Transitioning from long-stay services to community mental health networks

Towards deinstitutionalization in the WHO South-East Asia Region
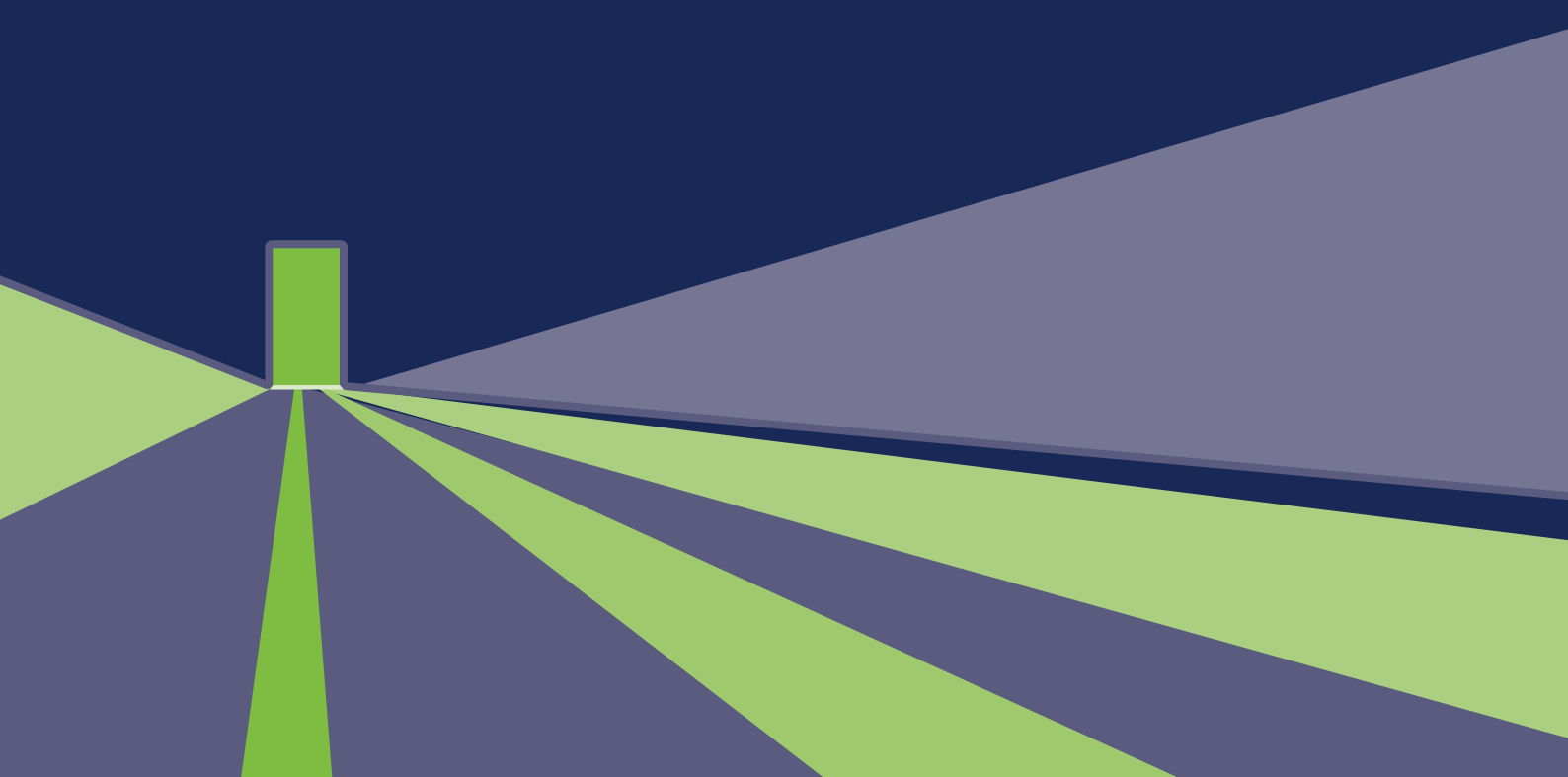
Bangkok, Thailand, 12–14 March 2024

World Health Organization

REGIONAL OFFICE FOR **South-East Asia**

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Abbreviations

CPQ   Community Placement Questionnaire

CRPD   Convention on the Rights of Persons with Disabilities

mhGAP Mental Health Gap Action Programme

ILO   International Labour Organization

Meeting objectives

General objective

- Support the process of deinstitutionalization of people with severe mental health conditions in Member States in line with Paro Declaration.

Specific objectives

- Identify opportunities for strengthening policy and legal reforms to expand community-based mental health networks and strengthen care practices;
- Analyse deinstitutionalization processes, share regional experiences and identify current barriers; and
- Explore methods for monitoring and evaluating the deinstitutionalization initiatives.

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Inauguration

Dr Jos Vandelaer, WHO Representative to Thailand welcomed the participants

Welcoming the participants, Dr Vandelaer stressed the importance of deinstitutionalization in the regional context. Institutionalization should not be the norm for people with mental health conditions. To ensure that this happens, mental health should be part of primary health care, and services should be provided as close to communities as possible. This requires a change of mindset, and the Paro Declaration *(1)*, adopted by Member States in 2022, provides an impetus. The experience of COVID-19 revealed the importance of mental health, and that communities can tackle health issues effectively. Dr Vandelaer described Thailand's strong mental health system and how it was linked to the village health volunteers.

Opening remarks by Ms Saima Wazed, Regional Director of WHO South East Asia Region

In her recorded speech, the Regional Director discussed the need to transition from long-stay services to community mental health networks in the WHO South-East Asia Region. She highlighted that 13.7% of the population in the Region suffers from mental health conditions, with a high treatment gap of up to 95%. Investment in mental health is low, and challenges include lack of investment, scarcity of human resources, stigma, and lack of prevention and promotion programmes.

Ms Wazed emphasized the benefits of deinstitutionalization, such as greater personal autonomy and improved quality of life. Deinstitutionalization is also cost-effective and allows for the allocation of resources where they are most needed. The importance of strengthening community-based mental health services was also stressed. She acknowledged that deinstitutionalization should be context-driven and culturally attuned. The Regional Director also announced the release of a report on deinstitutionalization in the Region and expressed hope for change and improved access to mental health services. The full text of the speech is in Annex 1.

Remarks by Dr Benjamas Prukanone, Assistant Director-General, Department of Mental Health, Ministry of Public Health, Thailand

In her remarks, Dr Prukanone identified that gatherings such as this meeting were very important in strengthening collaborations to address many types of health issues, to improve the health and well-being of the people of the Region. The challenges are multi-faceted and dynamic, requiring innovative and coordinated actions. Dr Prukanone considered the transition to community mental health systems as essential, explaining the advantages of such a transition, which include person-centred services leading to better outcomes and quality of life, reduced stigma, improved social inclusion and cost-effectiveness. Best practices supporting such transitions include capacity building, collaborations and stigma reduction.

Technical session 1

Regional perspectives: progress and way forward

Dr Andrea Bruni, Regional Advisor, Mental Health and Substance Abuse

The burden of mental health conditions in the Region is high and actions are being taken by WHO to address this issue. These include the PARO Declaration *(1)* by the health ministers of Member States at the Seventy-fifth Session of the WHO Regional Committee for South-East Asia on universal access to people-centred mental health care and services.

Based on the contents of the declaration, the *Mental health action plan for the WHO South-East Asia Region (2023–2030) (2)* has been developed, analyses carried out and several technical reports published, an interactive dashboard developed on the prevalence and burden of mental disorder, and a report published on deinstitutionalization of long-stay persons with mental health conditions. A series of webinars on different topics related to mental health are also being conducted regularly.

Global perspectives on deinstitutionalization and community-based mental health

Dr Devora Kestel, Director Mental Health, WHO headquarters

There is a need for a mix of services and support to cater for the full spectrum of mental health needs. Deinstitutionalization requires a shift in resources towards care in the community, coordinated by community mental health centres. Ten factors were identified for success in deinstitutionalization, including support at the highest levels, careful planning, engagement of residents, and stigma reduction. The effectiveness of self-help interventions, non-specialist counselling, and task-sharing with primary care providers in reducing the treatment gap and improving outcomes were also discussed.

The Mental Health Gap Action Programme (mhGAP) *(3)* for scaling up mental health care in low- and middle-income countries, and the integration of mental health into specific programmes and general hospitals were highlighted as one of the important aspects of supporting the deinstitutionalization process. The importance of mental health centres, mental health teams, supported living services, peer support services and clinical care in non-health settings was discussed. The crucial role of other sectors, such as education, employment and social services, in this process was also discussed.

Strengthening multisectoral support towards deinstitutionalization

Dr Helal Uddin Ahmed, National Institute of Mental Health, Bangladesh

The concept of deinstitutionalization and the importance of strengthening multisectoral support towards this goal was the focus of this presentation. Dr Ahmed emphasized the need for multisectoral collaboration, involving various sectors beyond health, to achieve a holistic approach to mental health care. Many key sectors within health, as well as sectors such as social welfare, education, finance and justice, need to be involved in the deinstitutionalization process.

A multisectoral approach was described, which includes policy development and advocacy, intersectoral coordination, capacity building, community empowerment and participation, research and evaluation, specific programmes for vulnerable groups, resource mobilization; improvisation

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in non-health sectors and implementation pathways are essential for the deinstitutionalization process.

The importance of evidence and research in the deinstitutionalization process was stressed. The need for a comprehensive and collaborative approach to deinstitutionalization, considering social determinants and involving multiple sectors to provide effective and community-based mental health care, was highlighted.

Health system perspectives towards deinstitutionalization

Dr Terdsak Detkong, Director, Bureau of Mental Health Academic Affairs, Ministry of Public Health, Thailand

Thailand has 18 psychiatric hospitals and a total of more than 4300 beds, with most inpatients staying for fewer than 30 days. Fewer than 20% of them stay for over 12 months. Mental health services are available at general hospitals and community hospitals.

The Mental Health Policy (2008) and the National Mental Health Action Plan Phase 3 (2023–2027) act as catalysts for service strengthening. Some actions in response to policy include promoting short stays, promoting home nursing, increasing telepsychiatry services, community participation and rehabilitation.

Community-based rehabilitation includes self-care and job training. Care plans are developed for individuals.

The role of Village Health Volunteers is to connect patients, families and mental health staff, promote mental health literacy, adherence, and long-term care, and work together with mental health staff, monks, temples, community leaders, police and Village Health Volunteers. The Ministry of Social Development and Human Security is involved in welfare and rehabilitation centres.

The service-related, patient-related and caregiver-related factors involved in addressing denationalization, and the policies and laws required, were also described.

Technical session 2

Barriers and facilitators to the implementation of psychiatric deinstitutionalization: a framework for sustainable action

Dr Cristian Montenegro, Researcher, University of Exeter, United Kingdom

The global persistence of psychiatric institutionalization, particularly in low- and middle-income countries (LMICs), consumes a significant portion of mental health budgets in these countries. Despite policy declarations and support from international organizations, the implementation of psychiatric deinstitutionalization remains complex and varies across countries. The Esidimeni tragedy in South Africa was given as an example of poor management of deinstitutionalization.

The barriers were categorized into different domains: planning, leadership, funding, knowledge/ science, power, interests and influences. Factors include services and support in the community, workforce, staff shortages, internal frictions, opposition from hospital staff fearing job loss, stigma and avoidance behaviour towards formerly institutionalized patients from community-based service providers, communities and the public.

The facilitators for these domains, such as the presence of a central mental health authority for coordination, direct fund transfer from reduced hospital expenditure to community-based services, and growth of disability insurance, were identified.

Steps to ensure a sustainable process of deinstitutionalization include a needs assessment, design and scaling up of the process, the financing of the transition, workforce development, implementation, monitoring and quality assurance, and involving different perspectives.

Limitations in the existing literature on deinstitutionalization was highlighted. Most work was developed from the late 1970s to the early 1990s, primarily based on the USA and Western Europe. The focus has been predominantly clinical, with little attention given to the implementation process. Additionally, the voices of caregivers, health care workers, and patients have been missing, leading to a skewed understanding of the implementation and impact of the process.

Some insights from qualitative sociology and oral history, including the ethical complexity of psychiatric deinstitutionalization, families reacting to instrumentalization, and the multiple definitions of "progressiveness" in the context of public/private simultaneity were highlighted.

Introducing the WHO SEARO regional report on deinstitutionalization: key findings

Dr Soumitra Pathare, Director, Centre for Mental Health Law and Policy, Indian Law Society

An overview of the report *Deinstitutionalization of people with mental health conditions in the WHO South-East Asia Region (4)* was presented. The prevalence of mental, neurological, and substance-use disorders and self-harm in the region, as well as the historical context of psychiatric institutions and recent shifts towards community-based services were described.

The policy and legislative landscape, including the ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) *(5)* by all member states, and specific policies in Sri Lanka, India, Thailand and Indonesia was highlighted. He also examined different service-delivery

models, such as psychiatric institutions, general hospitals with psychiatric units, and community-based residential care facilities. The availability of community-based services varies across the region, with India having the highest number of services.

The importance of monitoring and evaluation, with some member states having health management information systems for collecting mental health data, was emphasized. Factors impacting deinstitutionalization, including policies, governance, funding, services, stigma, discrimination, and resistance to the process, were outlined.

Key stakeholders in deinstitutionalization were identified, including government stakeholders, civil society organizations, the private sector, the mental health workforce, family members, caregivers, and persons with lived experience. The report also provides recommendations for policies and governance, stakeholder engagement and advocacy, service delivery and monitoring and research.

Country session 1

Implementation of the national strategy: expanding community care to move away from institutional care in Bangladesh

Professor Dr Avra Das Bhowmik, Director, National Institute of Mental Health

Bangladesh, with a population of 171.1 million, faces significant challenges in mental health. The prevalence of mental health conditions is high, with 18.7% of adults and 12.6% of children affected. Schizophrenia and bipolar disorder are the major mental disorders in the country. However, there is a substantial treatment gap, with 92% of adults and 94% of children not receiving the necessary care.

The existing mental health services in Bangladesh, including psychiatric institutions, psychiatric units in general hospitals, community-based mental health facilities, and tele mental health services were described. Pabna Mental Hospital and the National Institute of Mental Health play crucial roles in providing mental health care and are the only tertiary psychiatric hospitals in the country. The Mental Health Act in Bangladesh addresses involuntary admission and rehabilitation for individuals with mental health conditions. It establishes the formation of mental health review and monitoring committees at the district level, and outlines the duration of involuntary admission based on medical recommendations.

Bangladesh faces several challenges in mental health care. Insufficient resources, lack of funding for community-based services, and a shortage of residential facilities for rehabilitation and psychosocial services are major obstacles. Stigma and discrimination related to mental health, a weak referral mechanism, and a lack of data and evidence further compound the challenges. The recommendations to address these issues, including capacity building for health care providers, strengthening community-based services, advocacy for deinstitutionalization, and integration of mental health into primary health care were listed.

Strengthening mental health services in general health care to prevent institutionalization in Bhutan

Dil Kumar Subba, Senior Programme Officer, Pema Centre, Government of Bhutan

Mental health services are offered in various health care facilities, including national referral hospitals, regional referral hospitals and primary health centres. Additionally, there are other mental health services available, such as school-based services, prison-based services, civil-society-based services, case management, helpline services and rehabilitation services. There are no tertiary psychiatric care hospitals at present.

The mental health interventions are part of a national multi-sectoral strategy, and efforts are being made to integrate them into the National Five-Year Plan. A dedicated nodal agency has been established to harmonize interventions and ensure effective coordination. The primary health centres are guided by hospitals and provide free medical services. To enhance human resources in mental health, the country has implemented a psychiatry residency programme, counselling courses and reviews of the pre-service curriculum.

The need to take mental health services closer to the community, standardizing mental health services, training and research, integrating traditional services, and implementing monitoring and supervision was highlighted. Teleconsultation services are also mentioned as a means to provide specialist services remotely.

Strengthening integrated services in general health care, ensuring diverse specialized services for different age groups and conditions, monitoring the quality of mental health services through monitoring and supportive supervision, and enhancing prevention efforts through community awareness, networks and mental health literacy was discussed as the way forward for preventing deinstitutionalization.

Policies and laws supporting deinstitutionalization in India

Dr Neha Garg, Director, Mental Health, Ministry of Health and Family Welfare, India

The prevalence of mental health issues in the country and the need for universal access to affordable and quality mental health care was highlighted, and the timeline of milestones in mental health care in India, including the establishment of national and district mental health programmes, the enactment of the Mental Health Act in 2017, and the implementation of the National Suicide Prevention Strategy, was presented.

The history of deinstitutionalization in India was discussed, emphasizing the shift towards community psychiatry and the involvement of families in the care of patients with mental illness. India ratified the UN Convention on the Rights of Persons with Disabilities (CRPD) *(5)*, in 2007, and passed the Rights of People with Disabilities Act in 2016, both of which aim to protect and promote the rights of persons with psychosocial disabilities.

Mental health institutions in India, including central and state-run facilities and rehabilitation homes for persons living with mental illness, were described. The criteria for the discharge of recovered persons from mental health institutions and the care provided to them after discharge was elaborated.

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The District Mental Health Programme was described as a decentralized approach to extending mental health services, while the care at Ayushman Arogya Mandir focuses on the promotion, screening and referral of mental health disorders. The National Tele Mental Health Programme was highlighted as a means of providing universal access to mental health care through mental health services provided via video link.

Technical session 3

Study report on institutionalization and human rights situation, especially of persons with mental health issues and psychosocial disabilities in Nepal 2023

Matrika Devkota, Koshish, Nepal

The study highlighted that the deinstitutionalization process in Nepal does not align with the United Nations Convention on the Rights of Persons with Disabilities (CRPD) *(5)*, leading to an increase in institutionalization. The research methodology used a mixed-study method, including qualitative and quantitative data collection through primary and secondary sources. The key findings of the study include the educational status of the respondents, duration of stay in institutions, reasons for coming to the institution, and various challenges faced by the individuals.

The study revealed that a significant percentage of respondents were illiterate or had only basic education. The majority of respondents had been living in institutions for more than two years. The main reasons for coming to the institution were being rescued from the road or being left by patrons. The study also found that most individuals faced restrictions on their movement and lacked important knowledge. Recommendations from the study include increased investment in community-based services and deinstitutionalization efforts, public awareness and stigma reduction, and the establishment of an independent monitoring body.

Human rights and mental health care in India

Pratima Murthy, Director and Senior Professor of Psychiatry, National Institute of Mental Health and Neuro Sciences, India

The evolution of psychiatric services and the state of mental health care in India was described. Different committees, reports and reforms that have shaped mental health care in the country were discussed. The need for community-based care, rehabilitation and the involvement of multiple stakeholders in providing mental health services was emphasized. The role of legislation, policies and initiatives such as the Mental Healthcare Act, Ayushman Bharat, and the NIMHANS Digital Academy in improving mental health care were highlighted.

The importance of comprehensive mental health services, involving the community in managing mental illness and reducing stigma was emphasized. The need for training, research and the integration of mental and physical health care was discussed. The presentation concluded by highlighting the importance of credible sources of information and the recognition of efforts in health promotion, particularly in the field of mental health.

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Country session 2

Indonesian mental health reform plan: towards deinstitutionalization and community care

Ministry of Health, Indonesia

Mental health conditions are the second-largest burden of disease in Indonesia, surpassing cardiovascular disease and diabetes. Depressive disorders, anxiety and schizophrenia have the highest prevalence. However, there are several challenges in the mental health sector, including limited access to mental health services, a lack of mental health professionals, and the need for improved partnership and commitment of budget.

The Indonesian Mental Health Reform Plan includes various approaches, such as mental health promotion, prevention, case management and social rehabilitation. The plan also emphasizes the importance of strengthening leadership and governance, providing comprehensive and integrated mental health services in community-based settings, implementing strategies for promotion and prevention, and strengthening information systems and research. The presentation also highlighted the progress made in achieving these objectives and the way forward to address the challenges in the mental health sector in Indonesia.

Towards strengthening mental health care system in Maldives

National Mental Health Department, National Centre for Mental Health, Ministry of Social and Family Development, Society for Health Education

The country has a population of 540 542, with 41.3% concentrated in the capital city. The prevalence of mental health issues, such as depression and self-harm/suicide, is high. The National Disability Registry reports a total of 5847 cases, including multiple disabilities, intellectual disabilities, autism and psychological disabilities.

The country has a limited number of mental health staff, including psychiatrists, psychologists, social workers and nurses. There are no specialized tertiary care psychiatric hospitals. The National Centre for Mental Health, established in 2019, offers both inpatient and outpatient services. Other mental health support includes free counselling services, training of mental health ambassadors and psychosocial support for special groups. The Ministry of Social and Family Development provides holistic treatment, rehabilitation and reintegration programmes.

Efforts are being made to expand community mental health services through primary health care reforms. The presentation emphasized the need for strengthening governance, establishing national guidelines, continuity of care, rehabilitation measures and telemedicine. Training, monitoring and evaluation of programmes, as well as mental health promotion and prevention efforts, were also highlighted.

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Strengthening and sustaining community-based mental health services in Myanmar

Dr Aye Moe Moe Lwin, NPO, NCDs and Mental Health, WHO Country Office Myanmar

There is a lack of updated national-level data on mental health prevalence and treatment gaps, but some survey data from specific regions are available. The organization and coverage of mental health services, including the role of health care workers at grassroots level in providing basic care, was outlined.

The current state of human resource development in mental health was described, as were issues requiring urgent attention, which include the impact of conflicts and the COVID-19 pandemic on mental well-being. Different approaches and models are being implemented to integrate mental health services into different settings, including schools and cyclone-affected areas. The Myanmar Epilepsy Initiative (MEI) has been successful in improving access to epilepsy care services. The recommendations for strengthening mental health care in Myanmar includes the need for service provision in the Essential Package of Health Services, awareness raising and budget support. The importance of community-based mental health services and the need for sustainable and accessible care for all was emphasized.

Preventing the need for long-stay care in Nepal

Dr Leepa Vaidya, Psychiatrist, Dr Suraj Tiwari, Psychiatrist, Ms Rachana Shrestha, Section Officer, Governance, Ministry of Health and Population, Mr Ram Kumar Thapa, Civil Society Organization, Sindhupalchowk.

The presentation highlighted institutions for inpatient mental health services, such as government-run psychiatric hospitals, medical colleges, private hospitals and district hospitals. The complications of inadequate mental health services include homelessness, abuse, exploitation and medical complications. The causes of prolonged stays were identified as scarcity of psychiatric institutions, mental health workforce and budget, as well as dominance of biomedical care and stigma.

The major paradigms for mental health systems development in Nepal include psychiatric services, mental health at primary health care and a psychosocial approach. The progress made between 2015 and 2020, such as the Community Mental Health Care Package, mental health services at basic health service level, and updates of mental health medicines was discussed. The proposed mental health service delivery model focuses on deinstitutionalization and the integration of mental health services into general health services. The presentation concluded with strengths, weaknesses, opportunities, threats and recommendations for strengthening the mental health system in Nepal. These included recommendations on specific health system improvements, strengthening human resources and multisector approaches.

Group work 1: Addressing challenges to deinstitutionalization

On the second day of the regional meeting, participants collectively addressed the main challenges to deinstitutionalization. Five groups were formed, based on similarity in terms of country context and focus on deinstitutionalization or prevention of institutionalization. Over the course of an hour, the five groups identified the main challenges relevant to their contexts and recommended actions or strategies to address the problem, which were then presented to the plenary.

The group consisting of **India and Bangladesh** shared common macro- and micro-level challenges, which included resistance among mental health professionals to the process of deinstitutionalization, lack of trained allied health professionals, unreadiness of communities to accept people transitioning from long-term institutions back into the community. Other systemic concerns, ranging from insufficient community services, poor availability of medicines, lack of financial support and persistent stigma, were also causes for concern. Some of their recommendations included improving coordination between the different sectors through national consultations and shared responsibility of a high-level intersectoral committee. They also recommended strengthening community services by ringfencing funds for primary mental health care and improving referral pathways so that people get the care and services they need commensurate to the severity of their condition.

Indonesia and Myanmar recognized political will and the lack of the resources for mental health as a major challenge. The absence of political will was as a result of decentralized governance in Indonesia and the current political climate in Myanmar. Prioritization of mental health was also impacted by funding instability and poor availability of data. The lack of a trained mental health workforce was also viewed as challenge. To strengthen political will, it was recommended that by-laws related to mental health are enforced, mechanisms are setup to increase accountability among local governments to implement existing policies, and periodic evaluations are done to monitor implementation. To improve mental health human resources, the team recommended increasing professional development, introducing a mental health curriculum in health colleges and ensuring even distribution of human resources across the country. To reduce turnover of mental health personnel in underserved areas, they proposed conducting needs assessment for professionals and also creating accessible courses for people from different backgrounds.

Among the countries focused on preventing institutionalization, **Nepal and Timor-Leste** saw the adoption of a holistic psychosocial care model in addition to the prevailing medical model as integral. They also recognized the importance of empowering communities, increasing their capacity to provide informal support, improving access to services and prioritizing social support systems. The group acknowledged the limited understanding among policy-makers of alternative mental health services to institutional care. They proposed increasing advocacy efforts, facilitating policy discussions and demonstrating the effectiveness of the community-service model in improving mental health care.

Maldives and Bhutan identified the lack of policies and guidelines for community-based mental health care as a major barrier to preventing institutionalization. The group also highlighted the inadequacy of services as a concern. To address this problem, they proposed developing a comprehensive system that meets the needs of people with mental health conditions through a strong referral system and improved capacity of mental health service providers.

Field visit

Participants visited and observed the functioning of the Srithanya Hospital in Nonthaburi, which was facilitated by the Ministry of Public Health, Thailand.

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Technical session 4

Deinstitutionalizing mental health: a story of reform in a women's shelter home in Dehradun, India

Dr Bhupinder Kaur Aulakh, WHO Representative to Bhutan

The background of the shelter home was described, highlighting the poor living conditions and lack of medical care for the 140 homeless women, including 106 with mental health conditions.

To address these issues, a multipronged approach was adopted and various interventions were implemented. The living conditions were improved through renovations, including the installation of air conditioning, fans and mattresses. The kitchen was also upgraded with new equipment such as a water purifier and refrigerator. The nutrition of the residents was enhanced by increasing their daily allowance and providing a balanced, nutritious menu prepared by a dietician.

Medical care was improved by introducing round-the-clock onsite medical services, traditional therapy, and physiotherapy for bed-ridden individuals. Safety and security were enhanced through the installation of CCTV cameras, the presence of women guards, and the replacement of male staff with female staff. Engaging activities such as open schooling, entertainment and physical activities were introduced to promote the residents' well-being.

Testimonials from residents express their improved sleep, mental peace through yoga, and satisfaction with the cleanliness of the shelter home. Data presented shows a significant reduction in the severity of illness among the residents, indicating the success of the reforms.

Efforts were made to reunite the residents with their families. Through networking with government officials, social media and NGOs, families were traced and legal approvals and travel documents were obtained. A total of 450 women have been reunited with their families and sent back home.

Contextual adaptation of the community placement questionnaire (CPQ)

Dr Sudipto Chatterjee, Mental Health Unit, Department of Mental Health and Substance Use, World Health Organization

This presentation discussed the contextual adaptation of the Community Placement Questionnaire (CPQ) for planning the transition from long-term institutional care to community living for individuals with mental health conditions. The objective of the study is to adapt and assess the reliability of the CPQ in diverse settings across regions for its global use as an open access tool. The CPQ is a reliable and valid standardized rating scale with nine sections and 48 items that estimate needs for care, abilities, social functioning and placement options. Section 9 of the CPQ focuses on accommodation/living facility options for the local context, including independent living, living with family or other familiar persons, independent group homes, supported group homes and various levels of staffed homes.

The study design is a multi-site, cross-sectional study that combines quantitative and qualitative methods. The study will be conducted in psychiatric hospitals that provide long-term care for at least 50 people with mental health conditions. The study population includes health providers

(CPQ raters) and individuals with mental health conditions and psychosocial disabilities who have been living in the institution for six months or more.

The study will involve engagement with WHO regional and country offices, national authorities, and advisory groups. The study protocol will be submitted for ethics review, and study sites will be selected and characterized. Community-based resources will be mapped through interviews with key informants and desk review. The CPQ will be translated and contextually adapted, and pre-focus groups and training workshops will be conducted with CPQ raters. Data collection, recruitment, pre-test reliability assessments, and post-focus groups with CPQ raters will be carried out. Data analysis will be conducted, and country-specific and cross-countries reports and recommendations will be developed. The expected results include strengthened capacities, the publication of an evidence-based CPQ toolkit, and the potential global benefit of using the CPQ for planning safe and effective transitions to community living.

Promoting decent work for people with lived experience in mental health

Dr Yuka Ujita, Senior Occupational Safety and Health Specialist, International Labour Organization, Bangkok

This presentation focuses on the International Labour Organization (ILO) and its efforts to promote decent work for individuals with lived experience in mental health. The ILO is a specialized agency of the United Nations that was established in 1919. It has a unique tripartite structure that includes governments, employers and workers.

The ILO's Decent Work Agenda, established in 1999, aims to promote opportunities for both men and women to obtain decent and productive work in conditions of freedom, equity, security and human dignity. This agenda includes guaranteeing rights at work, creating opportunities for decent employment, enhancing social protection and promoting tripartism and social dialogue.

The significant number of work-related accidents and diseases was emphasized, with nearly 3 million people dying from such causes globally. Additionally, there are 395 million non-fatal occupational injuries worldwide. The WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury provide further insights into this issue.

The ILO has developed various tools and initiatives to address health and safety at work. These include policy advisory support, technical assistance, international labour standards, codes of practice, guidelines, training tools and social dialogue. The organization has also established standards in the area of occupational safety and health, including the Occupational Safety and Health Convention and Protocol.

In terms of disability and work, the ILO has instruments such as the Vocational Rehabilitation and Employment Convention and Recommendation, as well as the Discrimination Convention. The organization also provides resources and reports on personal assistance policies for persons with disabilities.

The ILO's Global Business and Disability Network is an employer-led initiative that promotes the inclusion of people with disabilities in workplaces worldwide. The network showcases good practices and encourages businesses to lead the way in disability inclusion.

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Country session 3

Strengthening primary and secondary care to reduce institutional care in Sri Lanka

Dr Rohan Ratnayake, Director Mental Health, Ministry of Health, Sri Lanka

The timeline of the expansion of services at the primary and secondary levels, including the establishment of inpatient units, outpatient clinics, outreach clinics and mobile clinics, was presented. Mental health personnel, such as psychiatrists, medical officers, psychiatric nurses and social workers were increased, and sustained progress was made in developing in mental health care after the tsunami disaster in 2004, including the implementation of the Mental Health Policy of Sri Lanka from 2005 to 2015. The role of the National Institute of Mental Health in providing specialized care and support was emphasized, along with the implementation of various programmes and initiatives.

Novel supply chain and dispensing approaches, redirection of patients, home and community outreach services, and strengthened helpline services had been used to overcome service disruptions.

Several success stories and achievements in mental health care were highlighted, such as the establishment of the National Institute of Mental Health, the strengthening of human resources, inclusion of psychiatry in undergraduate medical education, training programmes for various mental health professionals, and the development of policies, guidelines and research initiatives. The challenges faced in mental health care include limited resources and funding. The current priorities include conducting a national mental health survey and addressing neurodevelopmental disorders.

Towards a paradigm shift in mental health: from institution-centred to community-based care in Thailand

Dr Suttha Supanya, Dr Terdsak Detkong, Dr Supasaek Virojanapa and Dr Yanika Valeeittikul, Department of Mental Health, Ministry of Public Health, Thailand

The mental health service structure in Thailand was described and compared to the WHO Pyramid Model. The current strength of the mental health workforce and psychiatric ward capacity in affiliated hospitals was detailed. Legislation related to mental health includes the Mental Health Act of 2008 and the Narcotic Addict Rehabilitation Act (2023). Community engagement is through the Village Health Volunteers and other stakeholders. The service flow for psychiatric and addiction patients in Thailand was described.

The challenges to deinstitutionalization in Thailand include financial limitations, infrastructure gaps and limited evidence base. The establishing of policy and legal frameworks, public awareness, and family and community support to promote deinstitutionalization needs to be prioritized to ensure success.

Strengthening mental health services through the municipalities in Timor-Leste

Anabela Clementina da Costa Guterres, Martinha Maria do Rego Mesquita (Ministry of Health Timor-Leste), Nicolau Vicente Ximenes (Psychosocial Recovery and Development in East Timor), Lauriano Fernandes (Association of Psychology of Timor-Leste)

Timor-Leste, a sovereign state since 2002, has a population of 1.3 million and is dealing with significant challenges, such as poverty, malnutrition and gender-based violence. The country has a limited number of health facilities, including one national hospital, five referral hospitals, 72 community health centres, and 340 health posts.

There are two psychiatrists and one clinical psychologist based at the national hospital, as well as mental health case managers, psychologists, nurse psychiatrists, nurses, counsellors, community facilitators and youth community volunteers based in various organizations and NGOs. The country also has several community mental health treatment centres that provide different levels of care and rehabilitation.

Timor-Leste has implemented key strategic policies and guidelines for mental health, but still faces challenges such as limited resources, lack of investment and a lack of knowledge and access to mental health services in the community. Recommendations to strengthen the service for mental health include increased investment and funding, strengthening the referral mechanism, and establishing a regional mental health network.

Group work 2: Country level action towards deinstitutionalization and preventing (re)institutionalization

On day three, the Member States each worked to develop a high-level action plan to increase deinstitutionalization and prevent (re)institutionalization. Countries discussed country-specific needs and contexts, identified corresponding actions with outcomes, and measures, resources, capacities and processes required to achieve the outcomes.

After a lively discussion, each country presented their action plans to the plenary.

Bangladesh began with their presentation identifying four major challenges in the country, namely (1) unequal distribution of resources for mental health (both human resources and funds); (2) unreadiness of communities (stigma, discrimination, resistance from professionals and low availability of psychotropic medication in health facilities); *(3)* poor multisectoral coordination; and, (4) the lack of data and evidence to improve access to quality care. The country has a robust policy-legislative landscape to enable successful deinstitutionalization, backed by political commitment of the government. However, it is impeded by poor enforcement and allocation of resources. Therefore, the team proposed converting policy to action by establishing monitoring and review committees in all districts, building human resources capacity through Mental Health Gap Action Programme (mhGAP) training, and establishing mental health centres and tele-medicine services at a sub-district level.

The next country, **Timor-Leste**, reported as a limitation a lack of knowledge among decision-makers and community members on the objectives and concepts of deinstitutionalization. The absence of human resources was a further challenge. To prevent institutionalization, the

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country representatives recommended building capacity of human resources to provide mental health services in the community and raising awareness among members. They recognized the role of government stakeholders towards allocating appropriate funds towards such services, disseminating guidelines on community mental health and psychosocial support, building a national network for mental health and psychosocial support, and establishing an appropriate coordination mechanism among relevant stakeholders.

Thailand was the next to present their action plan. The main challenges observed related to policy implementation that was impacted by poor budgetary and financial allocations, and the dearth of infrastructure for mental health care. Patients, families and providers also acknowledged a limited understanding of the process of deinstitutionalization, which hindered transitioning people to communities. Further, another major obstacle was the lack of integration of health with social and non-health sectors. All these challenges were influenced by existing social norms and biases, the changing economic situation and variances between urban and rural contexts. Their action plan consisted of three components. First, the strengthening of policy advocacy at all governance levels, including introducing legislation for rehabilitation services that consider the continuum of care required for people transitioning to communities. They also called for the adoption of such policies at the provincial level. Second, the training of all mental health cadres – in particular on the adoption and implementation of the Community Placement Questionnaire (CPQ). Capacity building would have to be supported by adequate financial allocation and the provision of consistent technical support. Lastly, they recommended the development of strong networks at national, provincial and community level, with the involvement of various ministries, including those for social development, labour, public health and digital economy.

They were followed by **Nepal**, which delved into the contextual challenges within the country. They reported that the legal ecosystem still supported the opening of institutions, which would need to move to community-care services and centres. Psychosocial care was yet to be recognized as formal care, with social workers and psychologists not an official part of the government system. Generally, the health system required strengthening. As a result, people with severe mental health conditions did not receive appropriate care and were subjected to homelessness and poverty. The team developed a detailed roadmap containing: (1) amending legal provisions that facilitate institutionalization, (2) strengthening delivery of psychosocial care in collaboration with social services, and (3) integrating mental health services into general health care. The roadmap is set out in Table 1.

Table 1. Nepal roadmap to address deinstitutionalization

Outcome	Activities	Timeline	Resources/capacity
1. Legal provisions facilitating institutional care amended	1.1. Organize series of advocacy events among parliamentarians, policy makers, line ministries on institutional care 1.2 Introduce measures against institutional care in upcoming revision of Disability Rights Act	1.1 Every three months starting from March 2024 1.2 By 2025	Ministry of Health and Population (MoHP) in collaboration with the National Human Rights Commission, organization of persons with lived experience such as Koshish
2. Psychosocial care strengthened in collaboration with social sector	2.1 Mental health sector works with existing social structures such as Gender Equality and Social Inclusion (GESI) to facilitate social protection 2.2. Organize policy discussion with social ministry to set up social care services	2.1 Ongoing 2.2 June 2024 and follow-up meeting when needed	Ministry of Women, Children and Senior Citizen, GESI section of MoHP, provincial and local government/ NGOs
3. Mental health services integrated into general health care	3.1 Organization and management survey to determine human resources required to implement district hospital mental health services in line with current mental health programme 2022 3.2 Expand inpatient care in larger general hospital 3.3 Continue integration of mental health at primary care level	3.1 2025 (first quarter) 3.2 July 2024 3.3 Ongoing	Policy Planning Division of MoHP, Ministry of Federal Affairs, Curative Service division, Epidemiology and Disease Control Department

The country team from **Indonesia** highlighted poor political will towards deinstitutionalization and the scarcity of mental health resources as the main challenges. The lack of political will was on account of decentralization that affected administration at provincial levels. To address this

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concern, the development of a "Mid-term National Plan" was proposed which defined indicators for screening people at risk, introducing psychiatric services in general hospitals, and increasing *puskesmas dengan layanan jiwa* (community health centres providing mental health services). Additionally, they proposed introducing a minimum standard of service that should be met by local governments that comprised of establishing community health centres with trained mental health personnel, ensuring municipalities have a shackle-free certification, improving availability of psychiatric medication and setting up supported living facilities. To address the poor availability of mental health resources, they recommended developing a roadmap to integrate mental health in primary care.

For **Sri Lanka**, the challenges to deinstitutionalization were the persistent economic crisis, inadequate awareness among mental health professionals, carers and community members, and issues related to human resource development. The action plan proposed by the team focused on (1) providing support to carers through training on emergency management, medication and home-based rehabilitation through district mental health teams; (2) integrating mental health services into primary health care by improving out-patient services and follow-up care; and (3) strengthening multisectoral collaboration through district psychosocial forums and district mental health progress review meetings.

Myanmar identified several similar challenges to deinstitutionalization, such as the lack of a legal-policy framework and protecting the rights of people with mental health conditions, a weak public health system and the shortage of trained mental health human resources. The strategy to address these challenges required multiple actions, including the enactment of a new mental health law that focuses on discharge planning and improving community mental health, strengthening and sustaining mental health care at a primary level, incorporating community integration in the long-term care of patients, raising necessary funds, developing rehabilitation programmes and community residential services, and conducting implementation research to identify gaps in the process of deinstitutionalization.

In addition to similar policy and health system challenges, the country team from **Bhutan** pointed to lack of community acceptance as a barrier to integrating people with severe mental health conditions in the community. The first step towards addressing the challenges described by the team was to undertake an assessment of the current situation, whereby people are institutionalized for a long period, which could include prisons and homebound shelters. This is important in a country where institutionalization of people with severe mental health conditions may occur outside of traditional mental health hospitals. The team also proposed adopting a holistic and compassionate mental health care model that engages all relevant stakeholders. Given the country's context, such an approach should leverage spirituality and technology. To prevent institutionalization, there should be a routine evaluation of policies and legislation related to mental health.

The **Maldives** team recognized that there was a limited understanding among policy-makers of the importance of preventing institutionalization and the necessary steps to be taken in this regard. Therefore, they proposed conducting a high-level meeting with relevant ministries and civil society to increase commitment to prevent institutionalization. To address the challenge of limited human resources in multiple sectors, they recommended developing a comprehensive training plan after an assessment of the capacity building needed to promote community services in order to enable

recovery of individuals with severe mental health conditions.

Lastly, **India** identified three major actions necessary for deinstitutionalization. The first would be to set up a National Steering Group comprising government, and representatives from civil society and people with lived experience, who would be responsible for evaluating the processes involved. The next proposed action was to increase the availability of community facilities providing outpatient, inpatient and emergency mental health services through the ring-fencing of funds for such services. Finally, the team suggested the mapping and registration of all public and private mental health establishments, particularly those providing long-term care facilities.

The presentations were followed by a discussion that emphasized the importance of supporting people with mental health conditions, their carers and families during the process of deinstitutionalization. In order for the process to be successful, these stakeholders should be supported to develop autonomy, ensuring that they are able to care for themselves and their loved ones without having to depend on institutional services.

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Annex 1. Regional Director's opening remarks

Overview: regional considerations

- In the WHO South-East Asia Region it is estimated that 13.7% of the population suffers from a mental health condition.

- The treatment gap for mental health conditions remains large – as high as 95% in some countries.

- More than 200 000 people die of suicide every year.

- People with severe mental disorders die 10 to 20 years earlier than the general population.

- Investment in mental health remains very low across the Region: only Maldives and Myanmar spend more than US$1 per capita on mental health.

- Challenges include: lack of investment, scarcity of human resources, widespread stigma, lack of prevention and promotion programmes, scarcity of data and lack of primary care mental health services in many countries. Many countries need to shift their focus from psychiatric hospitals to community-based mental health services.

Deinstitutionalization: moving away from long-stay services to community mental health networks

- The impact of mental health conditions is pervasive, touching individuals and societies alike, regardless of geographical location. 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 perpetuated.

- Transitioning from long-stay psychiatric institutions to community-based care is beneficial for both individuals and society at large. This shift in care 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 services 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 *Mental health action plan for the WHO South-East Asia Region (2023–2030)* provide impetus and pathways for establishing both deinstitutionalization and strengthening community-based services and support systems.

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- There are no one-size-fits-all solutions to deinstitutionalization. It must be a context-driven, culturally attuned process.

- I am pleased to release the report *Deinstitutionalization of people with mental health conditions in the WHO South-East Asia Region*, which acknowledges the complexities and unique contexts of each country within the 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.

- This meeting will be a milestone in improving equitable access to mental health services, and I look forward to actions in countries. WHO will remain committed to supporting countries in this endeavour, which is one of my priorities.

Annex 2. Programme

Day 1: Wednesday 12 March 2024

	Opening session	**Moderated by Olivia Nieveras**
09.00 – 09.10	Welcome	Jos Vanderlaer
09.10 – 09.20	Address by Regional Director	Saima Wazed, Regional Director, WHO South-East Asia Region (video)
09.20 – 09.30	Address by MOPH Thailand	Dr Benjamas Prukanone
	Technical session 1	**Moderated by India**
09.30 – 09.45	Regional perspectives: progress and way forward	Andrea Bruni
09:45 –10.00	Global perspectives on deinstitutionalization and community-based mental health	Devora Kestel
10.00 –10.15	Q&A	
10.15 – 10.30	Strengthening multisectoral support towards deinstitutionalization	Helal Uddin Ahmed
10.30 – 10.45	Health system perspectives towards deinstitutionalization	Terdsak Detkong
10.45 – 11.00	Q&A	
11.00 – 11.30	Group photograph and tea break	

	Technical session 2	Facilitated by Thailand
11.30 – 12.00	Barriers and facilitators to the implementation of psychiatric deinstitutionalization: a framework for sustainable action	Cristian Montenegro
12.00 – 12.15	Q&A	
12.15 – 12.45	Introducing the WHO SEARO Regional report: key findings	Soumitra Pathare
12.45 – 13.00	Q&A	
13.00 – 14.00	Lunch break	
	Country session 1	**Facilitated by Nepal**
14.00 – 15.00	Implementation of the national strategy: expanding community care to move away from institutional care in Bangladesh	Bangladesh
	Strengthening mental health services in general health care to prevent institutionalization in Bhutan	Bhutan
	Progress achieved in expanding community mental health services in the Democratic People's Republic of Korea	DPRK
	Policies and laws supporting deinstitutionalization in India	India
	Technical session 3 and plenary discussion	**Facilitated by Maldives**
15.00 – 15.20	Awareness and advocacy towards deinstitutionalization in mental health	Matrika Devkota
15.20 – 15.40	Human rights and deinstitutionalization in India	Pratima Murthy
15.40 – 16.00	Q&A	
16.00 – 16.15	Tea break	
16.15 – 17.00	**Plenary discussion**	

Day 2: Wednesday 13 March 2024

	Country session 2	Facilitated by Bangladesh
09.00 – 10.00	Bottom-up approach to moving towards community care and deinstitutionalization in Indonesia	Indonesia
	Expanding community mental health services through primary care reforms in Fafu Atoll	Maldives
	Strengthening and sustaining community-based mental health services in Myanmar	Myanmar
	Preventing the need for long-stay care in Nepal	Nepal
10.15 – 11.00	Tea break	
	Country session 3	**Facilitated by Bhutan**
	Strengthening primary and secondary care to reduce institutional care in Sri Lanka	Sri Lanka
	Towards a paradigm shift in mental health: from institution-centred to community-based care in Thailand	Thailand
	Strengthening mental health services through the municipalities in Timor-Teste	Timor-Leste
	Group work 1	**Moderated by Indonesia**
11.00 – 12.15	Group work: addressing challenges towards deinstitutionalization	Facilitated by Tanya Fernandes
12.15 – 13.00	Logistic announcement and lunch Break	
13.00 – 17.30	**Field trip to Srithanya Hospital**	**MOH Thailand**

Day 3: Thursday 14 March 2024

	Country session 3	Facilitated by Bhutan
09.00 – 09.45	Strengthening primary and secondary care to reduce institutional care in Sri Lanka	Sri Lanka
	Towards a paradigm shift in mental health: from institution-centred to community-based care in Thailand	Thailand
	Strengthening mental health services through the municipalities in Timor-Teste	Timor-Leste
	Technical session 4	**Facilitated by Sri Lanka**
09.45 – 10.15	Community Placement Questionnaire (CPQ)	
Q&A	Sudipto Chatterjee	
10.15 – 10.45	Promoting employment opportunities for people with lived experience in mental health	
Q&A	Yuka Ujita, ILO	
10.45 – 11.00	Deinstitutionalizing mental health: a story of reforms in women's shelter home in Dehradun	Bhupinder Aulakh
11.00 – 11.15	Tea break	
	Group work 2	**Moderated by Timor-Leste**
11.15 – 13.00	Country-level action towards deinstitutionalization and preventing (re)institutionalization	Facilitated Tanya Fernandes
13.00 – 14.00	Lunch	
14.00 – 15.30	Group presentations and discussion	
	Closing session	
15.30 – 16.00	Wrap-up and closing remarks	Thailand / Andrea Bruni
16.00 – 16.30	Tea break	
	End of the meeting	

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