psychiatrists, 0.4 mental health nurses, and 0.3 psychologists per 100 000 population (2).
- Expenditure on mental health is low (0.5% of the total government spending on health) (2).
- Stigma towards people with mental health conditions is prevalent in Bangladeshi society, which may lead to social exclusion, hampering transition from institutions to the community (7).

### ■ **Key stakeholders**

- The Ministry of Health and Family Welfare (MoHFW) and Directorate General of Health Services (DGHS) lead mental health efforts, with a focus on community-based mental health services and strategic planning (7).
- National Institute of Mental Health (NIMH) and Pabna Mental Hospital provide specialized mental health services (4).
- NGOs such as the Sajida Foundation and ADD Bangladesh actively contribute by providing community-based mental health services, capacity building, and advocacy support (8, 9) .
- Private health care institutions, including medical colleges and clinics, contribute to mental health services in Bangladesh. They may provide specialized care, psychiatric consultations, and outpatient services (10).
- WHO and UNDP provide technical guidance and resources, and collaborate with the government and stakeholders to strengthen mental health systems and integrate mental health into primary care.

### ■ **Good practices**

#### *Collaboration between stakeholders in the mental health system*

In Bangladesh, multiple NGOs, such as the Sajida Foundation, ADD Bangladesh and Innovation for Well-Being Foundation, are working towards developing effective community-based mental health care. Their aim is to construct models that can subsequently be replicated by the government and implemented nationwide. Their work may include but is not limited to:

- empowering communities and families to provide support for those with mental health conditions;
- providing livelihood support for those with severe mental health conditions;
- providing psychosocial support through initiatives such as tele-counselling; psychiatric consultations, and training individuals in mental health first-aid;
- working closely with the government to improve mental health policies, programmes, and legislation; and
- providing follow-up support to those discharged from inpatient psychiatric care and linking them with other relevant stakeholders to ensure comprehensive care.

These efforts require NGOs to work closely with the local support systems and government institutions such as the union parishad and district-level administration. Some NGOs also collaborate with psychiatric institutions such as the NIMH and Pabna Mental Hospital. Further, by demonstrating evidence-based models of community-based care, they may incentivize the government to adopt these practices.

These collaborative efforts showcase the power of multiple stakeholders working in unison to provide comprehensive community-based mental health care.

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## Bhutan

- population: **782 455** (1)
- DALYs (per 100 000 population): **1579.4** (11)
- income group: **lower-middle** (3)

### Context

Formal mental health services were first established in 1997 with the launch of an outpatient department at Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) (12).

From the outset, mental health policies and programmes have focused on community-based mental health services and the integration of mental health care into the primary health care (PHC) system (13).

Bhutan is committed to improving mental health care, which is demonstrated by the establishment of the Pema Centre in 2022 as a nodal agency to spearhead mental health efforts and foster intersectoral collaboration (14).

### Relevant data

- psychiatric institutions: **0**
- psychiatric units in general hospitals: **1**
- intermediate care/community residential facilities: **0**
- community-based mental health facilities: **0** (5)

#### Admissions

- beds in psychiatric institutions: **0\***
- total number of admissions in psychiatric institutions: **0**
- involuntary admissions: **0**

#### Length of stay

- inpatients staying < 1 year: **713\*\***
- 1–5 years: **0**
- 5 years: **0** (11)

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\* There are 20 inpatient beds in JDWNRH; the Pema Centre has proposed a 60 bedded facility, but none seem to be long stay (for a duration of more than 1 year). \*\* This refers to patients admitted to JDWNRH since there are no mental hospitals in Bhutan.



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### ■ **Challenges and barriers**

- There is an absence of mental health legislation to protect and safeguard the rights of persons with mental illness.
- Specialized services are provided only at JDWNRH in Thimphu, hampering accessibility to such services for a large section of the population (15).
- There is a shortage of trained mental health professionals, with only four psychiatrists and no licensed psychologists (15).

### ■ **Key stakeholders**

- The Pema Secretariat is a comprehensive mental health hub working to implement policies, foster collaborations and provide proactive mental health services.
- There are no long-stay psychiatric institutions in Bhutan; mental health care is provided primarily in general hospitals. JDWNRH is the only hospital that provides specialized mental health services.
- Some halfway homes and community rehabilitation centres have been established by NGOs and civil society organizations for vulnerable groups; however, there are no dedicated halfway homes for those with mental health conditions (15).

### ■ **Good practices**

#### *Pema Secretariat*

Established in 2022 under the Royal Command of Her Majesty the Gyaltsuen, the Pema Secretariat is the central agency for mental health in Bhutan, undertaking vital roles encompassing policy formulation, programme implementation, data consolidation, and stakeholder coordination. It consists of a multi-divisional structure, out of which the Restoration and Rehabilitation Division, in particular, carries responsibilities that align with the principle of deinstitutionalization.

The Restoration and Rehabilitation Division is further divided into three sections: Treatment and Rehabilitation Services, Reintegration and Continuing Care Services, and Community and Outreach. Working together, these sections will formulate strategic plans, improve service accessibility, collaborate with relevant agencies, establish shelter and livelihood support services, and foster a supportive environment for affected individuals.

Encouraging a comprehensive approach to mental health care, the Pema strives to provide a wide array of services, which would include treatment and rehabilitation programmes, peer support services, aftercare and relapse services, skills development and vocational training, halfway homes, community integration programmes, and more.

This holistic approach showcases a robust commitment to moving away from institutionalization, emphasizing accessible services and supportive environments, aligning with global principles of deinstitutionalization for improved mental health services in Bhutan (14).

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## India

- population: **1 417 173 173** (1)  
.....
- DALYs (per 100 000 population): **2443**  
.....
- income group: **lower-middle** (3)  
.....

### Context

Mental health services in India trace their origins back to the colonial era, when psychiatric institutions were first established. However, since then, efforts have been made to develop and strengthen community-based services and mental health care at the primary health level (16).

Mental health policies, programmes and legislation highlight principles of deinstitutionalization such as the development of community-based mental health services, rehabilitation and reintegration of persons with mental health conditions, and intersectoral collaboration (17).

The District Mental Health Programme (DMHP), established in 1996 under the National Mental Health Programme (NMHP), is a flagship community-based mental health initiative operated by subnational governments with assistance from central government (18).

### Relevant data

- psychiatric institutions: 136 (46 government-run institutions)  
.....
- acute psychiatric inpatient wards: –  
.....
- intermediate care/community residential facilities: 223 (19)  
.....
- community-based mental health facilities: 167 000 (Government of India, Ministry of Health (Mental Health Division), communication, 1 March 2024)  
.....

#### Admissions

- beds in psychiatric institutions: –  
.....
- total number of admissions in psychiatric institutions: –  
.....
- involuntary admissions: –  
.....

#### Length of stay

- inpatients staying < 1 year: 68%  
.....
- 1–5 years: 25.7%  
.....
- > 5 years: 6.1% (19)  
.....

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### ■ **Challenges and barriers**

- The slow and incomplete implementation of the Mental Health care Act, 2017 and the National Mental Health Policy, 2014 (20) both present a challenge.
- Trained mental health professionals are scarce. In 2017, there were only 0.29 psychiatrists, 0.07 psychologists, and 0.80 mental health nurses per 100 000 population (19).
- Stigma and discrimination associated with mental illness are prevalent in India. Many people with mental health problems do not seek help as they fear discrimination, leading to underdiagnosis and undertreatment of mental illness.

### ■ **Key stakeholders**

- The Ministry of Health and Family Welfare (MoHFW) is the primary government ministry that oversees the implementation of mental health programmes and policies at the national level (21).
- The Ministry of Social Justice and Empowerment implements the Deendayal Disabled Rehabilitation Scheme, which provides rehabilitation services to people with psychosocial disabilities (22).
- Since mental health is a concurrent subject, the governments of states and Union Territories (UTs) are responsible for implementing and adapting mental health programmes, legislation and policies at their level.
- The Central Mental Health Authority (CMHA), the State Mental Health Authority (SMHA), Mental Health Review Boards (MHRB), the high courts, and the Supreme Court have been recognized as important statutory bodies by the Mental Health care Act, 2017 (17).
- NGOs and civil society organizations are key players in the process of deinstitutionalization. Their work may involve grassroots intervention, offering psychosocial support, advocacy and awareness raising, capacity building and policy evaluation.

### ■ **Good practices**

#### *Banyan's Home Again Initiative*

The Banyan is an NGO based in Chennai, Tamil Nadu, that offers comprehensive services to those with mental health conditions. One of their flagship programmes, the Home Again initiative, offers inclusive living options to women with psychosocial disabilities.

These homes empower their residents by granting them autonomy and the opportunity to live with dignity, all while receiving tailored support based on their specific needs. These homes are typically situated within community neighbourhoods, promoting interaction with the broader community. This not only aids their integration into society but may also reshape the attitudes of community members.

The effectiveness of the Home Again Programme has garnered recognition as a successful model of residential care for individuals with mental health conditions from esteemed international organizations such as *The Lancet* and WHO (23). There are currently 125 homes in 23 locations (24).

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### *Ayushman Arogya Mandir*

In a major step towards providing affordable, accessible and quality health services in India, more than 165 000 sub-centres and primary health centres have been upgraded as Health and Wellness centres (renamed “Ayushman Arogya Mandir”).

Launched with the vision of providing comprehensive, affordable, and quality health care services to citizens across rural areas, these centres are focal points for a range of health care services, including mental health interventions. They are key platforms for implementing the Mental, Neurological, and Substance Use Disorder Care Package, facilitating community participation, and reducing stigma surrounding mental health issues.

Staffed by mid-level health providers, known as community health officers, and other staff, the centres provide screening, counselling and referral services for individuals with mental health concerns (25).

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## Indonesia

- population: **275 501 339** (1)
- DALYs (per 100 000 population): **1241.4** (26)
- income group: **upper-middle** (3)

### Context

Indonesia follows a decentralized model of health services; provincial governments play a key role in planning and implementing mental health services (27). Mental health services are accessible at various levels within districts and provinces, consisting of primary, secondary and tertiary care options.

The devastation caused by the 2004 tsunami initiated a push towards community-based services and the integration of mental health care into the primary health care systems to reduce the burden on psychiatric institutions (10).

### Relevant data

- psychiatric institutions: **49**
- psychiatric units in general hospitals: **370**
- intermediate care/community residential facilities: **150**
- community-based mental health facilities: **310** (26)

#### Admissions

- beds in psychiatric institutions: **11 340** (27)
- total number of admissions in psychiatric institutions: **55 700**
- involuntary admissions: **357**

#### Length of stay

- inpatients staying < 1 year: **187 590**
- 1–5 years: **7220**
- > 5 years: **0** (26)

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### ■ **Challenges and barriers**

- There is uneven implementation of mental health services in the country due to decentralization of power across provinces.
- Stigma, discrimination and low mental health literacy result in unethical practices such as shackling of those with mental health conditions by family members. These factors also act as barriers against help-seeking behaviours (28).
- Mental health professionals are scarce. There are only 0.4 psychiatrists, 0.2 psychologists, and 2.3 mental health nurses per 100 000 population (25).

### ■ **Key stakeholders**

- The Ministry of Health formulates mental health programmes and policies; however, their implementation comes under the purview of the district and provincial governments.
- The Ministry of Social Affairs runs a handful of long-term residential care facilities called *pantis* (27).
- The Tim Pelaksana Kesehatan Jiwa Masyarakat (TPKJM) are multisectoral teams that operate at the provincial, district or village levels and participate in a range of activities from psychoeducation to handling mental health emergencies (29).
- The Komunitas Peduli Skizofrenia Indonesia, Perhimpunan Jiwa Sehat, and other local NGOs focus on advocacy and awareness for people with mental disorders and their families (30, 31).

### ■ **Good practices**

#### *Rebuilding mental health services in post-tsunami Aceh*

The province of Aceh in Indonesia was one of the worst hit regions of the 2004 tsunami. Prior to the tsunami, there was only one mental hospital in the province, which was damaged in the aftermath of the tsunami. Consequently, there was an urgent need for mental health interventions in this disaster-struck region, but a severe lack of mental health facilities (10).

As a result, in a significant move, over 100 local and international organizations mobilized to provide support to bridge this treatment gap. Their arrival highlighted the need for community-based mental health services; one of the main developments during this period was the development of a training course on community mental health nursing. Furthermore, the community in Aceh collaborated to establish day-care centres for those with mental health conditions. Another key outcome was the establishment of the first psychiatric intensive care unit in the Jantho General Hospital in Aceh, Besar.

After most of these organizations left, the Indonesian government collaborated with WHO to establish sustainable community-based mental health interventions through the integration of mental health services into the PHC system.

The collaborative efforts of mental health stakeholders in Indonesia in response to a significant mental health crisis in the aftermath of the tsunami exemplified the potential of intersectoral collaboration in advancing mental health care (10).

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## Maldives

- population: **523 787** (1)  
.....
- DALYs (per 100 000 population): **1375.6** (32)  
.....
- income group: **upper-middle** (3)  
.....

### Context

The National Mental Health Policy (2015–2025) prioritizes community-based services and mental health integration into primary and general health care. Long-term residential facilities are to be minimized, with a focus on rehabilitation for societal reintegration. Multisectoral collaboration with schools, prisons, NGOs, child and family protection services, local authorities, and police services is emphasized (33).

In Maldives, the health system operates on a tiered structure, with varying levels of services offered at different health care facilities. At the PHC level, mental health conditions are identified, and individuals are then referred to higher levels for treatment. There are no dedicated psychiatric institutions in the country for long-stay psychiatric service users (34).

### Relevant data

- psychiatric institutions: –  
.....
- psychiatric units in general hospitals: **8** (5)  
.....
- intermediate care/community residential facilities: –  
.....
- community-based mental health facilities: **0** (5)  
.....

#### Admissions

- beds in psychiatric institutions: **0** (5)  
.....
- total number of admissions in psychiatric institutions: –  
.....
- involuntary admissions: –  
.....

#### Length of stay

- inpatients staying < 1 year: –  
.....
- 1–5 years: –  
.....
- > 5 years: –  
.....

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## ■ **Challenges and barriers**

- There is a need to strengthen mental health services at the primary and secondary levels through adequate financing and the establishment of effective government structures (34).
- There is a lack of human resources and expertise for mental health service delivery. There are 3.2 psychiatrists, 1.2 psychologists, and 0 mental health nurses per 100 000 population (32).
- Specialized mental health services are concentrated in the Greater Malé region, hampering accessibility for those living on other islands (34).

## ■ **Key stakeholders**

- The Ministry of Health is responsible for mental health policies, laws, and programmes development, along with overseeing public health services and the Health Protection Agency.
- The Health Protection Agency implements public health programmes, including mental health initiatives, and collaborates with various sectors (34).
- The Indira Gandhi Memorial Hospital (IGMH) is the largest government hospital in Maldives, located in Malé. It has a mental health ward with nine beds and an outpatient clinic. The Centre for Mental Health (CMH) within IGMH provides specialist mental health services and acts as a referral point and centre of excellence (35).
- Regional and Atoll Health Services deliver health care, including mental health services, at regional and atoll levels, managing primary health centres and island pharmacies (36).
- NGOs and private sector entities offer a range of mental health, substance use, and neurological support services, including counselling, psychosocial support, advocacy, and awareness initiatives (34).
- HPSN is a residential facility for individuals with disabilities, including severe mental health conditions, and the elderly. The National Mental Health Policy (2015–2030) recommends that HPSN be converted into a facility for those with mental health conditions, with the aim of providing rehabilitative care to help reintegrate them into society (33).
- During the COVID-19 pandemic, a needs-based mental health network was established, incorporating all mental health NGOs and private sector entities involved in delivering mental health services. However, their presence is primarily in Greater Malé, limiting their outreach to atolls and islands (34).

## ■ **Good practices**

### *Aasandha Universal Health Coverage Scheme*

Aasandha, a state-owned enterprise, administers the Husnuvaa Aasandha universal health care scheme in Maldives (36). In recent years, in a significant development, the scheme has been expanded to encompass the treatment of mental health conditions (37). This expansion signifies that Maldivian citizens can access free mental health treatment through public health care facilities. Many private health care facilities are also empanelled into this system, with a portion of the costs covered by Aasandha while the rest are covered by out-of-pocket expenditure.

This scheme encompasses inpatient and outpatient treatment, the cost of prescription medicine, and overseas treatment when specialized services are unavailable within Maldives. This marks a significant step in prioritizing mental health treatment in Maldives, ensuring the accessibility and affordability of such treatments for the citizens of Maldives.



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## Myanmar

- population: **54 179 306** (1)
- DALYs (per 100 000 population): **1219.3** (38)
- income group: **lower-middle** (3)

### Context

In recent years, the country has experienced numerous crises, which include the political crisis caused by the coup d'état in February 2021, the COVID-19 pandemic, and Cyclone Mocha. Consequently, the mental health of those living in the affected areas is poor.

The National Mental Health Policy and Strategic Plan 2021–2025 aims to integrate mental health into the Essential Package of Health Services, achieve decentralized planning and foster multisectoral collaboration (39).

Mental health care is mainly provided by the public health system at the primary, secondary and tertiary levels (40).

### Relevant data

- psychiatric institutions: **2**
- general hospital with psychiatric inpatient wards: **17**
- intermediate care/community residential facilities: –
- community-based mental health facilities: **0 0** (5)

#### Admissions

- beds in psychiatric institutions: **1100** (5)
- total number of admissions in psychiatric institutions: **18 636**
- involuntary admissions: –

#### Length of stay

- inpatients staying < 1 year: **21 528** (38)
- 1–5 years: **280**
- > 5 years: **187**

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### ■ **Challenges and barriers**

- The recent political crisis and its aftermath have had a significant impact on the mental well-being of the citizens as well as on the functioning of the health system.
- The current Lunacy Act of 1912 fails to prioritize human rights, rehabilitation, treatment and care in relation to mental health. A new law was drafted but has not been endorsed.
- Myanmar lacks community-based mental health facilities such as halfway homes for individuals transitioning from institutions.

### ■ **Key stakeholders**

- The Ministry of Health is responsible for developing and implementing mental health policies and programmes and for providing mental health services at different levels of the health system.
- The Ministry of Social Welfare is involved in social support programmes for people with mental health problems and their families.
- The Ministry of Legal Affairs oversees the legal framework and human rights aspects of mental health.
- International and local NGOs, community-based organizations, and United Nations organizations, such as United Nations Children's Fund (UNICEF), United Nations Office on Drugs and Crime (UNODC) and WHO, provide technical and financial support for mental health initiatives.
- The Ministry of Education has university psychology departments that offer training and conduct research on mental health (40).
- The Mental Health Psychosocial Support (MHPSS) Working Group is present in the region with the primary purpose of enabling sustainable coordination and information sharing between MHPSS actors in Myanmar, harmonizing group understanding of principles for MHPSS intervention, facilitating referrals and, in emergency situations, disseminating the UN Inter-Agency Standing Committee (IASC) Guidelines for MHPSS in Emergency Settings (41, 42).

### ■ **Good practices**

#### *Aung Clinic: pioneering progressive mental health care in Yangon*

In a country fraught with crises, the Aung Clinic in Yangon serves as a beacon of progressive mental health care, championing human rights, recovery and community inclusion. People with mental health conditions can avail themselves of the services at the clinic, regardless of their diagnoses. The services provided include psychosocial counselling, psychological assessments, art therapy and peer support. Its emergency services play a crucial role in addressing crisis situations promptly, reducing the necessity for hospital admissions. Furthermore, outreach services are offered to those with lived experience and their families online or over the telephone. Additionally, the Aung Clinic actively collaborates with local government services and NGOs in Yangon (23).

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## Nepal

- population: **30 547 580** (1)  
.....
- DALYs (per 100 000 population): **1773.7** (43)  
.....
- income group: **lower-middle** (3)  
.....

### Context

Nepal has been working towards enhancing mental health services at the community level for several years.

The primary goal of mental health services in Nepal is to promote the rights and well-being of individuals with mental health conditions by providing them with care, support and rehabilitation within the community.

From the outset, institutional treatment for psychiatric conditions has not been the focus. Formal mental health services were introduced with the establishment of an outpatient department at Bir Hospital in 1961. Since then, multiple initiatives have focused on setting up community-based mental health services (10).

### Relevant data

- psychiatric institutions: **10** (44)  
.....
- psychiatric units in general hospitals: **46** (5)  
.....
- intermediate care/community residential facilities: –  
.....
- community-based mental health facilities: **0** (5)  
.....

#### Admissions

- beds in psychiatric institutions: **50** (5)  
.....
- total number of admissions in psychiatric institutions: –  
.....
- involuntary admissions: –  
.....

#### Length of stay

- inpatients staying < 1 year: –  
.....
- 1–5 years: –  
.....
- > 5 years: –  
.....

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### ■ **Challenges and barriers**

- Inadequate funding and stigma at the community level negatively impact the implementation of community mental health programmes (45).
- Remote and rural areas face limited access to urban-centric mental health services, hampering effective community-based alternatives (46).
- There is a dearth of mental health professionals. There are only 0.6 psychiatrists, 0.1 psychologists, and 0.4 mental health nurses available per 100 000 population in the region (43).
- There is limited availability of reliable data and research on mental health and deinstitutionalisation outcomes, which can make it challenging to advocate for necessary resources and evidence-based practice (46).

### ■ **Key stakeholders**

- The Ministry of Health and Population oversees the mental health programme in the country and formulates policies, strategies and plans for mental health care.
- The Mental Health Directorate is the proposed unit within the Ministry of Health and Population that will be responsible for implementing and monitoring the mental health programme.
- NGOs in Nepal, including those led by individuals with mental health experiences, play vital roles in advocating for rights-based mental health care. They also provide essential services and conduct awareness-raising activities through various channels, although these efforts are project-specific and tied to global advocacy events.
- The government collaborates with NGOs to support homeless individuals affected by mental health conditions, employing a private–public partnership (PPP) model to fund organizations aiding in the treatment and rehabilitation of this vulnerable population (46, 47).

### ■ **Good practices**

#### *Koshish*

Koshish is an NGO established in 2008 and led by individuals with lived experience to promote mental health and psychosocial well-being in Nepal. Some of the work done by Koshish that aligns with the principles of deinstitutionalization and community-based mental health care are:

- providing mental health and psychosocial support services to people living with or at risk of mental health conditions and psychosocial disabilities in the community, particularly vulnerable populations;
- advocating for the adoption, amendment, and implementation of laws, policies, and programmes that are in line with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the Constitution of Nepal and that ensure the protection of the dignity and rights of persons with mental health conditions and psychosocial disabilities;
- promoting self-advocacy and empowerment of persons with mental health conditions and psychosocial disabilities through the formation of self-help groups, peer support networks and user-led organizations;
- collaborating and partnering with various sectors, such as health, education, social protection, employment and justice etc.; and
- initiating an Inclusive Community Mental Health Program in four municipalities, in collaboration with local governments. The project directly targets 5400 people with mental health conditions or psychosocial disability, as well as various community groups, health workers, teachers, students and government officials at all levels (47).

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## Sri Lanka

- population: **22 181 000** (1)
- DALYs (per 100 000 population): **1379.4** (48)
- income group: **lower-middle** (48)

### Context

Over the last four decades, psychiatric care in Sri Lanka has transitioned from an asylum-based approach to a district-wise hospital-based care delivery model (49).

The National Mental Health Policy (2020–2030) prioritizes community-based services, community involvement in treatment, and rehabilitation for those with mental health conditions in society (50).

Currently, community care is primarily delivered through outreach clinics situated at peripheral and remote health care centres.

The mental health policy calls for the establishment of at least one intermediate care facility in each province. The Kudil intermediate care facility in Jaffna is an example of a successful model of intermediate care (49).

### Relevant data

- psychiatric institutions: **1**
- psychiatric units in general hospitals: **118** (5)
- intermediate care/community residential facilities: **21** (48)
- community-based mental health facilities: **49** (5)

#### Admissions

- beds in psychiatric institutions: **1407** (5)
- total number of admissions in psychiatric institutions: **6755**
- involuntary admissions: **5686**

#### Length of stay

- inpatients staying < 1 year: **6243**
- 1–5 years: **95**
- > 5 years: **1** (51)

### Challenges and barriers

- The existing Mental Health Act is outdated and does not adequately address processes of deinstitutionalization.
- There is a dearth of mental health professionals. There are only 0.58 psychiatrists, 2.93 Mental Health Nurses, and 0.29 psychologists per 100 000 population (51).
- There is no clear demarcation in funding allocated to hospital-based and community-based services, making it difficult to ascertain expenditure on mental health.
- The quality and availability of services varies across provinces.

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## ■ **Key stakeholders**

- The National Mental Health Advisory Council (NMHAC) serves as the key advisory body at the national level, chaired by the Secretary of Health, providing crucial policy direction.
- The National Committee on Mental Health (NCMH) provides administrative and technical guidance for implementing National Mental Health Policy.
- The Directorate of Mental Health, under the Ministry of Health, oversees coordination and collaboration with all stakeholders involved in the policy's implementation.
- At the provincial and district levels, the Provincial Mental Health Committee (PMHC) and the District Mental Health Committee (DMHC) will be formed respectively to govern policy implementation (50).
- The National Institute of Mental Health is the largest mental hospital in Sri Lanka and provides inpatient care and rehabilitation services such as a day-care centre, occupational therapy, and activities to improve daily living and promote social reintegration (52).
- NGOs such as Nest and the National Council for Mental Health offer residential mental health facilities (53, 54).
- Some community psychiatric services engage volunteers from the local community or public officers from non-health sectors at the field level to facilitate services and deliver assistance (49).

## ■ **Good practices**

### *From asylums to decentralization*

Historically, Sri Lanka's mental health system relied heavily on the asylum model, with three major mental health asylums in Colombo, notably the Angoda mental hospital, which faced substantial criticism for its shortcomings. In 1938, a report on the Angoda mental hospital exposed inhumane practices and deplorable conditions for inmates, leading to his recommendation for the decentralization of mental health services in Sri Lanka (55).

Subsequently, the first outpatient clinic was established in Colombo General Hospital in 1939. In 1949, the first 24-bed acute psychiatric unit was established. This trend of decentralization of psychiatric services gained further momentum in the aftermath of the 2004 tsunami, when the need for community-based mental health services became abundantly clear (56). In response, a new mental health policy was formulated, emphasizing community-based mental health services, comprehensive care and the development of new cadres of mental health workers. Concurrently, the Angoda mental hospital was transformed into the National Institute of Mental Health (NIMH). While initially comprising 1728 beds when constructed in 1928, the NIMH now operates with 1500 beds, reflecting a reduction in the number of beds over time (52, 57).

In recent years, hospital-based mental health teams in Sri Lanka have extended their services to encompass community-based care, incorporating outreach clinics, residential rehabilitation centres, home-based care, community resource and support centres, and telephone helplines.

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## Thailand

- population: **71 697 030** (1)  
.....
- DALYs (per 100 000 population): **1341.9** (58)  
.....
- income group: **upper-middle** (3)  
.....

### Context

Thailand initiated the integration of mental health services into the public health care system following the Health for All by the Year 2000 policy by the WHO in 1978. It has since become the primary model of mental health service delivery (59).

Mental health care, spanning primary, secondary and tertiary levels, encompasses a wide spectrum of services, including rehabilitation, preventive measures and the promotion of mental well-being in addition to psychiatric treatment.

A robust Health Management Information System (HMIS) is in place for mental disorders and substance use; thus, all health facilities collect data on a regular basis (60).

### Relevant data

- psychiatric institutions: **20**  
.....
- psychiatric units in general hospitals: **118** (5)  
.....
- intermediate care/community residential facilities: **116**  
.....
- community-based mental health facilities: **3183** (5)  
.....

#### Admissions

- beds in psychiatric institutions: **5630** (5)  
.....
- total number of admissions in psychiatric institutions: –  
.....
- involuntary admissions: –  
.....

#### Length of stay

- inpatients staying < 1 year: **97 720** (58)  
.....
- 1–5 years: –  
.....
- 5 years: –  
.....

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### ■ **Challenges and barriers**

- There is a need to strengthen the capacity of primary and secondary health care providers to diagnose and treat mental disorders, as well as to monitor and supervise their performance (60).
- The mental health workforce is unevenly distributed, which may hinder accessibility to mental health services for parts of the population, particularly in rural and remote areas (60).
- The number of mental health professions is insufficient to meet the needs of the population, particularly in remote rural areas. There are only 0.29 psychiatrists, 2.9 mental health nurses, and 0.27 psychologists per 100 000 population (58).

### ■ **Key stakeholders**

- The Department of Mental Health at the Ministry of Public Health serves as the national authority for mental health in Thailand. It is responsible for national mental health policy, strategy, planning and development.
- The village health volunteers (VHV) are the main community mental health care personnel who work at the primary health care level. They provide mental health education, screening, psychological support and continuity of care for people in their communities.
- The local health personnel at the primary medical care level (health centres and primary care units) and the secondary medical care level (community and general hospitals) provide mental health services such as counselling, monitoring, referral and integration of mental health care into general medical care.
- The multidisciplinary mental health team at the tertiary medical care level (regional, university and psychiatric hospitals) provides specialized psychiatric care and rehabilitation, as well as training and supervision for local health personnel and community networks (59).

### ■ **Good practices**

#### *Village health volunteers: the backbone of the mental health system in Thailand*

Village health volunteers (VHVs) are a crucial component of Thailand's public health. VHVs are recruited from local communities and serve as a bridge between people and health personnel. They actively engage in community-level public health efforts, fostering the development of healthy and secure communities, mitigating vulnerabilities and enhancing resilience, including in the context of mental health (61). Their work encompasses psychoeducation, early detection of mental health disorders, facilitating treatment, and continued care or community rehabilitation. Another of their key responsibilities is to plan and implement activities to encourage community participation in mental health, thereby fostering awareness and concern for mental health conditions (62).

As of 2020, the Ministry of Public Health was managing over 1 million VHVs, highlighting the extensive reach and impact of these volunteers in Thailand's public health initiatives (63).



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## Timor-Leste

- population: **1 341 296** (1)
- DALYs (per 100 000 population): **2273.4** (64)
- income group: **lower-middle** (3)

### Context

The model of mental health service delivery is predominantly community-based and integrated into the primary health care system.

Mental health care is also family-centric; government mental health services lean towards biomedical model of care (65).

There is a National Mental Health Strategic Plan 2018–2022, developed through consultations between multiple stakeholders, including NGOs and families of those with mental health condition. Owing to a lack of capacity and the COVID-19 pandemic, it was not fully implemented (66).

### Relevant data

- psychiatric institutions: –
- psychiatric units in general hospitals: **1** (5)
- intermediate care/community residential facilities: **2**
- community-based mental health facilities: **5** (5)

#### Admissions

- beds in psychiatric institutions: –
- total number of admissions in psychiatric institutions: –
- involuntary admissions: –

#### Length of stay

- inpatients staying < 1 year: –
- 1–5 years: –
- > 5 years: –

### Challenges and barriers

- Mental health is a low priority for the government owing to more pressing socio-economic issues.
- There is a lack of policy and legislative frameworks to establish standard procedures of care and treatment protocols and protect the rights of those with mental health conditions.
- There is a severe dearth of mental health professionals at every level. There is only one psychiatrist and two psychologists for the entire population.
- There is widespread stigma and discrimination against people with mental health conditions, which can hamper help-seeking. Since the communities are close-knit, stigma can prevail even after recovery (66).

### Key stakeholders

- Mental health programmes are developed, implemented and monitored by the Mental Health Section under the Ministry of Health. This section is headed by a medical officer and comprises two mental health programme officers.
- There is a case manager in each municipality, however, currently the level of mental health care provided by them is unclear (66).
- Psychosocial Recovery & Development in East Timor (PRADET) is a key NGO, established in 2000, which is involved in a wide range of psychosocial efforts, including providing counselling, advancing clients' rights in the community and capacity building for those with mental health conditions (67).
- Mental health care is primarily family-centric; families are expected to play an important role in bringing their relatives with mental health conditions to appropriate care and support them through their recovery (65).
- The National Hospital at Dili provides tertiary care and consists of a 12-bed psychiatric ward. The two psychiatrists and the only clinical psychologist in TimorLeste work here.
- There is a Mental Health Care Centre at Laclubar in Manatuto municipality; however, there is a need to improve the standards of care (66).

### ■ **Good practices**

Prior to 1999, there were no mental health services in TimorLeste until the creation of Psychosocial Recovery and Development in East Timor (PRADET), through a collaborative effort with Australian mental health practitioners. This initiative saw the training of sixteen Timorese health workers in basic mental health practices in Australia, who then returned to constitute the foundational team of PRADET. The key responsibilities of PRADET's staff included assessment, diagnosis and treatment for persons with mental health conditions, as well as training district health nurses in providing follow-up care (68). In 2002, it was constituted as a national NGO.

Since its inception, PRADET has played a pivotal role in the mental health efforts in Timor-Leste, providing psychosocial services to people experiencing trauma, mental illness and other psychosocial issues. One of their key programmes is Programa Asistencia ba Moras Mental (PAMM), which is a community-driven response programme addressing the personal, collective, social and economic toll of traumatic mental disorders. From 2002–2015, PAMM worked closely with the Government Mental Health Service to provide psychosocial support in eight districts. In 2015, a pilot rehabilitation centre for those with mental health conditions was then opened at the PRADET office in Dili Hospital. The centre focuses on enhancing life skills to increase self-reliance and even supporting clients to establish small, home-based enterprises, facilitating integration into broader society. The PAMM team also conducts mental health training for various segments of the community, including public health staff, community leaders, and the families of clients (67).

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