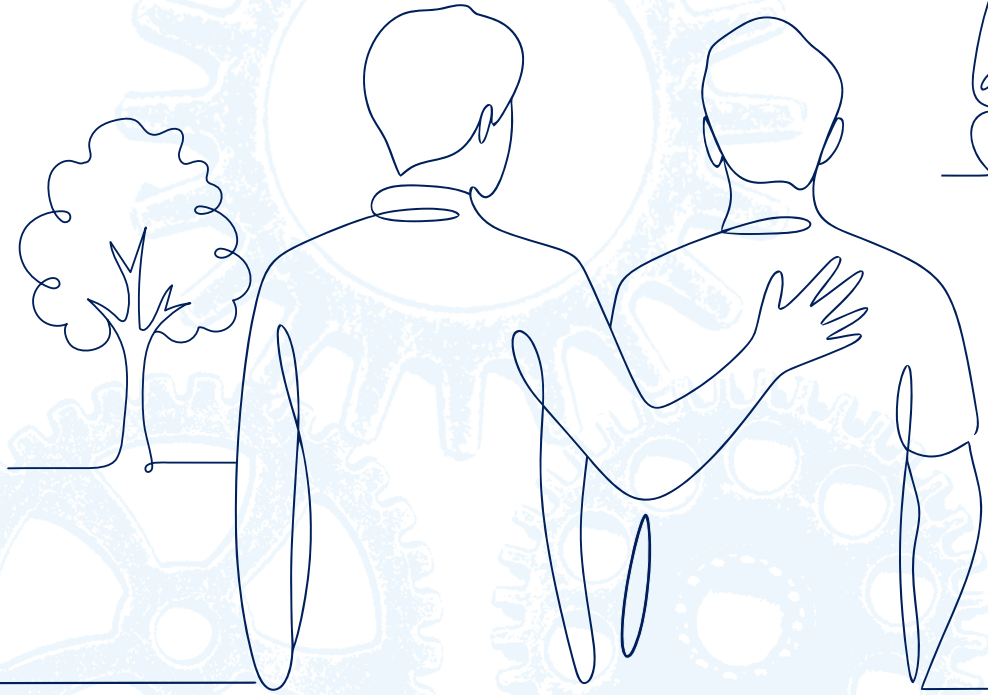
Supporting the transition to community-based mental health and social care

Practical guide to the deinstitutionalization of psychiatric hospitals



World Health Organization

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Practical guide to the deinstitutionalization of psychiatric hospitals

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Foreword

In recent decades many countries have made meaningful progress in developing community-based mental health services. Moreover, rights-based approaches have gained traction as people with lived experience increasingly have voice in shaping mental health policy and services. These developments have shown that people living with mental health conditions, including those with complex needs, can flourish in their communities when given the right support.

Yet progress has been uneven. Psychiatric hospitals continue to dominate mental health systems in many countries, consuming a large share of scarce financial and human resources for mental health. Many people remain confined in institutions, usually isolated from the support networks that are central to recovery, and often exposed to human rights violations.

In many countries deinstitutionalization (DI) remains one of mental health's most important – and unfinished – transformations. This is both a systems failure and an ethical one. Change is possible; and hospital leaders have a key role. This guide offers concrete steps and practical tools for contributing to mental health system reform.

The guide is grounded in international human rights instruments and diverse country experiences. It calls for a shift away from thinking of DI as a purely technical exercise in service reorganization to understanding it as a shared endeavour – shaped by people with lived experience, families, communities, health and care workers, managers and policy-makers – to build systems that uphold rights, dignity and participation in community life.

Progress also involves resources. The difference between what is needed and what is funded remains vast. Accelerating DI in any country demands political will and financial investment. Yet even in the least resourced settings, reform can begin: with practical steps to reduce admissions, strengthen community links and shift the culture of care.

No one can do this alone. DI depends on concerted action across health, housing, social care, employment, the wider community and people with lived experience themselves. This guide cannot substitute for that collective effort or for the central government leadership that must go with it.

For hospital leaders ready or requested to act, whether leading from within the system or seeking a place to start, this guide provides the tools and direction to move forward towards a world where care in the community is a real option for everyone.

Tedros Adhanom Ghebreyesus
Director-General
World Health Organization

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Abbreviations

CAPS	centro de atenção psicossocial [psychosocial care centre]
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DI	deinstitutionalization
EU	European Union
LMHS	local mental health services
M&E	monitoring and evaluation
NGO	nongovernmental organization
PNASH	Programa Nacional de Avaliação do Sistema Hospitalar/Psiquiatria [National Programme for the Evaluation of Hospital Services in Psychiatry]
PWLE	people with lived experience (of mental health conditions or mental health systems, particularly institutional care)
SRTs	serviços residenciais terapêuticos [therapeutic residential services]
WHO	World Health Organization

Glossary

Network of community-based mental health services

A network of interconnected services that typically includes a mix of:

1. Mental health services integrated in general health care, e.g. at general hospitals and primary health care.

2. Community mental health services, such as community mental health centres or teams, supported living services, psychosocial rehabilitation programmes, and peer support services.

3. Services beyond the health sector that deliver mental health care in non-health settings (e.g. schools and workplaces) and services that support access to social care (e.g. housing, legal assistance, education and employment).

Deinstitutionalization (DI)

DI, in the context of this guide, is defined as the planned transition from institutional care provided in stand-alone psychiatric hospitals to a comprehensive network of community-based mental health services and supports.

DI is not simply releasing residents from hospitals. It involves system-wide reform that also includes redesigning policies, laws and financing mechanisms; developing new community-based mental health services and supports; and shifting mindsets and practices to value people's rights to autonomy and social inclusion.

Institutional practices

Routines and attitudes that:

1. prioritize control, compliance and efficiency over people's needs, wills and concerns;

2. limit residents' personal agency or coerce them to receive treatment;

3. isolate residents or force them to live together;

4. create rigid hierarchies, depersonalized care and passive roles;

5. create or reinforce residents' dependency on the institution.

Long-stay resident

Person living in a psychiatric facility for an extended period (e.g. 6 months or more).

Mental health

A state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their communities. Mental health is an integral component of health and well-being and is more than the absence of mental disorder.

Mental health condition

A broad term covering mental disorders and psychosocial disabilities. It also covers other mental states associated with significant distress, impairment in functioning or risk of self-harm.

Psychiatric hospital

A psychiatric hospital, in the context of this guide, is defined as a stand-alone tertiary care hospital that provides specialized services, including inpatient care for people with mental health conditions. The term excludes psychiatric inpatient units in general hospitals or community mental health services.

Psychosocial rehabilitation

A process that helps people with mental health conditions live independently in their communities. It focuses both on building a person's own skills and on changing their environments so they can have the best possible quality of life. Psychosocial rehabilitation can involve many supports, such as social, educational, occupational, behavioural and cognitive interventions to help people take on meaningful roles and enhance their recovery.

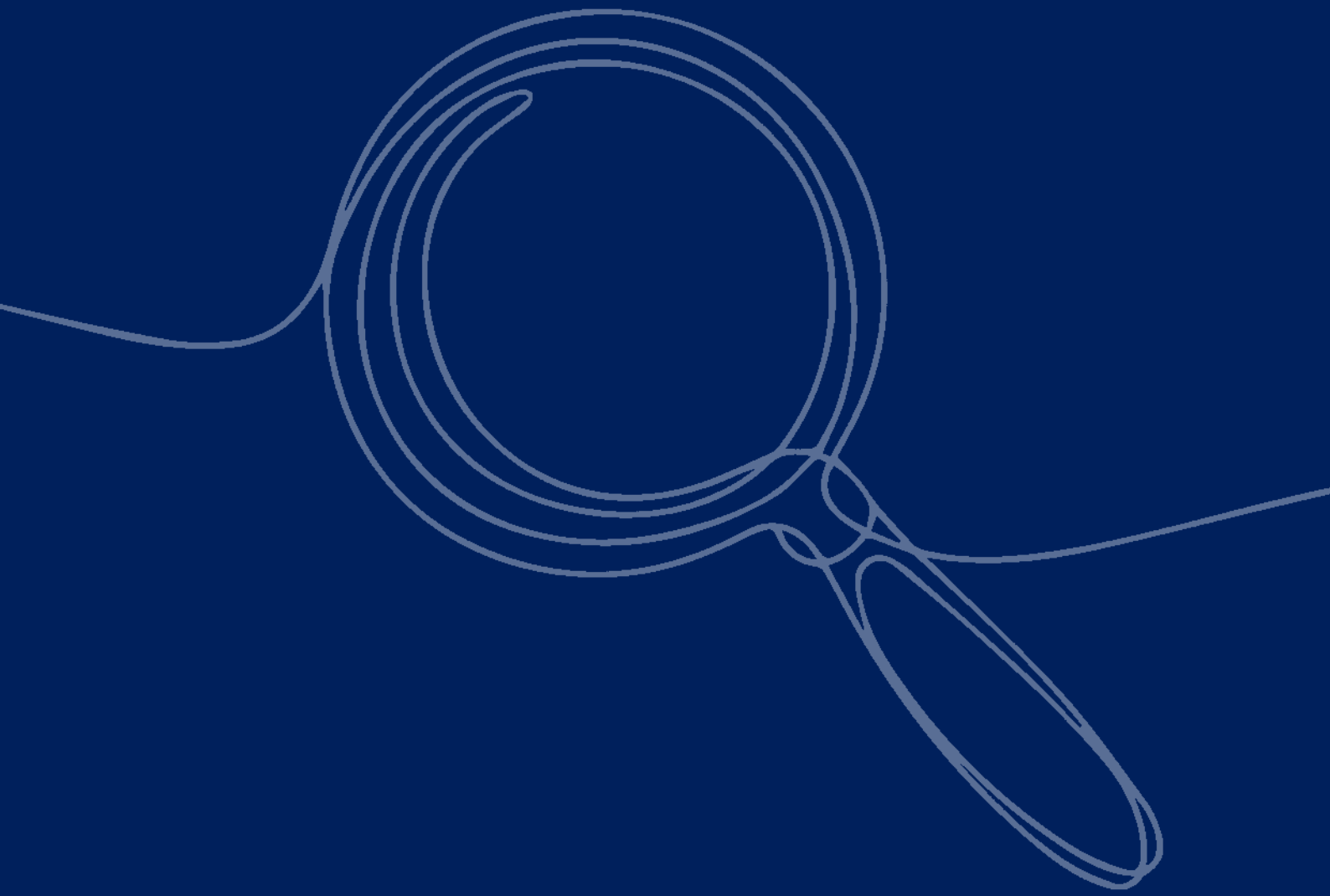
Secondary mental health care

Mental health care provided by specialists through general hospital-based services, community mental health centres or teams, crisis management services, outreach services, day care and psychosocial rehabilitation programmes. It typically involves specialized care and usually requires referral.

Supported living

A service that helps people live independently by supporting them to find and keep suitable housing, especially if they lack stable accommodation and have complex, long-term mental health and social needs. Support can include help with basic needs, such as food and clothing, and may be provided for short or long periods. It can be delivered in a group home or an individual's home, with the type and intensity of support tailored to the person.

Executive summary



81%
of countries still provide mental health services in psychiatric hospitals[a]

47%
of mental health expenditure goes to psychiatric hospitals[c]

28%
of people admitted to a psychiatric hospital stay for more than six months[e]

49%
of countries have a registry for incidents of seclusion and restraint[f]

6.2
psychiatric hospital beds per 100 000 population worldwide, i.e more than half of mental health inpatient beds are in psychiatric hospitals[b]

66.5
per 100 000 population was the global median admission rate to psychiatric hospitals[d]

16%
of people admitted to a psychiatric hospital stay for more than a year[e]

49%
of admissions to psychiatric hospitals and psychiatric units in general hospitals are involuntary[g]

Notes: a n = 138. b n = 123. c n = 49. Note the very low number of reporting countries (49) for this statistic. The proportion of mental health expenditure that goes to psychiatric hospitals is likely much higher in many countries. d n = 118. e n = 63. f n = 133. g n = 45.

Source: Mental health atlas 2024. Geneva: World Health Organization; 2025 (https://iris.who.int/handle/10665/382452). Licence: CC BY-NC-SA 3.0 IGO.

An effective mental health system comprises a coordinated network of person-centred, community-based services that uphold rights, foster inclusion and enable people to live independently and be included in the community, with dignity.

Yet psychiatric hospitals where people stay for a long time continue to dominate mental health systems in many countries. They often consume most public mental health resources – beds, staff, funding – yet reach only a small fraction of people in need.

By design, psychiatric hospitals usually separate people from their homes, communities and support networks, sometimes for years. Isolation limits opportunities for a meaningful life and can undermine recovery. Institutional settings often depersonalize care and are frequently associated with human rights violations.

Deinstitutionalization (DI) is essential to building a rights-based mental health system that expands access and improves quality of care. DI is more than a service redesign. It is a strategic priority for mental health policies and care and a legal imperative grounded in international human rights law, including the United Nations Convention on the Rights of Persons with Disabilities, and regional instruments such as the Inter-American Court of Human Rights. Achieving it requires coordinated action, investment and a fundamental shift in care practices to emphasize dignity, agency, self-determination and citizenship.

About this guide

Building on WHO policy resources, this guide offers psychiatric hospital leaders, and senior managers practical steps to plan and implement key aspects of DI. It draws on global experience and expertise, recognizing that DI is understood and implemented in different ways across different settings.

More information on the methods used to develop this guide are included in Annex 1. Annex 2 explores key areas of uncertainty, debate and concern that emerged during development.

Scope

DI involves reorganizing services. It requires building a network of community-based mental health services and taking a comprehensive set of actions within the psychiatric hospital. WHO has already produced detailed guidance on the former, but what has been missing is a practical guide that focuses on what psychiatric hospital leaders can do in their own services to move towards DI.

So this guide covers actions in psychiatric hospitals and their surrounding communities, including local networks of services and supports. It focuses on the DI of adults living in psychiatric hospitals, primarily those who have been there for 6 months or longer, referred to in this guide as long-stay residents.

Although not the main focus, many of the actions in this guide also apply to the DI of:

1. adults living long term in non-psychiatric institutions, such as social care facilities; and
2. adults living long term in psychiatric hospitals with substance use conditions, neurological conditions (e.g. epilepsy, dementia), or neurodevelopmental conditions.

Some actions in this guide (e.g. recovery, employment, independence) may not apply or need major adaptation for people with progressive conditions such as dementia. For them, care should prioritize safety, dignity, continuity, caregiver support, and long-term quality of life, rather than expecting functional improvement.

Institutions for children and adolescents as well as forensic psychiatric facilities are outside the scope of this guide.

Audience

This guide focuses on what hospital leaders can do locally. Hospital leaders often hold direct responsibility for planning, staffing, budgeting and discharging residents. They can also influence broader system change. Hospital leadership impacts DI because holding on to or moving away from long-stay institutional care shapes how the whole mental health system is organized and resourced.

But DI is not driven by hospital leadership alone. Meaningful progress on DI depends on senior policy- and decision-makers with the authority to mandate change, reallocate resources and oversee service reorganization. This guide is therefore also aimed at senior policy-makers – including health system planners and national and subnational health and mental health programme managers – who must create the conditions that enable change at the hospital level and hold hospital leaders to account.

Similarly, this guide will also be important for community partners who must work closely with hospitals to help build community-based alternatives and ensure continuity of care.

DI requires coordinated action across many actors. The role of hospital leaders in this process is not to retain control, but to support the redistribution of authority – creating the conditions for genuine participation by people with lived experience (of mental health conditions or mental health systems, particularly institutional care) (PWLE) – including long-stay residents – as well as families, workers and community stakeholders.

Structure

This guide moves from why DI matters to how psychiatric hospitals can help make it happen.

Chapter 1 introduces DI, outlines its benefits and situates the guide within WHO's global policy work. It describes global progress in DI and the critical role of stakeholder engagement.

Chapters 2–4 offer a practical framework for DI at the local level. The process is organized into three phases – plan, prepare, provide – and three areas within the influence of psychiatric hospitals:

- the entrance (reducing **admissions** and shortening stays);
- the inside space (changing **practices** to uphold human rights and improve quality of care); and
- the exit door (increasing **discharges** while ensuring continuity of care and supports to promote social inclusion).

Actions are presented at three levels of responsibility.

LEADERSHIP

Actions within the direct remit of hospital leaders.

PARTNERSHIP

Actions requiring collaboration with a range of actors.

MANDATE

Actions that depend largely on higher-level authorities.

How to use this guide

Each hospital faces unique operational, financial and community realities, and many will have already begun their DI journey. The actions presented here are intended to guide implementation – not as a rigid checklist, but as a set of evidence-informed practices that can be adapted to context.

Progress is rarely linear. Actions should be chosen based on what is most feasible and impactful at any given time, rather than followed in strict sequence.

System-level actors are encouraged to use this guide to inform their decision-making on mental health policy, and to better understand hospital-level challenges and supports required for successful DI.

Setting pragmatic yet ambitious goals and engaging stakeholders throughout the process are essential.

Key strategies

Reduce long-stay admissions

Change institutional practices

Increase long-stay discharges

Phases of action

Plan

Lay the foundation for change

- Transition governance
- Situation analysis
- Community services mapping

Prepare

Mobilize for community-based care

- Task-sharing with care providers
- Secondary health care service development
- Family and peer capacity-building

- Workforce training
- Shared care protocols
- User–provider relationship-building
- Peer-support programmes

- Individual assessments
- Tailored discharge and recovery plans
- Support and care coordination
- Hospital-linked services
- Housing and social supports
- Individual skill-building

Provide

Create lasting transformation

- Proactive discharge planning
- Shift to short-stay services
- Resource reallocation to community
- Alternatives to admission
- Advocacy and collaboration

- Basic needs provision
- Rights-based, recovery-oriented care
- Evidence-based interventions
- Address coercive practices
- Reduce institutional norms
- Staff development
- Quality care standards

- Gradual relocation to community
- Family education and support
- Follow-up and ongoing clinical care
- Responsible downsizing

Stakeholder engagement
Inform, consult, involve, collaborate with PWLE, staff, families

Monitoring & evaluation
Data collection, analysis and dissemination

Levels of responsibility:

LEADERSHIP • PARTNERSHIP • MANDATE

Background

1

1.1 A path to transformation

Deinstitutionalization (DI), as discussed in this guide, refers to the planned transition from long-term institutional care in stand-alone psychiatric hospitals to a comprehensive network of community-based mental health services and supports (*1*).

DI, properly implemented, is equally defined by what it is not (see Box 1.1). It is not simply relocating services. DI represents a shift from restrictive environments to systems in which people with mental health conditions have greater choice and control over their lives and the support they receive (*2*).

Box 1.1. What DI is not

DI is not:

- closing psychiatric hospitals without supports;
- discharging people without follow-up and continuity of care;
- moving people into smaller facilities that reproduce institutional practices (transinstitutionalization);
- transferring responsibility to families without adequate support;
- a cost-cutting exercise;
- relocating services without reforming care practices.

DI is central to mental health reform and reorganization of services. It enables governments to redesign services, adopt evidence-based interventions, fulfil human rights obligations, and protect people's dignity.

Achieving it requires system-wide reform: developing or updating policies, laws and financing; establishing community services and social supports; and reshaping the culture and practice of mental health care (*3–5*).

The discharge of long-stay residents must proceed **in parallel** with developing capacity for community-based services. DI cannot succeed unless people leaving institutions have access to health care services that address both mental and physical health as well as safe and decent housing, psychosocial rehabilitation, social protection, and meaningful opportunities for participation in community life. The latter covers relationships, social roles and supports, and collective spaces in which people live (*6*). Social and cultural activities, cooperatives and peer networks typically are key to building autonomy, recovery and community living (*7*).

Progress in DI depends on cross-sector collaboration. In many countries, stigma, social disadvantage, discrimination, financial incentives and limited community support options reinforce default reliance on long-term institutional care. These determinants need to be addressed.

As mentioned, DI requires that systems place greater value on promoting rights and social inclusion (*8*). This means rethinking how authority is exercised, and what counts as valid knowledge about a person's life and needs, especially hospital residents' own opinions. Without on overall change towards rights-based care, people may leave hospitals with little improvement in their rights, independence or community participation (*9*). The risk of **transinstitutionalization** (see Box 3.6) should thus be assessed throughout the DI process, especially during planning, service development, resource reallocation and monitoring. DI succeeds when people can re-enter community life as people with a voice, real choices and the support they need to thrive.

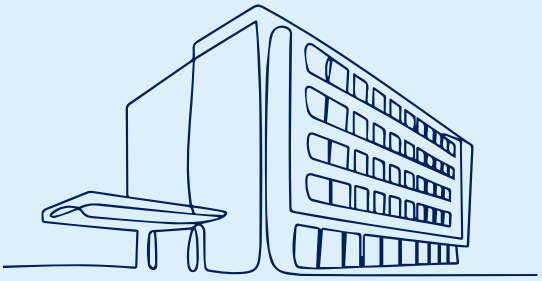
When DI is treated as bed closure alone, it increases the risk of houselessness or neglect. When implemented responsibly, there is no evidence of increased houselessness or imprisonment (*10*). With adequate investment, planning and community capacity, DI improves social functioning and quality of life for people with long-term support needs (*11*).

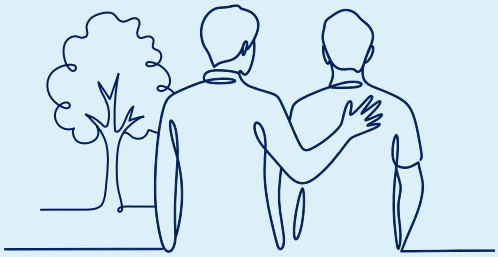
Global frameworks support DI. The *Comprehensive mental health action plan (2013–2030)*, endorsed by all World Health Organization (WHO) Member States, recommends systematically shifting the locus of care away from long-stay psychiatric hospitals, and it mandates WHO to provide guidance and support for DI (*12*).

Further, the United Nations Convention on the Rights of Persons with Disabilities (CRPD), specifically Article 19 and the United Nations Committee on the Rights of Persons with Disabilities' General Comment No. 5 on this article, affirms the right of persons with disabilities to live independently and be included in the community (*13, 14*). Additional guidelines from the committee outline specific actions for upholding this right (*5*).

Appropriately funded, comprehensive community mental health and social services – delivered by trained care providers and supported by community networks – are much better placed than psychiatric hospitals to meet mental health and social needs, provide personalized care, and prevent abuse and neglect (see Fig. 1.1) (*1, 4, 15*). Evidence shows that in low- and middle-income countries, community-based care delivers positive health and social outcomes, reducing stigma and improving functioning and quality of life for people with mental health conditions (*16–18*), and that these outcomes are better than for institutional care (*19*). In short, DI improves people's lives.

Fig. 1.1. Comparing institutional and community-based care





Institutional care is more likely to:	vs	Community-based care is more likely to:
Serve a limited number of people, often those with significant conditions lacking access to alternative care.	1 Accessibility	Provide care closer to or at home, in familiar environments, and reach more people.
Be linked to coercion, restraint, abuse, and neglect.	2 Rights and safety	Uphold rights and autonomy; and safeguard against abuse and neglect.
Offer impersonal, restrictive and shared living quarters with limited privacy.	3 Living conditions	Support people to stay at home, or offer homelike settings with private spaces and personal possessions.
Impose routines and institutional practices that reduce independence.	4 Autonomy	Promote choice in care, daily activities, and living arrangements.
Disconnect residents from family and community, leading to isolation or reduced social functioning.	5 Social connection	Maintain relationships, jobs, and social supports; and foster inclusion and agency.
Involve ineffective care with poor outcomes and learned helplessness.	6 Health outcomes	Lead to positive physical and mental health outcomes.
Risk stress, workplace violence, and distress from coercive practices.	7 Impact on staff	Offer opportunities for more meaningful work, enhanced therapeutic relationships, and skill development.
Be associated with stigma for residents and staff, and public mistrust of the mental health system.	8 Stigma	Reduce stigma and exclusion, promote acceptance, and encourage help-seeking.

Box 1.2. DI myths and facts

Myth: DI cannot succeed for people with complex, long-term mental health needs.
Fact: evidence shows that well-planned DI improves recovery, health outcomes and social integration, including for people with enduring or complex needs (*11, 20, 21*). Concerns about houselessness are linked to poorly planned discharges, not DI itself (*10*). A very small proportion of people does not easily transition out of long-term institutional care. They need flexible, person-centred community alternatives and individualized planning and support (see Consider readiness for discharge).

Myth: DI leads to job losses.
Fact: DI reshapes the workforce rather than reducing it. Hospital staff often transition into community-based roles, gaining new competencies and opportunities for professional growth. DI also expands employment for social workers, occupational therapists, mental health nurses (*22*) and peer workers.

Myth: DI increases overall costs.
Fact: long-term costs are often comparable to institutional care, even though community services require upfront investment and temporary dual running costs (*23, 24*). In some settings DI has generated savings (*25*). Well-designed community-based systems are more cost–effective (*26*). When used as a cost-saving measure however, without adequate funding and planning, costs may shift to families (*27*).

Myth: DI is not possible in low-resource settings.
Fact: many low- and middle-income countries are successfully implementing DI by strengthening health systems, supporting families, mobilizing community resources, and adopting rights-based, recovery-oriented care (*1, 3, 4*). Examples in this guide include Brazil's long-term shift from large psychiatric hospitals to community mental health centres and supported housing (see Box 3.10), the Republic of Moldova's development of community mental health centres as alternatives to long-stay institutions (see Box 3.13), Chile and Peru's use of national policy reforms to favour community services over long stays (see Box 4.11 and Box 2.7), and Sri Lanka's transformation of Angoda Hospital (see Box 4.3). Other cases – including from Ghana (see Box 4.9), Lebanon (see Box 2.5) and Uganda (see Box 1.4) – show that progress is possible even in the most constrained or challenging of contexts.

See Annex 2 for further exploration of common areas of uncertainty, debate and concern surrounding DI.

1.2 DI progress

DI rarely follows a straight path. In most countries, it begins with pragmatic steps – responding to urgent problems or opportunities – rather than a fully developed national plan (*28*). Progress is uneven and often slow, regardless of income level (*3, 4, 29–31*). Setbacks or reversals may occur for reasons beyond hospital leaders' control.

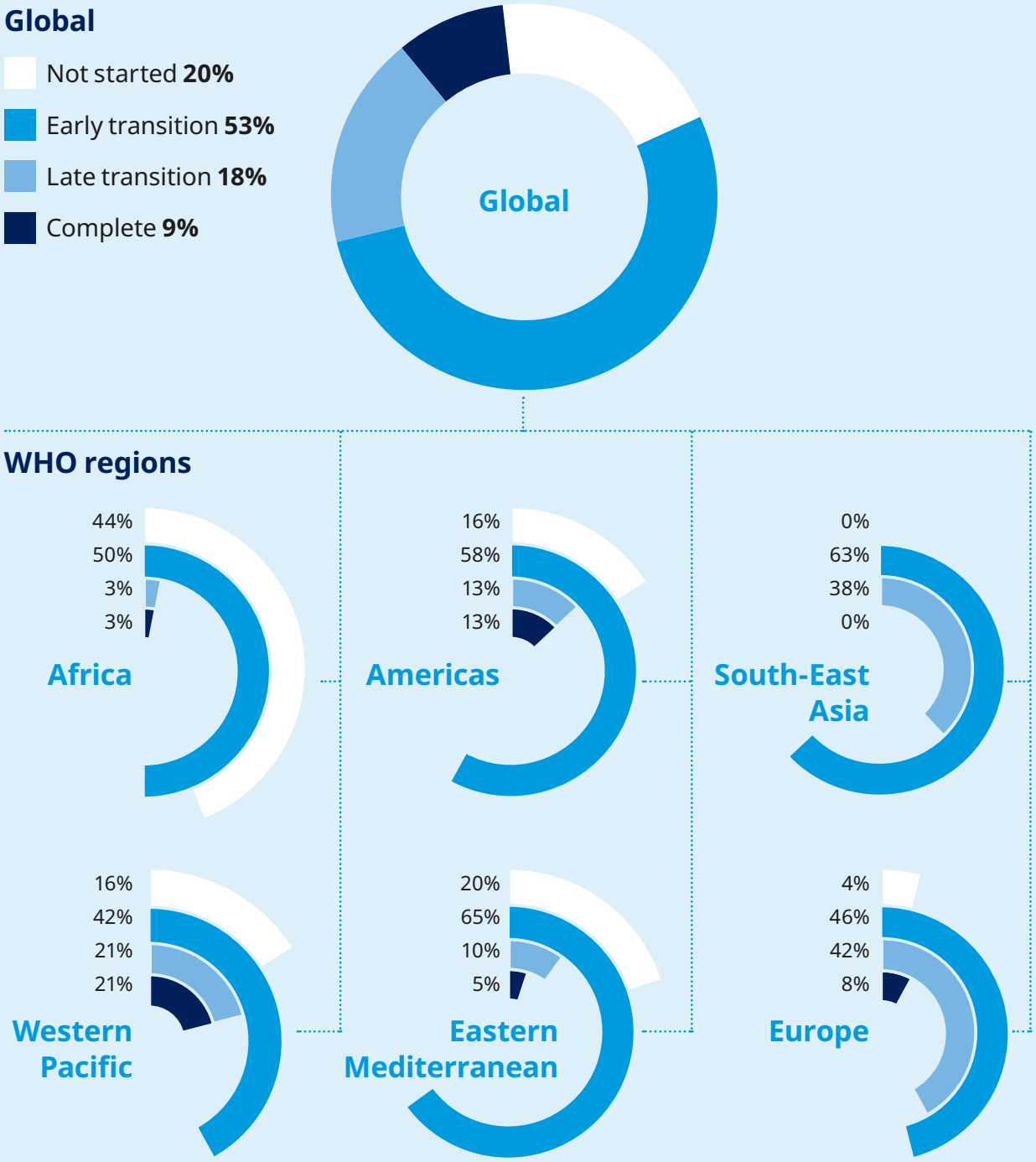
DI is not a time-limited reform. Sustaining advances requires continuous commitment and dedicated funding over the long term. Experiences from around the world have shown that when senior policy-makers deprioritize community-based mental health care – for example by redirecting resources, dismantling coordination structures or shifting focus to containment over care – hard-won gains can stall or erode.

Findings from WHO's Mental Health Atlas 2024 reflect this variability (*32*). Among 138 responding countries, four stages of transition emerged based on the balance between psychiatric hospitals and community services (see Fig. 1.2).

Globally, progress is slow: in more than half of reporting countries, beds and services remain concentrated in psychiatric hospitals. Among 54 reporting low- and middle-income countries, more than a third had not yet begun DI.

These patterns underscore that while progress on DI is achievable everywhere, its pace depends heavily on local realities and strong commitment to change.

Fig. 1.2. Status of mental health service reform in WHO regions



Notes:
Not started: no beds or services for mental health in general hospitals or community facilities
Early transition: more beds and services in psychiatric hospitals than in general hospitals and community facilities.
Late transition: more beds and services in general hospitals and community facilities than in psychiatric hospitals.
Complete: no more psychiatric hospitals.

Source: WHO, 2025 (*32*).

1.2.1 A gradual shift

During early transition, enhancing quality of care and dismantling institutional practices inside psychiatric hospitals are vital interim steps. These measures protect rights and help create the conditions for broader system change. They include changing the culture of care – engaging residents in decisions, acknowledging their perspectives, and challenging entrenched institutional norms (*33*).

In practice, DI involves three simultaneous areas of activity:

- **reducing institutional practices** across the mental health system;
- **developing community-based alternatives**, e.g. supported housing, community mental health teams and psychosocial rehabilitation; and
- **redefining and scaling back significantly** the role of psychiatric hospitals in providing long-term care.

The goal is a mental health system centred on community-based care, anchored in secondary health care (e.g. general hospital units, community mental health centres or teams) for acute and specialist needs, and primary health care for routine support and integrated physical health care, complemented with a range of community supports. As the network of community-based mental health services grows, overall reliance on psychiatric hospitals (including length of stay and bed numbers) should decline and can largely be replaced (*34, 35*).

Important

- Interim improvements to psychiatric hospital care may be necessary to safeguard rights, but investment must prioritize community services.
- Psychiatric hospitals should not be reinforced or expanded (*5, 36*). Costly upgrades rarely manage to change institutional culture and make closure harder (*29, 36*).
- Any shift to community-based services must ensure continuity of care and address both mental and physical health as well as social care needs.
- Care must be taken to prevent replicating institutional practices in community settings or transferring residents to other institutional or quasi-institutional settings (see Box 3.6).

1.3 Policy guidance

Transitioning from institutional to community-based care requires strong policy frameworks that create enabling conditions to ensure sustainability and guide implementation across health, social and housing systems.

DI does not happen in a vacuum (*34, 35*)

Example facilitators

- Political will
- Collaboration
- Funding
- Laws and policies
- Peer support
- Well-trained workforce
- Supportive community

Example barriers

- Poor planning
- Limited knowledge
- Lack of services
- Stigma

1.3.1 WHO's policy guidance

WHO's *Guidance on mental health policy and strategic action plans* (*37*) provides a roadmap for policymakers to reform mental health policies, with a focus on tackling stigma and discrimination, and upholding people's autonomy, dignity and human rights. It comprises five modules.

1 Introduction
Challenges in mental health policy and the case for reform.

2 Policy areas for reform
Directives, strategies and actions in leadership and enablers, service organization, human resources, assessment, interventions and support, stigma and social determinants.

3 Process for policy reform
Key principles and steps for developing, implementing and evaluating mental health policy and strategic action plans.

4 Case scenarios
Country scenarios illustrating approaches.

5 Directory
Of policy areas, directives, strategies and actions.

Find all modules of the guidance at: https://www.who.int/publications/i/item/9789240106796 (*38*).

WHO's policy guidance (especially Module 2) largely focuses on high-level policy actions to create enabling conditions for successful DI. Hospital leaders can actively contribute by creating momentum and demonstrating feasibility. Below are some examples of actions they can take to support broader reform efforts.

Enabling actions for hospital leaders

Leadership and coordination

- Develop integrated referral pathways and clear guidelines for transitioning people, including crisis response and follow-up care.
- Implement hospital-linked services, to coordinate care across sectors.
- Attend multisector meetings to align efforts and troubleshoot gaps.

Finance

- Work with stakeholders to raise funds for DI activities.
- Dedicate part of hospital budget to community transition programmes and outreach.

Training and supervision

- Ensure staff can access professional development opportunities.
- Organize clinical supervision and case reviews for person-centred and rights-based care.

Information and research

- Document and share outcomes of DI to advocate for reform.
- Use data from pilot projects to demonstrate DI effectiveness.
- Take part in external evaluations to validate progress and identify gaps.

PWLE involvement

- Establish advisory panels to involve PWLE in hospital governance and DI planning and implementation.
- Employ and train peer workers to support discharge planning and community follow-up.
- Create opportunities for residents to adopt roles beyond being a service user, e.g. mentors, trainers, artists.

Law reform

- Implement rights-based practices and document outcomes to inform legislative change.
- Review hospital policies and align with national mental health laws.
- Work with legal actors to facilitate legal mechanisms for community-based care.

Service strengthening

- Work with service planners to relocate crisis services to community settings.
- Organize training and supervision to embed mental health in general health care settings.
- Support families to be effective care providers.
- Work with local stakeholders to secure appropriate housing and social inclusion opportunities.

See Annex 3 for further reading on policy-level guidance for DI.

1.4 Stakeholder engagement

Successful DI depends on collaboration among a wide range of stakeholders, including people with lived experience (of mental health conditions or mental health systems, particularly institutional care) (PWLE), families and carers, community leaders, service providers, health workers, local authorities, policy-makers, and legal oversight bodies such as mental health review boards, tribunals or commissions. Transparent, timely communication is essential, as is engaging local communities to explain changes, build understanding and develop the partnerships needed to plan and implement the transition.

Among all stakeholder groups, PWLE and their representative organizations hold a central role. They typically understand what institutions can do to people, what genuine recovery requires and what community-based services must look like to be safe, effective and rights-respecting. PWLE must be engaged as active partners throughout DI – not only as advisors, but as co-designers, leaders, trainers, evaluators, advocates and safeguards against the reproduction of institutional practices in new settings.

Families and carers play a similarly vital role. While some can be unsupportive or worse, the vast majority provide years of support, often with limited information, respite or recognition. Their perspectives can deepen understanding of people's histories, needs and strengths; and they are central to planning safe, sustainable transitions to community living. Families and carers should be involved in care planning whenever the person wishes them to be. They should be offered clear information and support, recognizing their own rights, limits and well-being.

Hospital staff across professional groups are also important. They have deep understanding of what is operationally and professionally feasible, and they should help shape DI, not simply implement it. Staff from different professional groups should be supported to explore how their roles will evolve, connect with relevant standards and advances in their fields, identify what they need to make change real, and feed that knowledge into planning. Professional associations and unions have collective bargaining power that can be directed towards systemic positive change – advocating to governments for the funding, staffing and policy conditions that make DI viable.

Meaningful engagement of all these groups helps to build trust and legitimacy, foster innovation, mobilize resources for continuity of care, and anchor DI in lived experience and cross-sector collaboration.

At the local level, stakeholder engagement focuses on operational partnerships, transitional care and advocacy. It is not a one-off task. Rather, it must be continuous, embedded across all DI activities, from discharge planning to service redesign and quality improvement.

1.4.1 Key activities and processes

Understand your stakeholders

- Begin with a **stakeholder analysis**.
  - **Identify local actors** involved in DI or service development (39) (see Table 1.1).
  - Use simple, rapid methods – brief interviews, surveys, informal conversations – to **understand priorities, concerns and expectations**. Consider stakeholders' relationships with one another as well as their attitudes towards and potential influence over the DI process. Consider the challenges to DI and identify who can change things for the better.
  - Identify **early supporters and potential opponents**. Discuss any arguments for or against DI and confront prejudice and self-interest directly, while demonstrating clear commitment to change (*40*).

Table 1.1. Likely local stakeholders and their roles in DI

	Stakeholders	Likely roles in DI
Psychiatric hospital	Long-stay residents	Participate in DI oversight; co-create recovery and discharge plans; join community inclusion activities.
	Hospital staff	Co-create and implement recovery and discharge plans; build community links; support task-sharing.
	Hospital management	Drive culture change; reallocate resources; monitor care standards.
Government and mental health system	Local health authorities	Approve service reorganization; integrate mental health into general health care; fund DI.
	Legal oversight bodies	Review long-stay care and involuntary admissions; monitor and safeguard rights; recommend community-based alternatives.
	General health workers	Deliver integrated post-discharge care; support community integration and task-sharing.
	Mental health workers	Provide specialized and referral care; manage crises; support community integration and task-sharing.
	Municipal/local government	Provide housing; co-fund community programmes; facilitate local partnerships.
	Social service planners	Collaborate on case management; coordinate housing, social benefits and job placement for community living.
Community	PWLE and representative organizations	Participate in governance; co-design services, recovery and discharge plans and evaluation tools; co-lead staff trainings; advocate for rights; act as peer supporters and transition mentors.
	Families and carers	Participate in discharge planning; receive psychoeducation; support peer education, social inclusion and continuity of care.
	Community and spiritual leaders	Challenge stigma and discrimination; support social integration; create platforms for inclusion through livelihood, cultural and artistic activities.
	Local businesses and employers	Offer vocational and supported employment opportunities.
Civil society	Nongovernmental organizations (NGOs) and civil society	Co-deliver community supports; raise awareness; advocate locally; support PWLE in defending their rights.
	Grassroots organizations and activist groups	Mobilize support for DI; amplify PWLE voices; monitor implementation.
	Universities, professional schools and research institutes	Support knowledge exchange, conduct applied research, contribute to workforce development and evaluation.

Create a shared strategic vision

- Work with stakeholders to develop **a shared vision** for DI that can guide decision-making throughout the transition. A shared vision helps build ownership, reduce uncertainty and set realistic expectations (*41*).
- Explore and address the **concerns** of groups opposed to community living; and engage them constructively to reshape or reduce their opposition (see Build acceptance and momentum for change).
- Use the shared vision to agree **high-level objectives**, such as major bed reductions and eventual hospital closure or repurposing (e.g. as a training centre, general hospital or research hub) (*42*).

Key discussion topics for creating a shared vision

- Q Why is change needed? (What are the benefits of DI and the risks of maintaining the status quo?)
- Q What is the hospital's mission now and how will it evolve after DI?
- Q What does the situation analysis tell us?
- Q How might DI affect different stakeholder groups?

Use purposeful approaches

- Choose engagement **methods based on purpose**: inform, consult, involve, collaborate (*43*) (see Annex 3 for list of tools) (*43, 44*).
- Tailor approaches for each stakeholder group and maintain **feedback loops** so their input shapes decisions, e.g.:
  - regular assemblies with residents and workers to review plans and progress;
  - joint hospital-community meetings to discuss priorities;
  - stakeholder working groups with visible follow-up; and
  - participatory monitoring and evaluation.
- Involve stakeholders, including PWLE and families, **early** enough, and with sufficient emphasis, to genuinely shape priorities and values, to avoid commenting on decisions already made (see Fig. 1.3) (*45*).
- Obtain PWLE's **informed consent** before they participate in DI activities. Revisit it periodically, with clear opt-out options (see Box 1.3).

Fig. 1.3. Meaningful engagement of PWLE

Entry points

Community advocacy

Leaders and speakers in user-led and grassroots initiatives, community dialogues and public campaigns supporting DI.

Peer support

Roles to support people before and after discharge, co-facilitate recovery planning and offer peer-led groups.

Governance

Members of DI steering groups, hospital boards, and rights or complaints committees with real decision-making power.

Planning

Co-design of strategic priorities and transition timelines, including decisions on bed reductions and new community services.

Monitoring and evaluation

Co-researchers and members of participatory monitoring groups that track rights and inclusion, and review evaluation findings.

Workforce development

Co-facilitators of staff education on rights-based care.

Service design

Co-creation of community supports (housing, crisis alternatives, day services) and redesign of inpatient admission and discharge pathways.

Box 1.3. Practical tips for engaging PWLE

- **Start early:** involve PWLE from the start, before priorities and pathways are fixed.
- **Share decision-making:** give PWLE real influence over DI, including in governance, service design, staff training, monitoring and evaluation (M&E), discharge planning, and quality improvement.
- **Value expertise:** treat lived experience as equal to professional expertise; compensate PWLE for their time and offer paid roles where possible.
- **Diversify voices:** offer multiple entry points, and engage people from different backgrounds, ethnicities, genders, and social classes.
- **Offer support:** use accessible language and formats, and provide training and reasonable accommodations as needed.
- **Ensure consent:** focus on genuine understanding rather than formal documentation when seeking informed consent.
- **Close the loop:** show how PWLE input has influenced decisions and actions.

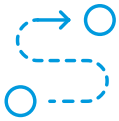
1.4.2 NGOs: vital partners in DI

NGOs, including disability- and user-led groups, are essential DI partners. They often have strong community trust and can be more agile and innovative than formal systems (*33, 46–48*).

NGOs must have adequate capacity – and be accountable to governments – to deliver quality services. Their roles should align with rights-based principles and long-term sustainability. Over-reliance on NGOs should be avoided.

Diverse roles of NGOs

Assess family and community needs



Map stakeholders and service gaps

Pilot and scale community-based supports

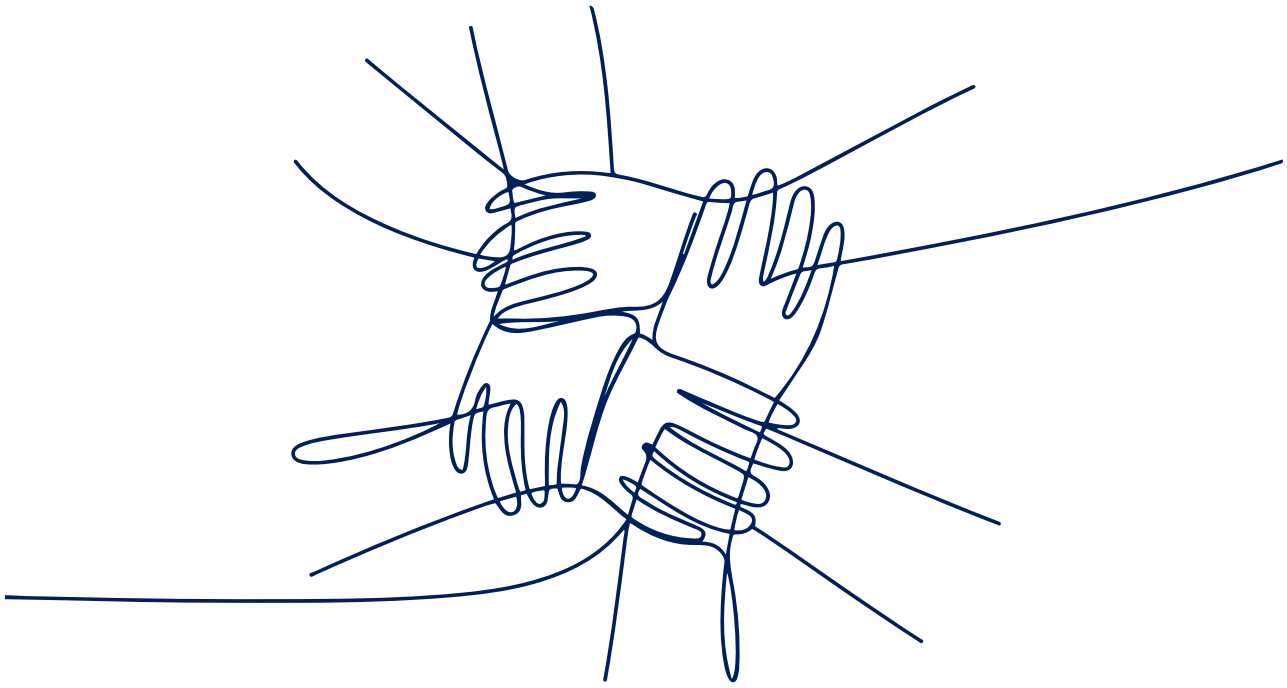
Reach underserved groups through grassroots approaches

Raise awareness of mental health conditions and services

Advocate for systemic change and amplify PWLE voices

Provide technical and educational support (e.g. training)

Offer interim funding, staff or infrastructure to address gaps



CASE STUDY

Box 1.4. NGO partners in DI: examples from the real world

Uganda: DI teams to support transitions

YouBelong's Home initiative uses multidisciplinary teams to coordinate support and care so that long-stay residents can return home from Uganda's national psychiatric hospital (*49*). Over five weeks, before and after discharge, the teams prepare individuals and families, plan follow-up, and link people to housing, transport, and medicines. A mixed-methods study reported strengthened family relationships, reduced stigma, fewer relapses and greater hope (*50*).

Chile: family-run small group homes

In Santiago, the Association of Relatives of Psychiatric Patients (AFAPs) – a family-led NGO that emerged from relatives' groups at El Peral psychiatric hospital – operates small group homes for people leaving long-stay institutions (*51*). The NGO tenders for public contracts to run community houses. Families participate in governance and day-to-day support, while public mental health teams provide clinical care, psychosocial rehabilitation and supervision. Evaluations report greater autonomy and community participation, while noting that some homes risk reproducing institutional routines if not carefully monitored (*52*) (see also Box 3.6).

Liberia: community-based teams to prevent institutional practices

In Montserrado County, Médecins Sans Frontières supported primary health care workers to challenge institutional practices in the community (*53*). Teams of local nurses and mental health clinicians – trained and supervised by specialists – worked with community health workers to actively seek out people who were chained or confined in homes or in faith-based or private institutions. Once identified, individuals were supported to access treatment and, where appropriate, to return home. Psychosocial workers visited families, offering psychoeducation and problem-solving support to prevent re-institutionalization (*54*). Programme reports described reduced use of restraints and improved functioning and inclusion (*55*).

Plan

Planning for DI helps understand why change is needed, what is possible, and how to set a safe, rights-based direction for transition.

In practice, DI rarely begins with a perfect plan. While careful planning remains essential, reform often starts when opportunities for change emerge – for example, following rights concerns, serious incidents, policy shifts, or successful pilot initiatives. Hospital leaders can build on these opportunities while progressively developing a coherent strategy for longer-term transformation.

2

LEADERSHIP

2.1 Establish a transition oversight committee

One potential early action in DI is to establish a dedicated transition oversight committee – a multistakeholder body that takes responsibility for planning, coordinating and overseeing the shift from hospital- to community-based care. This committee provides the governance structure for considering and making decisions, mobilizing resources and maintaining accountability across all phases of the transition. Meaningfully including PWLE from the outset strengthens the rights-based grounding of the process (see Box 2.1).

Before substantive work begins, the committee should aim to develop a shared understanding of DI principles and human rights obligations. Members may be called upon to explain and advocate for the process among their own institutions and networks. Investing in the committee's collective knowledge early and building a common vision will strengthen the quality and credibility of everything that follows.

CASE STUDY

Box 2.1. Indonesia: partnering with disability-led groups for DI

The Open the Gates pilot project, implemented in Indonesia between 2021 and 2024, shows the value of positioning PWLE as partners, not simply service recipients.

The project worked at both national and subnational levels. Perhimpunan Jiwa Sehat – the national organization representing people with psychosocial disabilities – shared project leadership with the Ministry of Human Rights and Law. Together, they set up the Working Group on Respect, Protection, Promotion, Enforcement and Fulfilment of Human Rights for Persons with Mental Disabilities with two strategic objectives: ensuring an inclusive life in society for people with mental health conditions and eliminating violence in institutions. The working group drewup a roadmap to support advocacy and multisectoral coordination for DI in Indonesia. As part of this work, Perhimpunan Jiwa Sehat members took government officials to visit institutions, using narratives of lived experience to change attitudes and build urgency for reform.

In Yogyakarta province, Perhimpunan Jiwa Sehat worked with NGO Pusat Rehabilitasi YAKKUM to revitalize local mental health working groups and support more inclusive planning of community-based mental health services. Its members also took part in local advocacy and training, and showed local service providers what rights-based care looks like in day-to-day work.

Source: Open the Gates Evaluation Report (2024), CBM Global Disability Inclusion, unpublished data, 20 April 2026.

2.1.1 Key actions and processes

Appoint committee members

- Define the committee's **mandate**. Agree its purpose, scope, structure, and terms of reference.
- Identify and recruit members from **across stakeholder groups**, including hospital leadership and staff, health system planners and managers, PWLE (including current residents), families, community service and support providers, and other relevant authorities.
- Agree on **roles and ways of working**. Allocate clear responsibilities, including by assigning focal points to lead specific areas of work based on skills and networks (see also Develop a transition plan and budget).
- Ensure the committee is adequately **resourced and supported**, including with dedicated time, administrative support, and access to relevant data and expertise.

Build the committee's knowledge of DI

- Seek information from **a range of sources**: workshops, conferences, discussions with colleagues and community partners, field visits, and reports on recent reforms.
- Connect with **those who have DI experience** – hospital leaders who have led transitions, government departments responsible for mental health or social welfare, community organizations, NGOs, service user and family organizations, and PWLE groups.

Box 2.2. Building knowledge about mental health reform

Topics to explore

- Common concerns and misconceptions about DI (see Box 1.2).
- CRPD, the Optional Protocol to the Convention against Torture, and other human rights instruments.
- National mental health laws and mandates for DI.
- Role of community-based services, including general hospitals and primary health care.
- Harms of institutionalization (mental, physical and social).
- Benefits of community-based mental health care and living.
- Evidence-based approaches to supporting transition to community life.
- Power dynamics and control practices in long-stay settings.
- Short- and long-term implications of DI for your hospital.

LEADERSHIP • PARTNERSHIP • MANDATE

2.2 Conduct a situation analysis

A good situation analysis identifies strengths, constraints and opportunities for DI. It looks at **internal** (hospital) and **external** (community) factors across discharges, admissions and care practices (see Fig. 2.1 and Box 2.3). Including PWLE and families, and their representative organizations, helps identify key gaps and barriers to care.

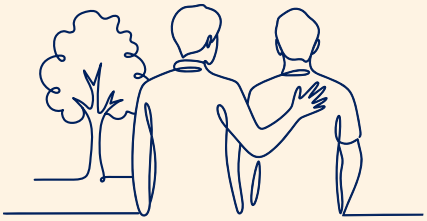
Fig. 2.1. Areas for assessment in a situation analysis

Internal

- ✓ Hospital's history of change and reform
- ✓ General characteristics of the hospital
- ✓ Workforce size, composition and dynamics
- ✓ Financial resources
- ✓ Admissions, occupancy and length of stay
- ✓ Support needs of long-stay residents

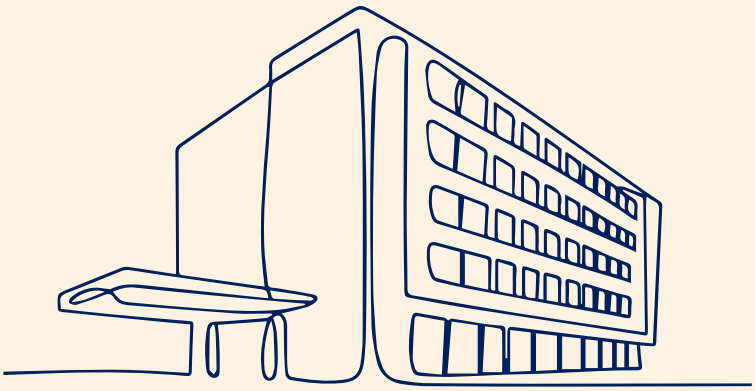
QualityRights Toolkit
Services and supports for long-stay residents, including:

- ✓ Medical, psychological and psychosocial rehabilitation services
- ✓ Standard of living
- ✓ Practices to uphold autonomy and shared decision-making
- ✓ Policies to prevent coercion, restraint, seclusion and violence (from staff, family or others)



External

- ✓ Existing or potential mechanism for coordinating networks of services
- ✓ Community-based living options for people with significant mental health conditions
- ✓ Mental health services in general hospitals or community mental health centres or teams
- ✓ Mental health crisis care
- ✓ Other community and family supports
- ✓ Opportunities for culture, leisure and collective life
- ✓ General health care services (at all levels of care)



Box 2.3. Practical tips for conducting a situation analysis

- **Combine quantitative and qualitative data** – hospital records, interviews, observations.
- **Speak with residents, families and staff** to understand lived experience, concerns and expectations.
- **Invite independent assessors**, where feasible, to improve accuracy and reduce bias.
- **Look for existing reports** and open-access tools to simplify data collection.
- **Use visual summaries** to support decision-making.
- **Be transparent** about data gaps.

2.2.1 Key actions and processes

Do an internal assessment

- Examine the hospital's **own history of reform**. Previous quality improvement efforts, discharge programmes, community reintegration efforts, rights-based reforms, or responses to critical incidents all offer lessons — what was attempted, what worked, what did not, and why.
- Identify how many **long-stay residents** are in the hospital. Review their family and social situation, general support needs, and how these are currently met. A detailed individual assessment comes later, but early information helps anticipate what community supports will be needed (see Box 2.4).
- Review all other admissions and identify anyone at high **risk of long stay**, e.g. people with no or insecure housing, court-ordered admissions, repeat admissions or no family support.
- Examine **workforce composition and dynamics**: staffing structures, workflows, roles, labour relations, and attitudes towards reform.
- Assess **service quality and human rights conditions** – daily routines, autonomy, participation in decision-making, and safeguards relating to coercion, seclusion, restraint or violence. An instrument for carrying out such assessments is the WHO QualityRights Toolkit (*57*). Its use has helped identify key gaps in care standards' alignment with the CRPD and plan concrete reforms in multiple countries (*58*); and enabled meaningful progress in challenging contexts (see Box 2.5).

Box 2.4. The Community Planning Questionnaire

The WHO Community Planning Questionnaire is a planning tool for quickly assessing what long-stay hospital residents need to move back into the community – across daily living activities, housing and other community supports.

Staff trained in using the questionnaire rate residents on ten dimensions, based on their own observations. The tool is designed to support situation analyses by providing an overview of the community services and housing supports that a group of residents will need – but it is not suitable for planning an individual's discharge.

The Community Planning Questionnaire has been tested and found reliable in diverse settings.

Source: Dahl et al, *in press* (*56*).

CASE STUDY

Box 2.5. Lebanon: using QualityRights to drive improvements in care

In Lebanon, the Ministry of Public Health's National Mental Health Programme is advancing DI as a core pillar of its national mental health strategy (*59*). This work continues despite compounded crises in a context where inpatient mental health care remains largely delivered through private and semi-private institutions.

WHO's QualityRights Toolkit has been used to support the ongoing reform since 2017, providing a practical framework for national discussions on human rights in long-stay mental health facilities, and a basis for improving quality of care. The toolkit was adapted to the Lebanese context – with language, scientific terminology and social concepts aligned to local frameworks – and 50 national assessors from diverse backgrounds have been trained in its use.

Early assessments in long-stay mental health institutions documented serious human rights violations. Two facilities were subsequently shut down by the Ministry of Public Health, and 252 residents were relocated to more rights-compliant settings (*60*).

More recently, joint assessments with WHO have informed facility-level improvement plans covering residents' rights, living conditions, safety, documentation practices, and re-integration pathways. Assessments have also enabled facilities to identify a small number of long-stay residents eligible for discharge and to standardize care pathways. QualityRights standards are now embedded in national standard operating procedures (in pilot phase) covering operations from admission to post-discharge care in both long-stay facilities and general hospital mental health units (*61*).

Additional sources: Rabih El Chammay, National Mental Health Programme Lebanon, personal communication 18 April 2025; and Layal Al Hanna, National Mental Health Programme Lebanon, and Edwina Zoghbi, World Health Organization Lebanon Country Office, interviewed on 29 April 2024.

Map community supports and services

- Identify **existing health and social services** and community supports for psychosocial rehabilitation and recovery (see Fig. 2.2). Alert health and social authorities to any critical gaps.
- For each mapped service or support, assess the extent to which it is **accessible**, rights-based, culturally responsive, affordable and acceptable to PWLE.
- Review potential discharge destinations for both **availability and quality**. Flag any settings that may reproduce segregation or limit autonomy.
- Assess readiness and **potential for partnership or expansion**. Community services and supports may be limited or unevenly distributed, but DI can still begin – hospital-led pilots often catalyse broader service development.

Identify priorities for action

- Use the situation analysis and shared vision to **prioritize areas for action**. DI feasibility and sequencing will depend on context (e.g. stable versus fragile settings; strong versus weak social protection systems; rural versus urban environments).
- While hospital downsizing and possible closure is the goal, early efforts may need to focus on **strengthening current systems** and building community links.
- Common priorities include:
  - reducing unnecessary long stays by revising admission and discharge criteria;
  - enhancing collaboration with community mental health providers and general health services to support continuity of care;
  - reallocating resources towards discharge, social inclusion and follow-up;
  - reducing institutional practices and enhancing rights-based care, including ending human rights violations such as electroconvulsive therapy without anaesthesia;
  - increasing individual involvement in care planning;
  - strengthening family support through community programmes;
  - enhancing staff skills through training and supervision; and
  - developing community-based services and supports for people transitioning out of hospital.

Fig. 2.2. **Example community supports for psychosocial rehabilitation, recovery and social inclusion**

Housing supports

- Supported living
- Housing first programmes
- Housing adaptations
- Transitional wards or half-way homes
- Crisis or respite housing
- Peer-run housing cooperatives
- Host families

Peer and recovery supports

- Peer support groups
- Peer-run helplines
- Peer mentors
- Advocacy and self-help organizations

Daily living supports

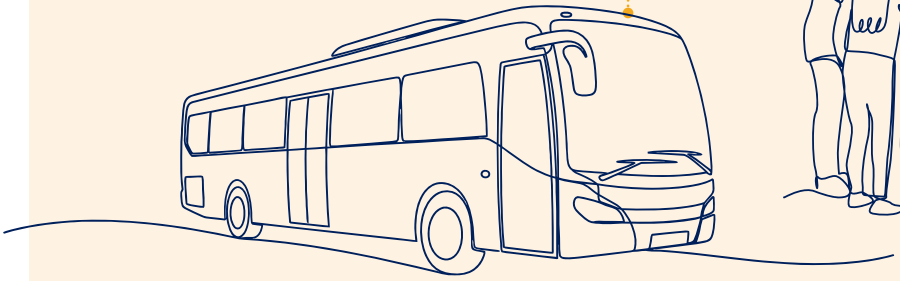
- Supported employment
- Vocational rehabilitation
- Day centres and clubhouses
- Life skills training
- Home help and home-care services
- Befriending initiatives
- Community volunteering opportunities

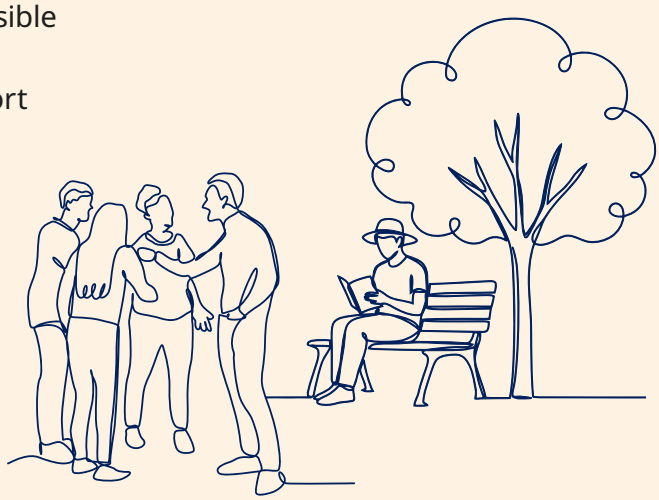
Financial supports

- Welfare benefits
- Cash transfer programmes
- Personal budgets or direct payments

Transport and accessibility

- Travel training and support
- Subsidized or accessible public transport
- Community transport schemes





Education and training

- Adult education
- Supported access to higher education
- Skills development workshops
- Digital literacy training

Legal supports

- Independent advocacy
- Legal aid and rights education
- Citizenship access services
- Safeguarding services
- Supported decision-making

Family and carer supports

- Family psychoeducation
- Carer support groups
- Respite services for carers
- Family mediation and counselling

Cultural, spiritual and recreational supports

- Faith-based programmes
- Arts and creative groups
- Sports and wellness activities
- Nature-based therapies (e.g. horticulture, ecotherapy)

LEADERSHIP • MANDATE

2.3 Develop a transition plan and budget

A transition plan provides a practical roadmap for shifting from hospital- to community-based care (see Annex 4 for a template). It may be initiated by the hospital or transition oversight committee, or mandated by authorities. The plan should outline actions, deadlines, roles, responsibilities, and resource needs.

DI changes staffing requirements. As inpatient care declines, fewer hospital roles are needed, while community services require more staff, potentially with different competencies. Plans must support staff through predictable milestones and protect job security, including through re-training for new roles where feasible.

Most systems will require extra short-term funding during DI, even if the process will ultimately free up resources. This includes upfront costs to establish new community services and supports, and double running costs to operate both hospital and community services in parallel until the transition is complete. Some fixed costs – buildings, utilities, core staffing – will persist even as resident numbers fall, and some costs can only be released when a whole ward or unit closes. This phase should be planned for and budgeted as an expected cost of reform.

The transition plan should be developed with stakeholders, guided by the shared vision, situation analysis, and agreed targets. It must remain flexible as tasks often overlap and challenges emerge. Timelines should be realistic, well-communicated and supported by adequate funding (*62*).

Box 2.6. Do no harm: safeguards for transition planning

Harm in DI is not limited to houselessness, neglect or interrupted care. It also includes lack of meaningful choice, loss of trusted relationships, and discharge into settings that reproduce control or isolation in new forms. Moving people from institutional to community care must be synchronized with the availability of accessible community support.

Minimum safeguards in transition plans may include commitments to:

- no discharge without person's consent;
- no discharge without housing, follow-up care and crisis support;
- no discharge without the person's meaningful involvement in planning;
- no assumption that family return is always appropriate or safe – family situations must be individually assessed, and support offered to families taking on care responsibilities;
- no substitution of one coercive setting for another;
- no transition targets that override personal readiness or preferences;
- continuity of trusted relationships wherever possible;
- acknowledge the power relations between groups and people involved in DI planning;
- ensure that recovery and discharge plans respond to assessed needs and are culturally appropriate; and
- support shared decision-making for transition.

2.3.1 Key actions and processes

Develop a budget

- Ensure the budget **covers a comprehensive set of activities** in the transition plan, considering current and anticipated resources (funding, staffing and time).
- Recognize that **financial management** differs by context; some hospital leaders may be able to reallocate internal funds directly.
- Plan for the progressive transfer of resources from hospital to community, aligned with discharge waves and community service development.
- Work with health, social welfare and finance authorities, and community partners to establish a viable **financing model** that does not rely on bed occupation for funding. This may include:
  - combining funding streams from health, social care and housing;
  - mobilizing additional funds, e.g. ring-fenced funding or external grants from national, regional or international partners (*63*); and
  - introducing new payment mechanisms or incentives for community-based care, e.g. payment-for-performance, outcomes-based payment, or fee-for-service (see Box 2.7).

Plan for a resource shift

- Develop a **phased plan for shifting resources** to communities, showing when beds or wards will close, when community capacity will be ready and available, and when budgets and staff posts will transfer (see also section 4.6).
- Plan explicitly for **temporary dual-running costs**, when the hospital continues operating at reduced capacity while community services are simultaneously being built (*23*). Budget for this phase from the outset and seek transitional funding to cover it.
- Identify which **costs** are fixed, which can be reduced in stages, and which can only be released when a whole ward or unit closes.
- Agree in advance **criteria for releasing** each phase of hospital funding, e.g. reduced occupancy, functioning community services, and adequate arrangements for follow-up, crisis support and housing.
- Build **safeguards** into the plan so that funding released through downsizing is tracked, protected and transferred to community-based services and supports rather than absorbed into general budgets or unrelated expenditure (*64*).

CASE STUDY

Box 2.7. Peru: comprehensive insurance as a lever for change

In 2013, as part of a broader set of changes to reform mental health, Peru added to its national health insurance package, and revised reimbursement schedules for psychiatric hospitals to favour outpatient and day-care services over long stays.

The change meant fees paid to mental health service providers for these services increased more than fivefold, transforming care provision and massively increasing access, especially among low-income Peruvians (*65*). Between 2012 and 2016, the number of outpatients quadrupled; and the share of out-of-pocket spending on psychotropic medicines fell from 94% to 32%.

In 2016, the same payment rules were extended to the growing network of community mental health centres, allowing people to access covered mental health care closer to home and gradually shifting use and funding from hospital-centred, out-of-pocket care towards community-based, pre-paid services.

Subsequent reforms consolidated these gains: the 2019 Mental Health Act (Ley 30947) established community mental health centres as the backbone of the system and mandated their nationwide expansion, further accelerating the shift from hospital-centred to community-based care.

Yet significant gaps between policy and practice remain. System fragmentation means reforms have not reached all Peruvians equally, with some social security systems still relying heavily on institutional care. And despite the rapid expansion of community mental health centres, coverage remains limited – especially in rural areas – and many centres face infrastructure and resource constraints (*66, 67*).

Think about staffing skills and structure

- Assess current **staffing structures and skillsets** and identify what will be needed after DI (*68*). Use service-mapping to visualize workforce requirements for new community services, which often require diverse roles: psychologists, nurses, occupational therapists, pharmacists, social workers, support and care coordinators, peer workers (*69*). Plan to both support existing staff to transition into new roles and engage new actors, e.g. service-user groups, NGOs, families, and peer workers (*23*).
- **Prioritize job security**. Fear of job loss is a major barrier to staff support. DI should involve role changes, not job losses (see Fig. 2.3). Staff should move with services into the community where feasible (see Box 2.8). Administrative and non-clinical staff, already experienced in working with people with mental health conditions may also transition into community-based support roles.

CASE STUDY

Box 2.8. Portugal: reorganizing and relocating the workforce

In Portugal, DI shifted roles rather than eliminating jobs. Beginning in the late 1990s, the Mental Health Law and National Mental Health Plan (*70*) gradually transferred responsibility for catchment areas from large psychiatric hospitals to local mental health services (LMHS) based in general hospitals and community teams (*71*).

Psychiatrists, psychologists and most mental health nurses employed in psychiatric hospitals were reassigned to LMHS, following their catchment populations rather than being laid off.

Many – especially early-career professionals – welcomed the move, seeing LMHS posts as more attractive, multidisciplinary and less isolated.

By 2025, LMHS covered more than 90% of the population and had significantly increased the number of community teams with the support of European Union recovery and resilience funds. The main workforce gap has been in psychosocial rehabilitation: social workers, occupational therapists and other rehabilitation staff remain in short supply.

Additional source: José Miguel Caldas de Almeida, Lisbon Institute of Global Mental Health, interviewed on 3 June 2024.

Fig. 2.3. Role changes, not job losses

Relocate

Medical staff
(e.g. psychiatrists and mental health nurses) to the network of community-based mental health services (general hospitals and community mental health centres).

Recruit

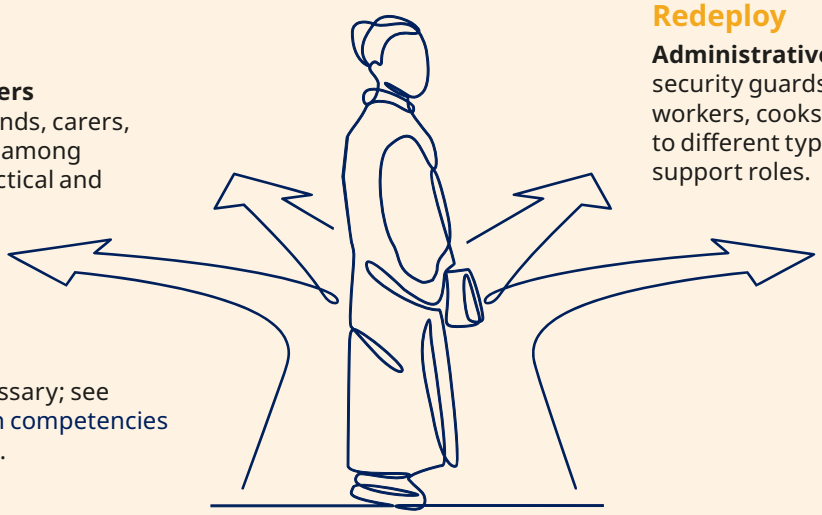
Additional health care workers
for the network of community-based mental health services, including social workers, psychologists, occupational therapists, peer workers.

Reengage

Informal care providers
including families, friends, carers, peers and volunteers, among others, to provide practical and emotional supports.

Redeploy

Administrative staff
security guards, laundry workers, cooks, secretaries to different types of support roles.



Retrain

the workforce as necessary; see section 3.6 Strengthen competencies for mental health care.

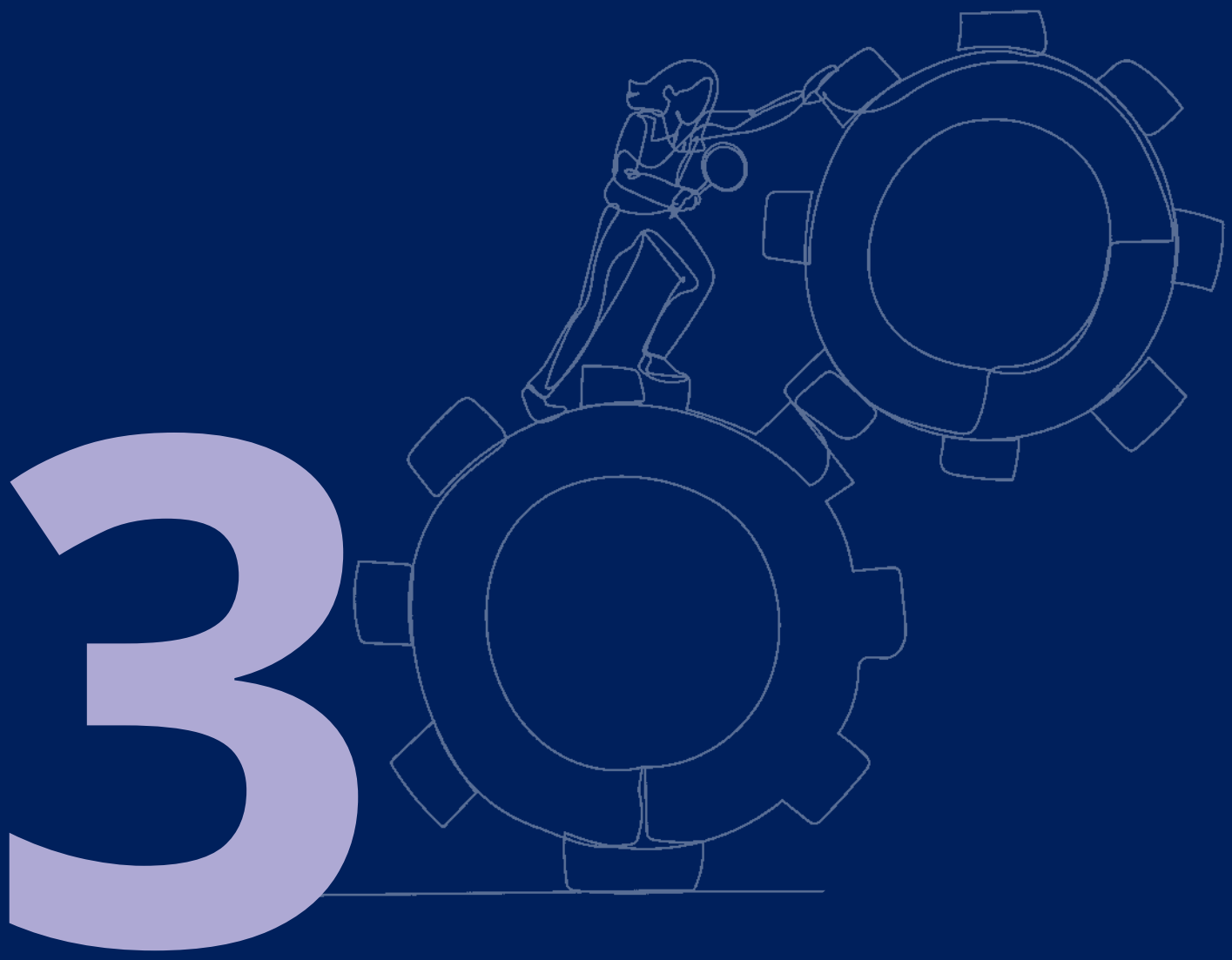
Plan for monitoring and evaluation

- Integrate a monitoring and evaluation (M&E) framework into the transition plan, outlining how the hospital will track progress and how it will engage with external oversight bodies.
- Plan to monitor **progress** against the overall DI plan through indicators that highlight key activities or milestones – such as discharges, admissions, care practices, unit closures – with clear means of verification.
- Plan to evaluate both the **systemic impact** of DI and whether people's needs are being met and continue to be met in line with their preferences and values. Measurement plans should also include indicators to capture social and relational outcomes that often matter most to PWLE and families, e.g. housing, livelihoods, relationships, quality of life, autonomy, social inclusion and dignity (see Annex 5 for example indicators). The support needs and expected outcomes of PWLE and families may be considered separately but both need to be taken into account.
- **Involve PWLE and families** in defining what good outcomes look like. Ask people directly about the outcomes they value and use their responses to shape what is measured.
- Where possible, plan to collect **disaggregated data** (e.g. by type of condition, disability, sex, age) to support equity.
- Identify resources, develop capacities and specify **processes** for data collection, analysis, and sharing, as well as roles and responsibilities for each part of the M&E system.

Prepare

Preparation ensures that people and systems are ready for the shift to community-based care.

Activities in this phase include identifying individual needs, supporting recovery planning, strengthening the workforce, adapting hospital processes, and ensuring community services and supports can respond effectively. These steps build confidence, reduce risk and ensure that transitions are coordinated and sustainable.



PARTNERSHIP

3.1 Build acceptance and momentum for change

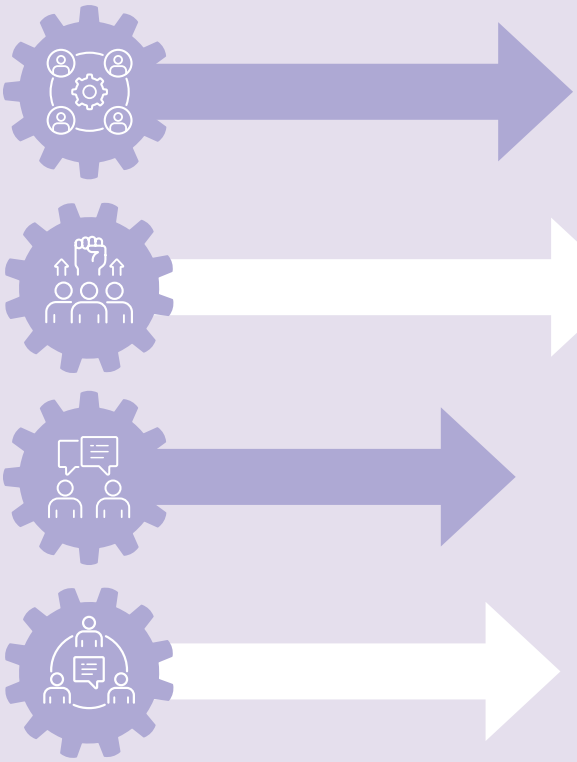
Sustained DI requires acceptance across all stakeholder groups. Staff may need to rethink long-held beliefs about residents' futures, and recognize people's strengths, capabilities and rights. Residents, families and communities also need to reassess assumptions shaped by years of institutional practice or stigma.

Resistance to change is natural, especially when change affects roles, relationships or routines. Understanding where it comes from can help tailor engagement strategies.

- Conceptual resistance stems from attachment to institution-based worldviews or professional identities.
- Material resistance includes concerns about job security, job location, workload or resource loss.
- Affective resistance arises from emotional attachment to roles, places or relationships.

Consensus-building must be meaningful and inclusive (see Fig. 3.1). Because power dynamics can obscure disagreement, processes should actively encourage open discussion. Expressed concerns, when surfaced respectfully, can strengthen solutions.

Fig. 3.1. Key pathways to acceptance



Engagement and negotiation
Actively involving stakeholders, including PWLE in planning and decision-making.

Advocacy
Promoting the benefits and ethical imperatives of DI.

Communication
Ensuring clear, consistent, acceptable and culturally sensitive messaging.

Consensus-building
Addressing concerns through dialogue and shared problem-solving.

3.1.1 Key actions and processes

Build trust among residents and families

- Introduce the **idea of discharge** early and gradually, with repeated opportunities for questions, reflection and reassurance.
- Involve **residents and, with residents' consent, families** in planning every step of transition, ensuring information is clear and transparent.
- Invite **people who have already transitioned** to community living to share their experiences.
- Support **family and user groups** with emotional support, information sharing, coping skills, and advocacy (*72*).
- Acknowledge common **fears** – safety, loss of routine, unfamiliar environments – and respond with empathy and practical solutions.

Foster collaboration with community providers

- Involve community providers in **joint planning** from the outset and emphasize their role in continuity of care and recovery.
- Provide **training** relevant to supporting people transitioning from long-stay hospital settings.
- Clarify **roles and communication pathways** to reduce uncertainty and avoid duplication or gaps.

Cultivate enthusiasm among hospital staff

- Explain that DI is an opportunity for **professional growth** and recovery-oriented practice, promoting community-based care as work that is meaningful, rights-based and broader in scope that institutional care. This can help motivate existing staff and attract new workers (see Box 3.1).
- Highlight how **skills** developed in psychiatric hospitals – managing clinical uncertainty, relational risk, ethical decision-making, and crisis response – are valuable in community settings. The need for experienced workers will expand after DI.
- Support **worker-led advocacy** for DI by facilitating links to professional associations, creating spaces for staff to participate in reform discussions, and enabling peer-to-peer exchanges at local, national and regional levels, including exchanges between hospital workers from settings with advanced reform experience and those in earlier stages of transition.
- Involve **collective bodies** – professional associations, service user and family organizations, social cooperatives – in shaping and supporting change.
- **Embed PWLE** in institutional culture, for example by involving them in governance, recruitment and supervision, organizing co-facilitated reflective spaces that challenge assumptions about risk and capability, and offering paid peer support roles that model relational engagement and recovery-oriented approaches.
- Develop, if possible, a **staff protection pledge** committing to role changes, not job losses; and plan for constructive engagement with unions and regulatory bodies.
- Recognize **staff contributions** and show how their work improves people's lives.
- Create forums for **candid dialogue** and reflection about professional identity shifts and the rationale for change.

CASE STUDY

Box 3.1. Argentina: from custodial wards to community-based care

In the city of Allen, Río Negro, the transformation of mental health care at Hospital Ernesto Accame shows how DI can be achieved by ending institutional logic rather than demolishing buildings.

Opened in 1925, Hospital Ernesto Accame was a regional general hospital providing medical, surgical and later psychiatric services within a single institution. By the late 20th century, its psychiatric wards were functioning as a de facto institution, characterized by prolonged confinement and limited social reintegration.

In the mid-1980s, following Argentina's return to democracy, Río Negro launched a provincial mental health reform grounded in human rights and community care (*73*). The psychiatric internment wards at Hospital Ernesto Accame were closed. Rather than transfer the 70–80 people who were living there to another institution, the reform prioritized discharge into the community, supported housing, family reintegration, and follow-up by multidisciplinary community mental health teams based in general hospitals.

Psychiatrists, psychologists and mental health nurses from Hospital Ernesto Accame were redeployed to work alongside social workers in crisis care and support for community living (*74*). They were joined by professionals from across Argentina, who were drawn by the model's community-centred ethos; and by lay operadores de salud mental, who were trained on the job to bridge clinical care and everyday life (*75*).

In 1991, Río Negro enacted a provincial mental health law formalizing the principles applied in Allen (*76*). The law officially oriented the provincial mental health system towards community-based care and social inclusion, positioning psychiatric hospitalization as an exceptional and last-resort measure, and explicitly rejecting harmful practices such as electroconvulsive therapy. By implementing the reform first and writing the law after, Río Negro used legislation to protect and expand the ongoing hospital-led DI process. In 2010, the provincial law helped inform development of a national mental health law.

Hospital Ernesto Accame never stopped operating as a general hospital, but today its mental health services are integrated into a local health network of community-based care rather than operating as a psychiatric enclave. It is one of 36 general hospitals in the province, all of which offer mental health services.

Build awareness and acceptance among the general public

- Maintain **open dialogue** with communities about DI plans.
- Support or initiate c**ommunity education** activities in schools, workplaces and public forums.
- Engage **local media** to share real stories of transition and social inclusion, with the informed consent of everyone featured.
- Use moments of **public debate or concern** to clarify available supports and reduce stigma.
- **Empower PWLE and families** to act as intermediaries and advocates: involve them in decision-making bodies that shape local services and promote social contact initiatives where individuals and families can share stories of DI and recovery.
- Involve **local communities** in practical inclusion efforts – e.g. home preparation, welcome-home events, or supporting participation in neighbourhood activities.

Box 3.2. Practical tips for building acceptance and momentum

These options can be adapted to context; not all are required in every DI process.

- **Host transition workshops** with residents, families, staff and providers to explore goals, expectations and negotiate shared goals.
- **Use trained peer workers and educators** to build trust and demonstrate the feasibility of community living.
- **Offer change management support**, including coaching, supervision and emotional support for staff.
- **Celebrate milestones** – successful discharges and re-provision, community participation, new partnerships.
- **Maintain open communication** through newsletters, meetings and informal check-ins.
- **With residents' agreement, invite the public into the hospital** through exhibitions or events that promote contact, which is the most effective way to reduce stigma (77).

LEADERSHIP

3.2 Assess individual needs and strengths

Safe and effective recovery and discharge planning requires comprehensive individual assessments. Going deeper than the overview of residents done during the situation analysis, these assessments build understanding of each person's medical, psychosocial and practical support needs, as well as their strengths, aspirations and risks (see Fig. 3.2) (*69*).

Assessments should extend beyond diagnosis, symptoms, functioning, and daily living skills to include the person's strengths, personal understanding of recovery and the forms of support that help them feel safe, understood and able to live as themselves. They should consider demographic factors, such as reproductive health or childcare needs (*78*), as well as the social determinants of mental health in a person's life – poverty, ethnicity, migration status, gender identity and history of violence or discrimination – that shape both the risk of long-term hospitalization and access to community supports (*4*).

Institutionalization can affect how people express their wishes – some residents may under-aspire due to years of coercion or learned helplessness. Assessment teams must be trained to recognize this and support people to articulate their own support needs (*79*).

Of note, staff too can be affected: institutional settings can normalize low expectations about community living for people with mental health conditions. Training and exposure to community-based care are therefore important for assessment teams.

Fig. 3.2. Key components of needs and strengths assessment

Interviews ✿ Records ✿ Observations

- ☑ **Recovery goals and preferences**
  Personal aspirations and strengths, preferred types of support, cultural, linguistic and spiritual needs.
- ☑ **Functional assessment**
  Daily living skills, cognitive functioning and decision-making capacity.
- ☑ **Clinical evaluation**
  Diagnosis and symptom severity, treatment history, co-occurring conditions, imminent risk of suicide, medicine needs and side effects.
- ☑ **Social and environmental factors**
  Housing status and safety of living environment, supports in community of origin, trusted social and family networks.
- ☑ **Economic and legal considerations**
  Income sources, transport and communication, legal issues.
- ☑ **Risk assessment**
  Risk of exposure to violence or other abuse, difficulties maintaining relationships, houselessness, and re-hospitalization.
- ☑ **History of service use**
  Previous interactions with health, social care, justice systems, barriers to accessing care (including stigma, mistrust).

Recovery and discharge plan

3.2.1 Key actions and processes

Ensure collaborative assessment

- Use culturally-sensitive approaches that fully **involve the person**. Their views, preferences and experiences should guide all decisions (see Box 3.3).
- Promote **interprofessional collaboration** among psychiatrists, nurses, social workers, psychologists, occupational therapists, peer workers and others already supporting the resident. Hold multidisciplinary meetings to synthesize findings and set priorities.
- With informed consent of residents, gather **input from families**, carers and community providers who know the resident well. Their input can help build a fuller picture of strengths, needs and future supports.

Document clearly

- Record findings in **clear, structured formats** shareable across care settings.
- Include clinical information, personal goals and identified additional support needs, e.g. housing, benefits, communication barriers.
- Flag any **risks to continuity of care**, e.g. lack of transport, digital access or documentation.
- Ensure individual **data is protected** according to national or local laws and regulations.

Update as needed

- **Re-visit assessments** periodically, in coordination with emerging community services. Update them when a person's condition changes, new information emerges or discharge timelines shift.
- Ensure final recovery and discharge plans reflect the **most current understanding** of needs, family circumstances and available supports.

CASE STUDY

Box 3.3. Trieste: stepwise assessment and discharge planning as an engine for DI

Trieste's dismantling of the San Giovanni asylum unfolded through systematic, person-by-person assessment and staged discharge, supported by profound changes in care practices and the rapid expansion of community-based services and supports.

Reform began by abolishing coercive practices – restraints, locked wards, seclusion – and opening the asylum's doors to create real conditions for reintegration. Residents were given back their basic human rights (*80*). They started participating in meetings, daily activities and decisions about their care, gradually re-establishing identity and autonomy while giving clinicians a richer, more accurate understanding of each person's abilities, needs and preferences.

Staff were reorganized into teams aligned with city neighbourhoods (*81*). These teams worked with long-stay residents to review clinical status, rebuild social networks and explore housing and work options. Tailored solutions followed: rights-based group homes on hospital grounds, supervised apartments in town, cooperative housing, or, where possible, return to family.

Discharges occurred in waves. People needing minimal support left first, followed by others with more complex needs, supported by emerging community services. After discharge, teams provided outreach and reviews to prevent relapse or readmission.

By 1980, the asylum had fully closed, replaced by a comprehensive network of community mental health centres, a small psychiatric unit in the general hospital, and diverse supported homes and work cooperatives, all financed from the former asylum budget.

Trieste has been internationally recognized as one of the most advanced community-based models of mental health care in the world, operating four 24/7 community mental health centres with very few hospital beds and a strong focus on social inclusion. A Rehabilitation and Residential Support Service runs day-care activities in partnership with volunteer and social promotion associations; and there is a network of social cooperatives covering a wide range of activities from cleaning and transport to gardening and handicrafts *(82*). Trieste's Mental Health Department also introduced personal budgets as a tool for individualized support, initially applied to housing solutions then later expanded to include work-related activities and social relationships (*83*).

LEADERSHIP

3.3 Set a path to recovery

Tailored recovery and discharge plans help people move successfully into the community by ensuring continuity of care and promoting long-term inclusion (*84*). Plans must cover mental and physical health needs, as long-stay residents often have comorbidities (see Fig. 3.3) (*1, 85*). They should also:

- capture the person's own account of their lived experiences, support needs and hopes;
- identify any care practices they found harmful and do not want repeated; and
- make space for social, cultural, spiritual or other frameworks that matter to them.

Each plan should include concrete actions, with clear timelines and responsibilities across hospital and community teams, as well as mechanisms for supported decision-making (*86, 87*). Where relevant, this may include a legal document such as an advance directive specifying what actions should be taken when a person is unable to communicate or make decisions for themselves due to illness or incapacity.

Plans should be easy to understand – including for people with limited health literacy – and regularly updated after discharge to remain relevant and effective.

Fig. 3.3. What to include in recovery and discharge plans

Needs and strengths assessment

Personal goals, strengths and autonomy

- Capture communication skills, hobbies, achievements, self-care routines and strategies.
- Set **realistic**, **meaningful** recovery goals.
- Establish mechanisms to ensure **self-determination**, such as informed consent, personal assistance or supported decision-making, and measures to prevent exploitation and abuse.

Living arrangements

- Plan for **housing** and any environmental supports necessary for safe, supportive recovery.

Health and crisis management

- Schedule appointments (not just referrals) with community-based services for physical and mental health care. Identify channels of communication and give clear guidance for **regular access and assessment**.
- List all **treatments**, including purpose and access, for mental and general health care. Detail instructions for any medicines and address any access barriers (such as cost or transport).
- Make a **crisis plan** that identifies early warning signs and triggers, specifies steps for managing crises, including emergency contacts and where to go, and how to access post-crisis follow-up.

Basic needs

- Ensure access to **essentials** – food, safety, and opportunities for work or education.

Social supports and benefits

- Facilitate access to welfare benefits, including personal budgets, as well as legal, transport and **daily living supports**.
- Connect to **family**, **friends**, **and peer support** groups.
- Identify opportunities for **cultural**, **spiritual and recreational** activities.

3.3.1 Key actions and processes

Co-create the plan with residents

- Make plans genuinely **person-centred** (*88*), co-developed not prescribed (see Box 3.4).
- With residents' informed consent, involve families, carers and other supporters; and engage **community groups** that can offer practical support.
- Plan for a gradual move (see section 4.3) and consider using **discharge checklists** or other tools to prompt residents and families to think through what they need for a smooth transition (*89, 90*).
- Work closely with **community providers**, including in primary health care, to coordinate follow-up across all health conditions.
- For people with **more complex needs**, plan for slower pacing, longer overlap between hospital and community teams, enhanced physical health care coordination, and individualized housing and support arrangements. Greater support needs do not mean less capacity for self-determination; all plans must be built with the person, not just around their clinical presentation.

Box 3.4. Practical tips to empower residents in recovery planning

- **Understand the person's context** – their relationships, community, work situation – before drafting the plan.
- **Train staff** to actively listen for the person's own priorities and sources of meaning (not just to gather information) and to validate, document and act on people's input.
- **Use peer support**, including peer mentors or PWLE-led groups, to help residents to actively participate in recovery planning.
- **Include the person's own words** in the plan to capture how they make sense of their distress, recovery and support needs, and what language or frameworks they do and do not want used. Accept that people may express themselves through metaphor, story, art, silence or non-clinical language.
- **Provide accessible formats of draft plans** (plain language summaries, visual aids) and allow time for reflection and discussion.
- **Make space for ambivalence:** people have the right to change their minds, revisit decisions, and express uncertainty without pressure.
- **Avoid tokenism** by embedding feedback loops and showing how people's input led to real changes.

For people with significant cognitive or sensory impairments

- **Adapt communication:** use picture boards, symbol-based systems, easy-read materials and audio formats when discussing plans; allow extra time and be alert to signs of discomfort, distress or enthusiasm as expressions of preference. Never interpret silence as agreement.
- **Observe and document:** use behaviour across different settings and routines to identify preferences; record what staff and family have learned about the person's likes, dislikes and communication style.
- **Support decision-making:** break choices into small, concrete options; return to decisions multiple times; use advanced directives or trusted communication supporters.
- **Create the right conditions:** hold conversations in familiar settings with consistent, trusted staff.

Agree community-living arrangements

- Ensure housing is **adequate, accessible and integrated** into community life (*33*) (see Table 3.1 for options).
- Prioritize return to **communities of origin**, where safe to do so.
- Offer **flexible choices** wherever possible and tailor solutions (home modifications, relocation, rent assistance) to the person's preferences (*91*).
- Conduct **family tracing** if needed, and assess practical barriers to return, e.g. family capacity, space, carer age, income, stigma, safety fears, or service gaps.
- **Work with families** to build confidence and readiness for discharge. Options include short family ward stays, targeted financial assistance for households in economic difficulty, and information or practical and emotional support to address safety fears and stigma.
- If return to family or an individual dwelling is not possible, explore **supported living** options – independent apartments, shared homes, or cohabitation with friends or others (see Box 3.5) (*46*).
  - For a small group of people with very high support needs, plan discharge to appropriate **staffed homes** (see Box 3.5).
- If community housing is not yet available, reduce institutional practices and improve quality of life while external options are developed. Repurposed hospital spaces for community living may serve as a **step towards DI** but are not the end-point.
- Always avoid recreating institutional models, or placing people in housing without adequate supports (see Box 3.6) (*62*). Carry out **post-discharge reviews** to ensure institutional practices are not continuing.

Table 3.1. Options for community living

Category	Description	
Independent home	Individual	In own home, living alone
	Group	With a few other PWLE, possibly with minimum support, e.g. one visit per week from care staff.
With family/ other familiar		Includes spouse, relatives, friends.
Supported home	Individual	In own home, living alone with minimum support, e.g. a few hours each weekday with a trained home help.
	Group	Living with a few other PWLE and minimum support, e.g. a few hours each weekday with a trained home help.
Staffed home	Low staffing	4–8 bed unit with some shared facilities and independent rooms, including separate rooms in a house or separate flats. Staff may include a warden and a small amount of daily domestic input; occasional overnight stays. Reasonable living and self-care skills expected.
	Medium staffing	24-hour availability of staff, supervision of basic living skills provided where necessary, meals cooked. Some degree of independence expected, e.g. ability to go out during the day unaccompanied.
	High staffing	24-hour cover by staff, including waking staff at night. Some degree of daily living skills expected, e.g. reasonable self-care. This environment would also be able to manage individuals considered at apparent high risk.
	Very high staffing	24-hour nursing, with high degree of supervision. For people with few daily living skills and possibly poor self-care skills. May also provide specialized nursing for persons in need of closer supervision due to apparent high risk or physical care needs, e.g. due to dementia.

Source: Dahl et al, in press (*56*).

CASE STUDY

Box 3.5. Supported living: examples from around the world

India: group homes for women

The Banyan's Home Again programme offers shared supported housing in urban and rural neighbourhoods for women with long-term mental health conditions (*92*). Small affinity groups (4–5 people) live together in group homes, with on-site clinical and social support. Across 136 homes, the programme has helped women move out of institutions and into community life with gains in quality of life, social integration and hope (*93*).

Chile: supported housing and staffed homes

Chile's mental health reform established multiple supported living options for discharged persons without family support (*94*).

- "Hogares protegidos" are for largely independent people, offering housing, meals, medication supervision and help with daily-living activities.
- "Residencias protegidas" are for people with moderate–severe dependency and provide the same basic housing and nutrition but within a therapeutic environment with higher staff presence and more intensive support.

By 2019, Chile operated more than 200 homes, serving nearly 1 900 people and funded mainly by the state with small co-payments and some municipal or charitable support (*94*). Implementation quality varies, and some homes still show institutional features, such as excessive rules and limited autonomy (*52*).

Trieste, Italy: community homes on hospital grounds

At the start of Trieste's DI process, housing options in the city for people leaving the hospital were limited. So as wards were unlocked and closed, some buildings inside the hospital grounds were turned into small community-style housing (*80*). Residents had keys, came and went freely, and participated in neighbourhood life. These residences were later replicated across the city as protected apartments run by the local health authority.

Box 3.6. Transinstitutionalization

Institutional dynamics can re-emerge in small settings and can be resistant to change (*29, 95*). DI must not result in new forms of institutionalization (*5, 96*). Closed or restrictive community facilities – including many religious, private and compulsory treatment centres, secure long-stay units, and some small residential facilities – can simply reproduce institutional models rather than end them (*97*).

- **Be cautious with group homes.** Group homes created for administrative convenience can impose strict rules, limit privacy and reduce personal choice. Without strong rights-based design and oversight, they risk recreating institutional cultures (*98*).
- **Prioritize individualized housing solutions.** Discharge planning should focus on supporting people to live in self-chosen housing with appropriate supports, promoting autonomy, participation and meaningful relationships, not dependence or segregation.
- **Ensure safeguards.** All housing options should protect against neglect, exploitation and control, and uphold residents' rights to self-determination, privacy and freedom of movement.
- **Support independent monitoring.** Community settings should be subject to regular, independent inspection by bodies that include PWLE, assessing not only physical conditions but whether residents exercise real choice, maintain relationships and participate in community life (see section 4.7).

Enable social inclusion

- Identify **daily living skills** that may need to be rebuilt – managing finances, cooking or navigating public services (see Strengthen residents' skills for independent living).
- Explore pathways into or back to **work or education**: phased returns, reasonable adjustments, links to vocational training, employment support services and options for self-employment.
- Help residents and families think through how to **rebuild key relationships**, acknowledging that some connections may have changed during a long stay.
- Review strategies and options for **re-engaging with community** organizations, recreational activities and cultural or spiritual life.
- Have **honest, practical conversations** about transition: what to tell others, what a person is and is not obliged to disclose, and how to manage a world that may expect full recovery before it has happened. Normalize difficulty as part of the process, not a sign of failure.

PARTNERSHIP

3.4 Coordinate support and care

Effective support and care coordination ensures continuous, person-centred support after discharge, reducing relapse and promoting social inclusion. Coordination teams typically oversee plans before and after discharge. They help people navigate services, rebuild family ties, respond early to crises, and advocate for missing services. Early relationship-building between residents and those who will support them in the community reduces anxiety and improves follow-up. Shared protocols and information systems are important to prevent fragmentation and gaps in care.

3.4.1 Key actions and processes

Appoint support and care coordinators

- Assign a **named coordinator** (also called case manager, recovery or transition coordinator, or community connector), to each resident where possible (*69*). This role can be filled by professionals from various backgrounds or by trained PWLE who have navigated discharge and transition themselves. If dedicated posts for this role are not feasible, look for support from external partners (see Box 3.7).
- Base coordinators in **accessible community settings** where people can get quick, routine support.
- Embed them in **multidisciplinary teams**, typically including: a nurse, a psychiatrist or other physician with mental health care experience, a psychologist, an occupational therapist, a social worker and a peer support worker (*72, 99, 100*).
- Treat residents and their **chosen family members and carers** as active team members.

Box 3.7. Practical tips for coordinating support and care

- **Share responsibility.** Partner with local organizations to co-deliver coordination; and rotate tasks where staffing is thin.
- **Extend capacity.** Train community health workers or NGO staff in basic mental health care, safeguarding and referral pathways.
- **Embed peer support.** Engage trained peer workers or recovery mentors to provide follow-up, navigation and emotional support.
- **Use simple technologies.** Call or text message for check-ins, reminders and crisis support; and log contacts in the shared system.
- **Offer group follow-up.** Offer group sessions for post-discharge administration, psychoeducation and social inclusion support.

CASE STUDY

Box 3.8. India: DI teams for continuity of care and social inclusion

In India, the Government of Kerala partnered with two NGOs to create multidisciplinary DI teams in state psychiatric hospitals and support long-stay residents to transition back into community life (*33*).

These teams assessed long-stay residents' needs and preferences, mapped housing and social supports, and co-designed exit plans. Family reunification was prioritized; when not possible, people were supported to move into small community group homes.

Before discharge, DI teams prepared residents through life-skills training, community reconnection and family engagement. Each person left with a tailored care package including for example home visits, phone-based follow-up, social care and cash transfers.

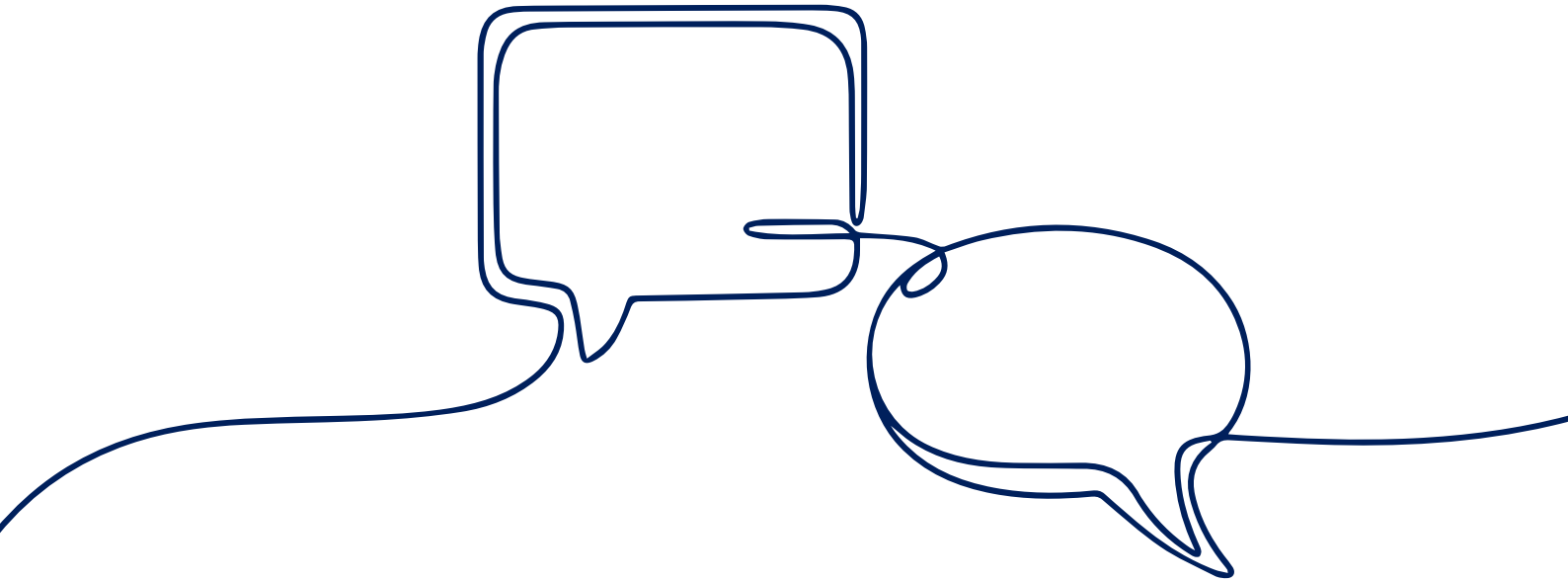
The collaboration achieved partial success. Of 100 participants, 64 returned to families and 16 moved to community group homes. Twenty did not complete transition and ultimately returned to hospital or were placed in other institutional settings.

Promote shared protocols and information systems

- Establish a **standard handover protocol** covering at minimum: reviewing the recovery and discharge plan and any advance directive, scheduling follow-up appointments, ensuring medicine supply, briefing families and peers, and arranging the logistics of discharge (see Annex 6).
- Co-develop standard **procedures with community partners** for key processes, including referrals, crisis response, family support and addressing common comorbidities.
- Define clear **roles and responsibilities** across hospital staff, community providers, coordinators, peer workers and families.
- Use a **shared information system** (preferably electronic) with appropriate safeguards for consent and data privacy. Such systems can also help coordinate health insurance and welfare benefits and reduce out-of-pocket expenses (*100*).
- Maintain **regular communication** among the multidisciplinary team (e.g. weekly check-ins or shared calendars).

Build relationships before discharge

- With the resident's informed consent, share **recovery and discharge plans** with all involved.
- Introduce coordinators, peer supporters and community providers **well before discharge**. Clarify roles and discuss boundaries, communication preferences and how to handle disagreements.
- Schedule **joint planning sessions** and informal conversations to build trust and set expectations.
- Organize a **visit to future accommodation** to reduce anxiety and test practicalities (access, transport, local services), as part of gradual exposure to community life.
- Frame discharge as a **relationship-building process**, not just logistics: invite residents and families to ask questions, express concerns and shape supports on their terms.



PARTNERSHIP • MANDATE

3.5 Invest in new and improved services and supports

DI requires a strong, responsive network of community-based services and supports that can meet diverse health needs, promote social inclusion and prevent new long-stays (*1, 101*).

Hospital leaders have a strategic role in shaping, strengthening and advocating for these services. For example, by integrating outpatient care with follow-up services, relocating referral care to general hospitals or specialized community mental health services (see Redirect resources for impact), and enabling task-sharing across providers (*3*).

Early hospital-led pilots can demonstrate feasibility and generate wider interest and investment in community-based care.

Fig. 3.4 highlights some of the priority areas for investment. Most countries will not have every service listed; but having every service is not a prerequisite for beginning DI.

Fig. 3.4. Priority community-based services and supports for investment

Crisis response

- Mobile crisis teams.
- Helplines or digital triage services.
- Stabilization units, peer-run respite centres, or acute wards in general hospitals. These should be linked to other mental health services and offer: 24/7 availability, rapid evaluation, and a few beds for short stays only.

Vocational and educational supports

- Pathways to employment, education and skill development, with appropriate accommodations.

Mental health in general health care

Community mental health services

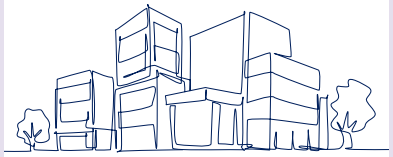
Mental health beyond the health sector

Primary health care

- First-line and follow up mental health care.
- Integrated care, including, possibly, collaborative care.

General hospitals

- Referral care, acute hospitalizations and treatment of physical health conditions.



Community mental health services

- Community mental health centres.
- Flexible multidisciplinary teams – psychiatrists, psychologists, nurses, social workers, peer support specialists – that are accessible and mobile.

Peer support and recovery

- Peer-led programmes, including support groups, respite care, helplines, mentoring, and advocacy.
- Personal assistance services.

Safeguarding and legal supports

- Legal advocacy, supported decision-making, and mechanisms to protect rights and autonomy.

Social and supported housing

- Diverse supported living services that promote autonomy and social inclusion.

Practical tips on supporting housing initiatives

- **Advocate with local government** for development of supported housing and emphasize its importance for safe discharge.
- **Redirect selected hospital resources** or staff time to support people living in community housing.
- **Partner with supported housing providers** to offer clinical advice, training or short-term staff support.
- Where appropriate, consider **repurposing parts of hospital grounds** for small, community-style housing as an interim step (not as a long-term substitute for independent community housing).

Notes
For more information on the mix of services and supports required for community-based mental health care, see: World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/356119).
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3.5.1 Key actions and processes

Improve hospital-linked services

- Establish **linkage services** – case management, psychosocial rehabilitation and DI coordination teams (*102*) – and transitional services that prepare long-stay residents for community living (e.g. transitional wards).
- Introduce **flexible care models** suited to community settings: mobile outreach, home-based support, day programmes and extended-hours clinics (*3*).
- Free up staff to support **community-based teams**, e.g. by running mental health rounds in general hospital units or clinics in rural community health centres (*27*).

Share tasks with non-specialists

- Identify **tasks suitable for sharing**, e.g. psychoeducation, basic psychosocial support, medication adherence checks, follow-up care and support for independent living (*1*).
- Transfer short-stay services, emergency mental health care and outpatient consultations to **general hospitals** and other outpatient clinics wherever possible (see Box 3.9) (*4*).
- Establish **clear guidelines** for task-sharing, outlining goals and roles to avoid both gaps and overlaps in care.
- Provide **targeted tools** and training for non-specialists and lay workers, including PWLE (*103*); and appoint existing mental health professionals to provide ongoing supervision and support, especially for complex cases (*72*).
- Where appropriate and with residents' informed consent, embed **families and carers** within task-sharing teams to enhance support networks (*104*).

CASE STUDY

Box 3.9. Belize: investing in community services

Historically dependent on the Rockview Psychiatric Hospital, Belize has shifted from an institution-centred mental health system to a community-based model by investing in new services and expanding its workforce (*105*).

From the 1990s, Belize began training Psychiatric Nurse Practitioners – a major task-sharing initiative enabling non-specialists to deliver assessments, treatment, follow-up in general health care facilities, and through home visits and outreach across all districts.

As the new nurse practitioners expanded community care, psychiatric hospital admissions fell and continuity of care improved. New services were created: acute psychiatric beds in general hospitals, a day hospital, nine district mental health clinics, community outreach programmes, and supported living options.

These investments drove a steady downsizing of Rockview Hospital, ultimately leading to its closure in 2008, with the last 22 long-stay residents transitioning to families or supported homes.

Belize's community network is still evolving, but its experience shows how targeted investment and task-sharing can help build community-based alternatives and reduce reliance on institutions.

Strengthen external connections

- Link community services to defined **catchment areas** so they can be proactively engaged in discharge planning and post-discharge support for residents from their area.
- Establish **referral pathways**, partnership agreements and shared mental health care protocols across levels of care.
- Ensure services and supports are **well-publicized and accessible** to community providers and the public.
- Facilitate joint training, shared case reviews, and regular communication between hospitals and community providers.

Co-design new services and supports

- Work with **local authorities, NGOs, PWLE, service users and families** to design services and supports that meet real needs, especially around housing (see Box 3.5 and Box 3.10).
- Where available, support **personal assistance services** or individual budgets, which strengthen choice and control over housing and other supports (*62, 106*).
- Partner with **employers and education institutions** to promote inclusion, e.g. through return-to-work programmes and reasonable accommodations.
- Link to **livelihood initiatives**, including collective work options that provide both financial independence and social engagement (see Box 3.11).

CASE STUDY

Box 3.10. Brazil: community houses and cash transfers

Brazil's therapeutic residential services [serviços residenciais terapêuticos (SRTs)] are small community shared houses for people who have spent at least two years in psychiatric hospitals and who lack social or family support (*107*). They offer a homelike environment with daily-living support, three meals a day and staffed by caregivers and a nursing technician. SRT I supports residents with higher autonomy, and SRT II provides continuous care. Each SRT is linked to a primary care clinic and a community mental health centre [centro de atenção psicossocial (CAPS)].

The Back Home Programme[Programa de Volta para Casa] complements the SRTs by giving eligible discharged persons a monthly psychosocial rehabilitation allowance (*108*). This cash transfer supports rental costs, daily living expenses and participation in community life. Beneficiaries live independently or with families, supported by local services and municipal follow-up teams. Studies show the programme helps restore civil rights, build affectionate relationships, and strengthen autonomy while reducing reliance on institutional care (*109*). One nationwide cohort study found that being a recipient of the Back Home Programme was associated with a 23% lower risk of psychiatric hospitalization (*110*). Broad social inclusion remains a challenge, and access varies regionally.

By 2024, Brazil operated 952 SRT houses nationwide, with capacity for more than 7 300 residents; and had supported 8 445 people through its Back Home Programme (*111*).

CASE STUDY

Box 3.11. Argentina: from hospital centre to social cooperatives

In La Plata, social and labour inclusion programmes for people leaving psychiatric hospitals emerged in 2009, within a day centre linked to the Alejandro Korn Neuropsychiatric Hospital (*112*). Hospital restrictions on participation and sales led service users and allies to create an independent organization – Movida de Locos – and move into a new community-owned space.

By 2021, Movida de Locos operated several social cooperatives – in ceramics, textiles, clothing, food and a radio show – and providing job placement and training for community health care teams (*113*). Members combined disability benefits with cooperative earnings to live independently, supported by community teams of professionals, volunteers and peers.

Over time it built connections with all the general hospitals and mental health services in La Plata, offering meaningful work opportunities and community participation after discharge. In 2020, it renewed formal ties with the Alejandro Korn Hospital through a joint gardening project on hospital land (*114*).

- Support the **integration of mental health care** in general hospitals and primary health care facilities through training, co-location of services or staff relocation (see Box 4.8).
- Facilitate or link to **peer support** initiatives: PWLE can uniquely connect with people going through DI and so can be compassionate listeners, educators, coaches, advocates, partners and mentors (*115–117*).
- Ensure new services meet **quality standards** for safety, staffing, rights and funding.

Box 3.12. Practical tips for expanding community-based care

- **Leverage community assets**. Partner with local NGOs, faith-based groups and community leaders who already provide social or health support. Train community health workers, lay providers or peer workers to extend outreach.
- **Start small and scale.** Pilot low-cost, high-impact models, e.g. peer-run groups, mobile outreach using basic transport, or community drop-in centres.
- **Use flexible approaches.** Prioritize home-based care, telehealth and mobile teams. Rotate staff or share resources across communities.

LEADERSHIP • PARTNERSHIP • MANDATE

3.6 Strengthen competencies for mental health care

Competent staff and care providers are essential for quality, community-based care. As DI progresses, community mental health workers, general health workers, community providers (e.g. peer workers) and families take on increasing responsibility for mental health support and care. Strengthening their skills, knowledge and support is critical to managing the complexities of DI, safeguarding rights and promoting recovery, while building on the existing strengths within communities.

Staff training must go beyond technical skills to help workers reflect on and rethink their roles and assumptions. DI also requires reforming organizational structures to create enabling conditions for sustainable changes. Most staff have been doing what their institution expects of them, and sustainable change depends not only on shifting attitudes and skills but also on reforming the regulations, workflows, and resources that shape what staff can practically do.

Hospital leaders can drive and advocate for capacity-building efforts across hospital and community settings respectively, covering all roles – clinical, managerial and administrative (*118*).

They can also support competencies of families, who often provide a major share of support, especially in low-resource settings and family-oriented cultures. Strengthening families' ability to navigate complex mental health conditions and care decisions improves outcomes and reduces reliance on institutional care (*104*).

CASE STUDY

Box 3.13. Republic of Moldova: reframing roles and elevating lived experience

In 2014, the Republic of Moldova began a systematic process of mental health system reform designed to move care away from three long-stay psychiatric hospitals towards community-based services built around new multidisciplinary community mental health centres and strengthened primary care.

The reform, implemented through the MENSANA project, unfolded in three phases (*119*).

- Phase 1 (2014–2018) piloted community mental health centres in four districts, trained the workforce in community psychiatry, and established a legal framework for DI.
- Phase 2 (2018–2022) scaled the model nationally, integrating primary care as the entry point. It positioned the community mental health centres as the main providers of person-centred secondary care through co-developed care plans, routine monitoring, home-based crisis interventions and links to social supports. The centres also coordinated with social services and regional hospitals for acute inpatient care and discharge planning.
- Phase 3 (2022–2026), focused on sustainability, embedding community mental health centres into legal and financing structures, maintaining new academic programmes, and culminated in the 2024 Law on Mental Health and Well-being.

The phased design helped mitigate abrupt disruptions in service provision. Ownership over the reform process shifted from project-led in Phase 1 to national – and local – government-led in Phases 2 and 3.

One demanding aspect was cultural change. Staff trained in custodial, hospital-based frameworks had to reconceive their roles as collaborative, community-based care providers. The project worked with universities and relevant training bodies to modernize curricula; and ran sustained train-the-trainer programmes on community mental health, clinical protocols, and family medicine. Multidisciplinary teamwork – across psychiatrists, nurses, psychologists and social workers – became the expectation.

Peer engagement was built into the system. User-led advisory councils were created in eight community mental health centres, giving people with lived experience a formal role in shaping services. Peer participation in international exchanges and a WHO meeting on mental health in all policies in 2025 strengthened the peer voice and shifted power dynamics away from institutional authority, sparking greater participation of people with lived experience in public dialogue, anti-stigma efforts and service improvement processes.

Additional source: Felix Bolinski, Trimbos Instituut, Kingdom of the Netherlands, personal communication, 23 March 2026.

3.6.1 Key actions and processes

Strengthen residents' skills for independent living

- Provide relevant **psychoeducation** on their condition and recovery (*120*).
- Connect residents to training that reinforces **daily living skills** (*2*).
- Involve residents in **transition planning** to reinforce agency and choice (see also Gradually expose residents to community life).
- Use **peer-led approaches**, especially for residents who may feel ambivalent or fearful about change (*121*).

Build capacity of families and carers

- Provide families and carers with **psychoeducation** on mental health conditions and recovery.
- Offer training for families and carers in:
  - **practical skills**, including medicine management, recognizing early relapse signs, emotional support, and self-care; and
  - **non-coercive approaches**, values-based care, and relational competencies that uphold dignity and rights.
- Support families and carers access social benefits and community groups.
- Families and carers often also need supports for **their own well-being**, as caring can be demanding and stressful (see also Support families and carers).

Develop and support the workforce

- Provide training on **person-centred, recovery-oriented and effective** interventions, tailoring content to role, experience and context (see Table 3.2). Training should be continuous and embedded, linked to supervision and performance systems, and focused on preparing workers for practice in community settings (*6*).
- Prioritize training that **shifts attitudes** (e.g. QualityRights training) (*122*) as well as skills (*123*) to challenge stigma, promote autonomy, and embed rights-based practice.
- Support staff to **understand local communities**' assets, networks and structures (e.g. through community support mapping) so that they can help people leaving hospital connect meaningfully with community life.
- Enhance support networks (*104*).
- Formalize and sustain **peer support roles** through paid, stable positions within the formal health workforce; prioritize PWLE of the facility for these positions.
- **Involve PWLE** in designing and implementing staff training. Provide ongoing support – including peer-to-peer training and mutual support groups – to enable meaningful participation.
- Regularly review **care practices** used in hospital and community settings to identify and address stigma or discriminatory norms.

Table 3.2. Focus of training for different groups of workers

Who to train	Training focus	
Hospital leaders	Strategic leadership, change and conflict management, system coordination	
Administrative and planning staff	Support and care coordination, service network administration, monitoring and evaluation	
Mental health professionals	Working in community settings, including: supervision and leadership, crisis response, referral pathways, informed consent, psychosocial rehabilitation, resource navigation, and outreach	
General health care providers *(including primary health care, general hospital staff)*	Basic mental health care, helping and communication skills, de-escalation techniques, referral and triage, psychosocial rehabilitation	Human rights and rights-based care; anti-stigma
Community providers *(e.g. lay workers, including PWLE)*	Needs identification, mapping of and linking to community supports, mental health promotion, community engagement, basic mental health literacy, referral pathways	
Peer support workers	Peer support principles and practices, recovery-oriented care plans and practices, coping strategies, advocacy	
PWLE in governance roles	Orientation to legal processes, system structures and decision-making frameworks	
Community leaders	Mental health awareness, referral support	

- Address the persistence of outdated practices: **rotating personnel** across sites and departments can reduce entrenched authority and support culture change.
- Support **staff well-being** through adequate resources, recognition, supportive supervision and decent working conditions (*124*).
- Manage **motivation and morale** throughout the DI process, e.g. by:
  - involving staff in reform design and implementation;
  - addressing workload pressures;
  - identifying champions to build momentum for change;
  - using language that recognizes expertise and responsibility; and
  - valuing peer workers as integral members of the workforce.

Provide

Activities in this phase support people to transition safely and sustainably into community life, while continuing to build up community mental health services and improve quality of care.

During this period, resources progressively shift from the hospital to the community, resulting in significant downsizing and, where planned, repurposing or closure. Because DI takes time, hospitals may need interim measures to reduce institutional practices and improve living conditions, safeguarding rights and dignity while community capacity grows.

4

LEADERSHIP • PARTNERSHIP • MANDATE

4.1 Change attitudes and institutional practices

Where DI is at an early stage or closure is not yet feasible, transforming institutional culture and practice is essential for building momentum (see Box 4.1). This includes replacing institutional terms with person-centred language, reorganizing hospital structures, policies and workflows to uphold rights; empowering staff through training and reflective practice; involving residents in everyday decision-making; and working with community partners to avoid replicating institutional routines.

Increasing community interaction is one of the strongest levers for cultural change, reducing isolation and helping rebuild social roles (*42*).

Box 4.1. What are institutional practices?

Institutional practices are routines, policies and attitudes that (*29, 125*):

- isolate people from the broader community or force them to live together;
- limit autonomy, choice and personal agency;
- prioritize control, compliance and efficiency over individual needs;
- reinforce dependency and passive roles; or
- create rigid hierarchies and depersonalized care.

Examples include:

- **Excessive rules**, e.g. bans on personal belongings, restrictions on movement, tightly controlled visits from family and friends.
- **Inflexible schedules**, e.g. fixed wake-up, meal, medication or activity times.
- **Lack of privacy**, e.g. shared sleeping spaces, poorly screened washing facilities.
- **Over-surveillance**, including security cameras in bedrooms and communal spaces, often without residents' informed consent.
- **Widespread use of coercive measures**, including forced medication, mechanical restraint, seclusion.
- **No real choice**, including staff-centred treatment plans made without the person, no options about therapy types, food, activities, or interactions with others.
- **Overmedication**.
- **Segregated, closed environments**, including locked rooms or wards, no access to phones or internet, no opportunity to work, study or maintain social relationships.

4.1.1 Key actions and processes

Promote person-centred support and care

- Build collaborative **therapeutic relationships** that support shared decision-making about treatments and daily routines. Respect cultural, social and spiritual identities.
- Use tools such as care planning meetings, feedback forms or informal check-ins, to **regularly review** and refine care practices and plans.
- Encourage flexible and culturally-sensitive routines, and support **personalization** of rooms and belongings.

Use non-stigmatizing language

- Review language used in hospital and community settings to identify and **address stigmatizing labels** (*126*) (see Table 4.1).
- Use **person-centred** language to validate the individual's worth and strengthen safety and trust.

Table 4.1. Stigmatizing terms and preferred alternatives

Word/phrase to avoid	Why avoid	Preferred alternative
Chronic patient	Reduces a person to a permanent condition; reinforces hopelessness.	**Person with long term support needs**
Dangerous case	Reinforces stereotype linking mental illness to violence.	**Person needing support for safety and well-being**
Mental patient (among other pejorative terms)	Stigmatizing labels that sensationalize mental health concerns.	**Person with a mental health condition** *(used in this guide)* **Person with a psychosocial disability** *(preferred term among many PWLE)* **Person with a mental disorder** *(used in medical discourse, including diagnostic frameworks, clinical guidelines, medical statistics and epidemiology)*
Schizophrenic/ psychotic person	Labels the person as their diagnosis.	**Person with schizophrenia/ psychosis**

Sources: Adapted from Volkow ND et al., 2021 (*127*), Everymind, 2026 (*128*), PAHO, 2026 (*129*).

Prevent and address coercive practices

- Commit to human rights-based, **non-coercive care**, including avoidance of restraints.
- Implement (in the hospital) or advocate for (in community-based services):
  - safeguarding policies, informed consent and supported decision-making (*79, 130*);
  - grievance mechanisms to track and respond to coercive incidents;
  - staff training on human rights and rights-upholding care practices; and
  - QualityRights or equivalent frameworks to uphold standards of care (*131, 132*).

Involve residents in daily decision-making and communal life

- Establish practices that give r**esidents and hospital staff** genuine agency, voice and influence. For example:
  - resident councils or advisory groups with decision-making over service operations;
  - shared forums where residents and workers have an equal voice;
  - collective meetings on discharge and day-to-day life; and
  - participation of PWLE in ward rounds and discharge meetings.
- Facilitate **resident-led roles**, such as orienteering new residents, leading group activities, or mentoring.
- Cocreate open and **inclusive communal spaces** and group activities that foster connection and increase community interaction (see Fig. 4.1). Ensure residents' agreement, especially for activities that invite the public into their hospital wards.
- Provide opportunities for **voluntary contributions** to the community, such as gardening or cooking; frame these as roles that build agency, not chores.

Fig. 4.1. Strategies for increasing community interaction

Create opportunities for inclusion

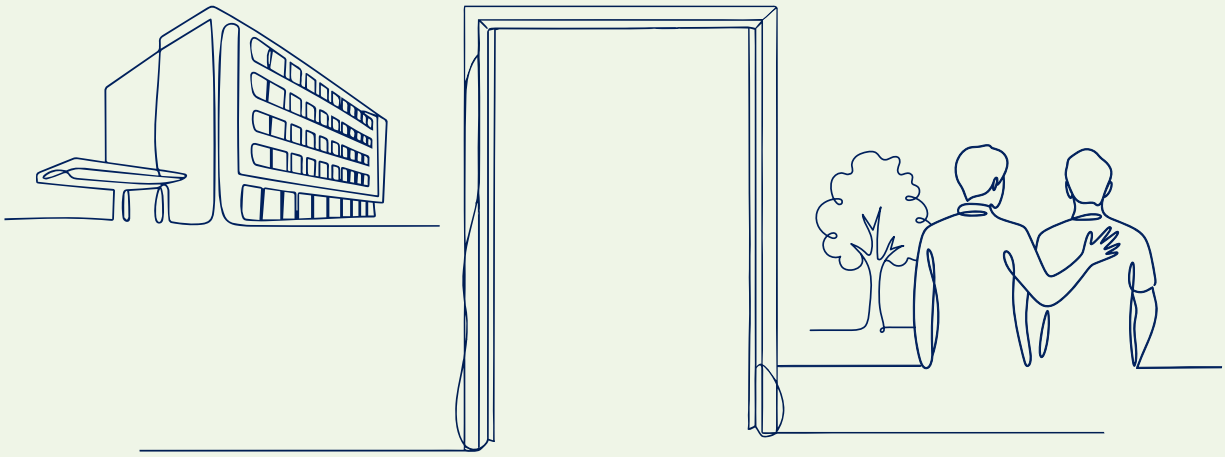
- Participation in community activities, e.g. volunteering, events (cultural and social), clubs
- Regular visits to public spaces e.g. parks, libraries, cafes

Normalize public presence

- Visibility and interaction in everyday settings
- Confidence-building outings and community-based activities

Welcome the public in

- Open days, exhibitions or cultural events
- Volunteer initiatives
- Joint activities with schools, universities, community groups, including peer-led organizations



Support social networks

- Connections with family, friends, informal supports
- Unlimited hours or opportunities for family visits
- Peer support groups in community settings

Build community partnerships

- Links with local organizations
- Joint programmes for contributing to community life

LEADERSHIP

4.2 Enhance quality of care

Enhancing quality of care means creating environments and routines that are dignified, responsive and recovery-oriented.

Hospital leaders can drive this transformation by promoting person-centred care; ensuring use of evidence-based interventions; and embedding standards for both clinical excellence and human rights. Involving PWLE in monitoring and improving quality of care is essential: they bring direct insight into what dignified, rights-respecting care looks and feels like (see also Monitor and evaluate).

Findings from the situation analysis will highlight priority areas for improvement.

4.2.1 Key actions and processes

Implement standards

- Meeting **basic needs** is non-negotiable (see Box 4.2).
- Ensure care practices align with national or international **standards and best practice guidelines**, including physical health guidelines for adults with mental health conditions (*133*).
- Support regular **audits and evaluations** in both hospital and community services, (*134*). Use findings to drive continuous improvement (see Monitor and evaluate).

Box 4.2. Meeting basic needs

- **Nutrition.** Provide balanced, culturally appropriate meals with respect for choice.
- **Water, sanitation and hygiene.** Ensure access to clean water, safe sanitation and personal hygiene facilities.
- **Space and privacy.** Avoid overcrowding; provide access to outdoor areas, personal space and privacy for rest, reflection, and relationships.
- **Safety and comfort.** Protect against neglect, abuse and exploitation. Maintain clean, well-ventilated, and temperature-appropriate environments, as far as feasible.
- **Clothing and belongings.** Respect personal property and provide access to appropriate clothing and storage.
- **General health care.** Ensure access to primary and specialist services for physical health conditions.
- **Health promotion and prevention.** Support well-being through physical activity, tobacco cessation support, vaccination and screening programmes, and health education.
- **Cultural and spiritual needs.** Respect and support cultural, religious, spiritual and personal beliefs and practices.
- **Communication and information.** Enable access to information and means of communication, including contact with others.

Support recovery-oriented support and care

- Ensure recovery and discharge plans focus on **strengths, goals and personal meaning**, not only on symptom management (see Box 4.3).
- Integrate **peer support**, skill-building and social inclusion opportunities. Formalize and compensate peer-support roles.
- Encourage staff to shift from providing care to supporting the person as decision-maker. Help them view **recovery as a personal journey**, not a clinical outcome, and to see themselves as companions and allies.

Use evidence-based interventions

- Offer a **full range** of evidence-based interventions – psychological, psychosocial, physical health and pharmacological (*136*).
- Provide protocols and **decision-support tools** at the point of care.

CASE STUDY

Box 4.3. Sri Lanka: hospital-led transformation of support and care

For decades, the Angoda Hospital in Colombo, Sri Lanka was an overcrowded, custodial psychiatric institution marked by poor infrastructure and widespread rights violations. Growing public scrutiny in the 1990s and renewed political attention after the 2004 tsunami created momentum for reform (*135*).

New hospital leadership pursued a stepwise approach to reform that began by improving basic conditions and protecting rights (*47*). Diets and water, sanitation and hygiene facilities were upgraded, medicine storage improved, and new incident-reporting, security and anti-bribery measures introduced. Staff received continuous training to shift attitudes, address abusive practices and strengthen skills in recovery-oriented care. Regular staff meetings and proactive media engagement helped build trust, transparency and public support.

Once basic standards were in place, Angoda began to systematically plan for discharge and community living. Hospital teams used assessments to identify discharge readiness and options, trace families, and link people to rehabilitation programmes such as horticulture therapy and income-generating work. Partnerships with NGOs enabled supported housing when family return was not possible. More than 90% of medium- to long-stay persons in Angoda were supported to return to their district of origin; 60% only required low levels of support. Nationwide expansion of district mental health services helped support continuity of care and reduce readmissions.

Today, Angoda has evolved into the National Institute of Mental Health. It is a smaller, better-regulated, rehabilitation-oriented facility with significantly reduced bed numbers, and a focus on specialized services, training and research.

Additional sources: Jayan Mendis, University Hospital – Kotelawala Defence University, interviewed on 4 June 2024; John Mahoney, United Kingdom, personal communication, 4 April 2026.

LEADERSHIP

4.3 Transition people gradually

Discharge during DI is not a one-time event but a staged, iterative and adaptive process. People typically leave in waves, based on individual readiness and system capacity at the location of where people will settle. Early groups generally require less intensive support; later groups often have more complex needs (see Fig. 4.2).

Importantly, people with complex psychosocial or physical health needs should not be excluded from DI. They may require more intensive, coordinated and individualized support, but planning must assume equal rights to community living, adjusting the pace, staffing, health coordination, and safeguarding needed to make that possible.

Recovery and discharge plans must be implemented in full, and post-discharge supports ensured so that people experience continuity, not abandonment.

4.3.1 Key actions and processes

Consider readiness for discharge

- Establish **criteria for assessing discharge readiness** (see Box 4.4).
- Include PWLE in discharge meetings. They bring a perspective focused on recovery and real-life functioning, not just risk, and can help teams move away from overly cautious decisions that keep people in hospital longer than necessary.
- Balance this with safeguards for **doing no harm** (see Box 2.6) and involve residents and families in readiness decisions to prevent premature discharge.
- For residents with **significant cognitive, sensory or physical health needs**, allow extra preparation time and work closely with community health and social support agencies to ensure placements with appropriate staffing and supports. Their transition may take longer, but must remain an active goal and be planned for accordingly.
- Collaborate with **community agencies** to align discharge timing with service availability.
- Use each discharge wave to **inform the next**, refining protocols, addressing system gaps, and strengthening community readiness based on lessons learned.

CASE STUDY

Box 4.4. Brazil: criteria for discharge readiness

Brazil's mental health laws and regulations state that DI must prioritize people with complex, long-term mental health needs who no longer require hospital-level treatment and can live in the community with appropriate support. In Brazil, teams working on long-stay wards assess discharge readiness along three axes.

1. **Clinical criteria** follow a natural scale of complexity: people with greater autonomy and stable health are discharged sooner; those with complex needs require more intensive preparation and support before discharge.
2. **Social criteria** are based on existing support networks: people with supportive families can be more quickly discharged to family with follow-up through community mental health centres. People with no effective family networks are directed towards supported living services.
3. **Quality and rights criteria** are based on hospital environments: people living in hospitals that do not meet national minimum standards are prioritized for discharge to protect safety and rights

Source: Pedro Gabriel Delgado, Universidade Federal do Rio de Janeiro, Brazil, interviewed on 23 May 2024.

Fig. 4.2. Staged, iterative and adaptive discharges

M&E
are essential to track outcomes, adjust strategies and ensure safety.

Lessons learned from earlier discharges help refine protocols, identify gaps and improve community readiness.

Early movers 1

Enable early successes and relieve immediate institutional pressure

Example support needs: basic housing, social benefits, regular monitoring and mental health care, peer support.

Profile
Higher levels of independence, fewer complex needs, and existing family or community ties.

Moderate support group 2

Typically require strong coordination with community providers and gradual transition

Example support needs: supported housing, case management, day programmes, vocational services, social benefits, peer support.

Profile
Moderate functional impairments, some behavioral challenges, or limited social networks.

High-need group 3

Often last to be discharged

Example support needs: 24/7 supported living, specialized clinical care, life skills training, social benefits, peer support.

Profile
Significant mental health conditions, cooccurring conditions, or histories of institutional dependency.

Capacity building
of community services must be ongoing throughout all phases of discharge.

Gradually expose residents to community life

- Use planned activities to **build familiarity and confidence**, strengthen daily living skills, and reconnect residents with community environments and people (see Box 4.5 and also Fig. 4.1) (*5, 84, 117*).
- Set a **clear timeline** for reducing restrictions, with milestones for increasing independence.
- Engage **PWLE** as companions, mentors, group facilitators and community navigators. They can:
  - accompany residents on community visits, rehearse daily living and help identify when a proposed placement does not feel safe or dignified;
  - run small groups for residents to share experiences, and explore fears, hopes and realities of discharge;
  - help people access services, and link to community networks; and
  - maintain contact after discharge through peer check-ins and activities that reduce isolation.

Box 4.5. Example activities to support gradual transitions

- **Psychoeducation**, including peer-led, for residents and families on mental health, treatment options, risk factors and coping strategies.
- **Staff-accompanied outings** to future neighbourhoods and community facilities, including markets, parks, places of worship and local services.
- **Visits to and from community** health and social care staff, community leaders.
- **Day programmes,** trial overnight stays or short community leave.
- **Staff-supported participation** in education (e.g. literacy classes, vocational courses or skills workshops) and leisure activities (e.g. sports clubs, arts groups, music events, faith-based groups).
- **Transitional housing** or recovery-oriented wards as intermediate steps (see Box 4.6).
- **PWLE support**, including sharing of lived experience stories and expertise.

CASE STUDY

Box 4.6. India: transitional ward for phased discharge

Devrai was a transitional ward within the Yerawada Regional Mental Hospital in Pune. Created by the hospital in partnership with NGO Parivartan, Devrai aimed to support the slow, structured discharge of long-stay residents with high dependency, unmet social needs and at least moderate functional capacity (*137*).

An abandoned ward was refurbished into group housing. Staff were trained in recovery-oriented practice, human rights and livelihood facilitation. Residents practised skills for independent living and engaged in structured activities.

Of the 47 people admitted to Devrai over three years, 20 (43%) were reunited with families; 13 (28%) obtained national identity cards and bank accounts; and around half joined collective livelihood initiatives (*137*). After discharge, the NGO team provided home visits and phone follow-up. Only two people were readmitted.

Coordinate the logistics of transition

- Follow handover protocols and confirm housing, transport, medicines, referrals and follow-up appointments.
- Share **relevant documents**, including the recovery and discharge plan and crisis contacts, with residents leaving the hospital and, with their consent, their families and carers (see Annex 6).
- Organize a **farewell event** and, where appropriate, a community welcome.

Support families and carers

- Offer families and carers psychoeducation and training and involve them in **discharge planning** and gradual transition activities.
- Ensure access to ongoing **emotional and practical support** through hospital-run or community-based services (*15, 138*). Options include: home visits focused on family well-being, peer support groups, respite services, psychological interventions, stress-management training and help accessing welfare benefits.

Maintain support and care

- With community partners, establish robust **follow-up systems** to facilitate continuity of mental and physical care and ongoing psychosocial rehabilitation (see Fig. 4.3).

Fig. 4.3. Example elements of follow-up systems to maintain support and care

Contact

Stay in touch and spot issues early.

- In-person visits or remote check-ins.
- Support access to mental and physical health services, including reproductive health services where relevant.
- Help strengthen family and social relationships.
- Link to community supports, including housing, employment and peer networks.

Monitor

Track recovery progress.

- Review recovery plans and assess progress towards goals.
- Look beyond symptoms and prioritize social inclusion.
- Check participation in community life, relationships and activities.

Reassess

Use post-discharge experience to update understanding of needs.

- Consider mental and physical health needs, including comorbidities.
- Include social, economic and other support needs.
- Assess risk and safety planning, especially for complex needs.
- Identify gaps in services and supports.

Adapt

Adjust support as health, environment and personal support needs change.

- Use monitoring and reassessment findings to update recovery plans.
- Involve the person meaningfully in decisions and next steps.

Goal: People don't just live in the community, they belong and thrive in it.

PARTNERSHIP • MANDATE

4.4 Prevent new long stays

Preventing new long-stays is essential: without active effort, vacated beds are quickly refilled. This requires creating clear so-called diversion pathways that redirect people away from hospital admission towards community-based, recovery-oriented services, ensuring that hospitalization is used only when genuinely necessary and for as short a time as possible.

Upstream, preventing new long-stays means addressing the conditions that drive people towards crisis and institutional care. Poverty, housing instability, family stress and social isolation are strong determinants of mental health conditions (*1*). Early identification, strong community-based services and collaboration with programmes that address social determinants can help prevent many readmissions.

Hospital leaders may not lead diversion efforts, but they can support them (see Box 4.7). For example, by promoting a culture that treats hospitalization as a last resort; or supporting pilot initiatives such as triage units or supported decision-making that can reduce unnecessary admissions and length of stay (*130*).

Box 4.7. Policy spotlight: supporting diversion pathways

By working with local authorities and justice system stakeholders, hospital leaders can help ensure that laws and procedures reduce unnecessary admissions and promote recovery-oriented responses.

- Review and revise **involuntary commitment criteria** to align with human rights standards.
- Support **mental health courts** and pre-arrest diversion programmes as non-custodial alternatives.
- Join consultations, advisory boards or advocacy coalitions and use the hospital's position to **influence policy, funding and service design** to reinforce diversion efforts.
- Promote **rights-based approaches** to ensure diversion pathways protect against coercion, support decision-making, and provide access to legal advocacy.

4.4.1 Key actions and processes

Facilitate interagency collaboration

- Join or initiate **planning forums** with community mental health teams, crisis services, law enforcement, housing providers, and social care, including NGO-run services with public oversight.
- Co-develop **diversion pathways and joint protocols**, including expansion of acute and crisis care in general hospitals, community mental health centres or teams or drop-in facilities (see Box 4.8).
- Strengthen coordinated responses to **psychiatric emergencies**.
- Advocate for **shared electronic health records** or care coordination platforms.

CASE STUDY

Box 4.8. Jamaica: shifting admissions towards general hospitals

Jamaica's long-standing mental health reforms emphasize decentralization and integration into general health settings. Early efforts focused on co-locating mental health beds and mental health officers – nurses with specialist training and field supervision – in general hospitals as a low-cost, high-impact response to workforce shortages (*139*). Initially, co-located services operated as a separate extension of the psychiatric hospital, yet they still improved referral pathways, communication and consultation.

Decentralization to regional health authorities in the 2000s further integrated mental health and physical health services. Each region established mental health teams led by regional psychiatrists responsible for administration, policy development, clinical practice and cross-sector liaison. Mental health nurses still provided the backbone of community care; and primary health care teams received training and supervision to further support task-sharing.

Today, all general hospitals in Jamaica provide emergency psychiatric care and have beds in open medical wards for people with mental health conditions, including acute schizophrenia. These beds, which are co-managed by psychiatrists and medical and nursing staff, account for a third of all psychiatric admissions (*140*), with evidence of equal or better outcomes compared with treatment in conventional psychiatric facilities (*141*).

The country's DI journey continues, the national psychiatric hospital continuing to downsize as community capacity expands.

Break cycles of repeated hospitalization

- Use hospital data to identify people with **frequent readmissions**.
- Make space for residents, families and staff to share concerns about **social determinants** and explore ways of addressing them, including linking people to relevant supports (*142*).
- Provide **peer support** to people with frequent admissions to offer relational continuity, early engagement and non-coercive support at points of crisis.
- Work with community partners to design **targeted strategies** e.g. intensive outreach, peer-led engagement and individualized crisis plans, including advance directives and treatment preferences.

Engage PWLE in diversion

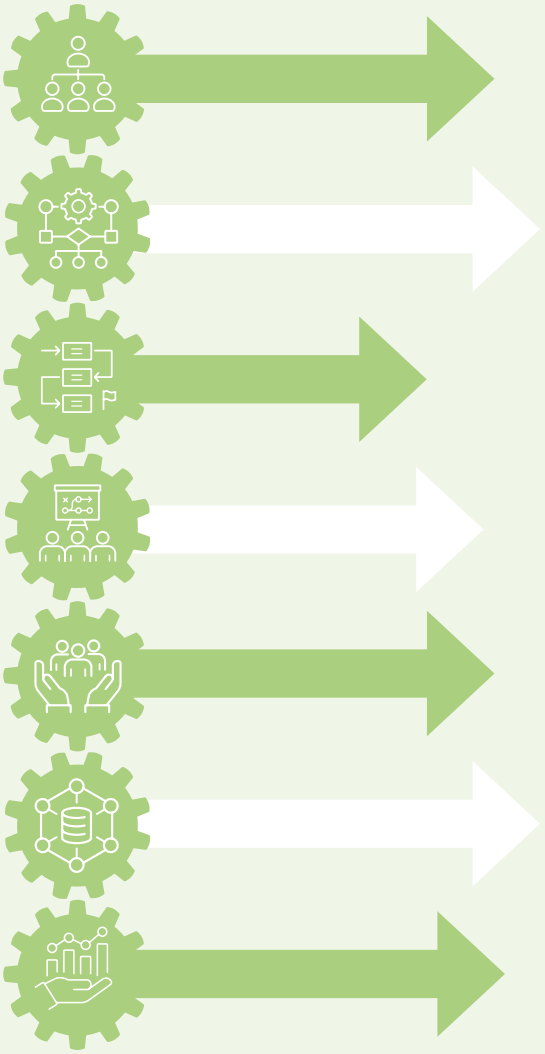
- Involve PWLE in **designing and reviewing** crisis response pathways, readmission prevention strategies and discharge oversight processes. Their input can help identify when administrative or cultural barriers are keeping people in hospital unnecessarily.
- Engage PWLE to help residents with **advance planning** and offer early post-discharge support to reduce reliance on admission as a default response to distress.
- Ensure PWLE are represented on mental health **tribunals and review boards** overseeing detention and compulsory treatment. Support them to share their expertise in these forums – to challenge unnecessary hospitalization and advocate for shorter, rights-based review cycles and least-restrictive approaches to admission.

LEADERSHIP

4.5 Rethink admissions practices

Reducing unnecessary admissions is not only about creating alternatives outside the hospital; it also requires rethinking admissions practices inside it (see Fig. 4.4). Every admission should be purposeful, time-limited and oriented towards safe and supported discharge. Improved admission and discharge practices can shorten hospital stays, support safe, timely transitions, and actively guard against admissions driven not by the person's needs or wishes but by family pressure, community discomfort or institutional convenience.

Fig. 4.4. Pathways to change in admissions practices



Leadership and culture
Setting expectations, communicating goals, rewarding performance.

Operational strategies
Early discharge planning, regular reviews.

Discharge infrastructure
Transitional programmes, streamlined processes.

External coordination
Shared care protocols and fast-track pathways.

Crisis prevention and management
Crisis plan and prevention protocols, crisis supports.

Innovative financing
Flexible funding, new payment models.

Data sharing
Admissions tracking, public reporting.

4.5.1 Key actions and processes

Improve admission and discharge processes

- Establish clear **admission criteria and protocols**, e.g. documenting housing status, confirming contact details for primary carers and verifying that family-initiated admissions are not coercive (*84*).
- Where available, require a **minimum stay in a general hospital** before admission to the psychiatric hospital (see Box 4.9).
- Build **therapeutic relationships** early to lessen risk of coercion.
- Refer to **crisis plans and advance directives** when arranging care, and support access to advocacy services appropriate to the person's communication, cultural and social needs.
- Keep **families and carers** involved, including by staying at the hospital where possible.
- Make **discharge planning** a core goal from day one, including for people at high risk of long stays.
- Remove **administrative bottlenecks** to discharge, e.g. delays in medicines reconciliation or transport arrangements.
- Establish links with **psychosocial rehabilitation** and community mental health services for rapid discharge support.
- Use regular **multidisciplinary reviews**, involving community staff and independent supervisors, to assess readiness for discharge and follow-up care.

CASE STUDY

Box 4.9. Ghana: community-first admissions

Under the Mental Health Act 2012 (*143*), Ghana is downsizing psychiatric hospitals by expanding district psychiatric units and integrating mental health into general hospitals. These units support reintegration and help target discharges, reducing populations in all three national psychiatric hospitals – including from more than 2000 in Accra to 350 by 2022 (*144*).

At Patang Hospital, a community-first admissions policy asks families seeking inpatient care to first go through district psychiatric units, though direct admissions are still accepted. There, contact people are confirmed, and social and family support pathways are established, reducing the risk of abandonment and ensuring reintegration planning begins immediately. Hospital staff work with the district units during and after inpatient care, referring people back to their communities as soon as they are medically stable.

Incentivize timely discharge

- Set **targets** for average length of stay and discharge timelines.
- Work with funders to explore **payment models** that reward timely, safe discharge.
- Advocate for or help establish **step-down options**, such as short-term support services or transitional housing (see Box 4.6).
- Use **flexible funds** to cover short-term obstacles to discharge, such as transport.
- Consider long-term support needs that cannot be met by families (see Box 4.10).

Box 4.10. Plan for long-term support

While most people can live independently or with families when supported, a small number may require long-term care that families cannot or do not wish to provide. For these people:

- **Advocate** for small-scale, community-based housing (see Box 3.5 and Box 3.6).
- **Avoid institutional** models of care.
- **Ensure access** to psychosocial rehabilitation, meaningful daily activities, social inclusion and opportunities for autonomy.

LEADERSHIP • PARTNERSHIP • MANDATE

4.6 Redirect resources for impact

As psychiatric hospitals downsize – and in some cases close – their resources must be deliberately and strategically reallocated (see Fig. 4.5). Without active planning, savings from bed closures are easily absorbed back into general budgets, leaving community services underfunded and people without adequate support after discharge.

Decentralizing resources affects all aspects of hospital management, from workforce and staffing to service contracts and operational systems. Hospital leaders must navigate funding changes, coordinate with external service planners, and ensure that every resident continues to receive appropriate care and support, throughout the process.

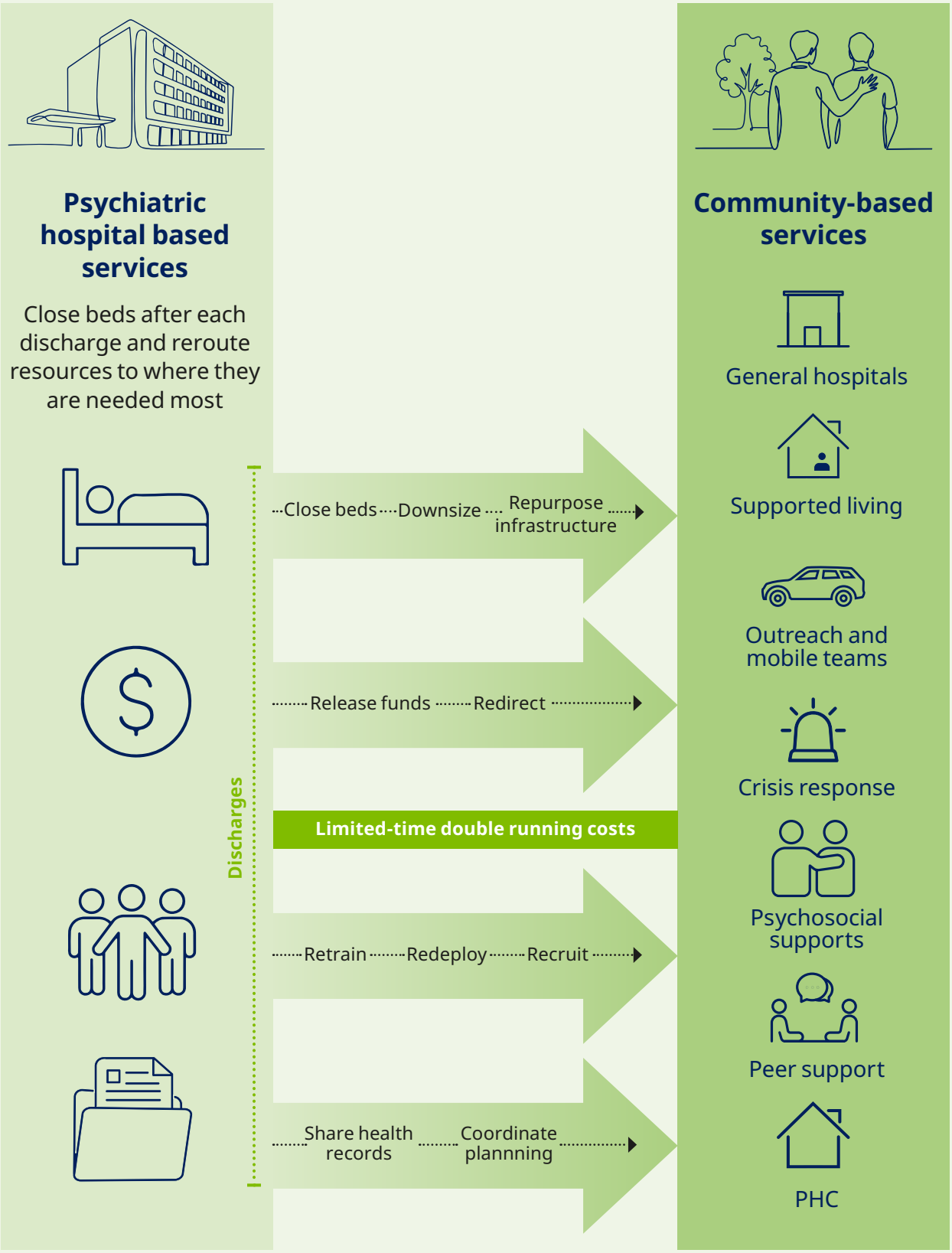
Resource reallocation works best when it is sustained and broad. This means:

- securing multi-year funding for community services – not short-term project grants – so they can recruit, retain staff and plan ahead;
- ensuring pay parity between hospital and community workers to prevent talent moving back into institutional settings;
- funding peer support and lived experience engagement as core DI infrastructure rather than optional extras; and
- prioritizing not only clinical continuity but the wider conditions that make community life possible.

Redirected hospital resources alone will rarely be sufficient, especially during the transitional period when both hospital and community services must be funded simultaneously (see Plan for a resource shift). Because people transitioning to the community often have multiple needs, hospital funding must be supplemented with resources drawn from health, social care, housing, welfare and other sectors, and actively coordinated through joint planning and commissioning. Individual budgets and self-directed care arrangements can further support people to plan their own lives in a personally tailored way (*23*).

Resource shifts should align with social justice principles and avoid contributing to exclusionary redevelopment.

Fig. 4.5. Progressive transfer of resources



4.6.1 Key actions and processes

Reduce capacity progressively

- After discharge, **close beds** to prevent readmission. In practice, resource transfers will not happen at individual bed level – they proceed in blocks, at ward level or larger scale, as fixed costs can only be released meaningfully once capacity stops operating.
- Redeploy or **retrain hospital staff** into community or transitional roles, drawing on their existing skills and institutional knowledge in service development. Maintain adequate staffing for remaining residents throughout.
- **Communicate clearly** with staff and unions about the timing of closures, redeployment and the phased shift of resources (see also Think about staffing skills and structure and Develop and support the workforce).

Redirect funding to community services and supports

- Use the phased resource shift plan (see Develop a transition plan and budget) to redirect funding released through bed and ward closures to **community-based alternatives**, e.g. community mental health centres, mobile mental health teams or general hospital units (see Fig. 3.4). Ensure redirected funding reaches not only clinical services but also **psychosocial supports** (see Fig. 2.2).
- Link each phase of bed reduction to corresponding growth in community capacity, so that **funding follows people** into community-based care rather than remaining tied to institutional infrastructure (see Box 4.11).

Box 4.11. State-led reallocation of resources: two examples from Latin America

In 1990, the Caracas Declaration marked Latin America's first regional consensus, convened by the Pan American Health Organization that psychiatric resources must shift from hospitals to community-based care (*145*). Brazil's Law 10.216/2001 and Chile's national mental health plans were direct expressions of this commitment. These frameworks both preceded the CRPD, which both countries ratified in 2008, further reinforcing resource reallocation not as a policy option but as a legal obligation.

Brazil: federal financing rules and regulations

Brazil's mental health reform combined legal changes with financing rules that redirected money from hospital beds to local community services as people were discharged. Regulatory ordinances in the early 2000s created specific federal payment lines for CAPS and SRTs, explicitly linking their expansion to reductions in psychiatric beds in the same municipality or region.

When long-stay residents left hospital, beds were closed and the corresponding federal funds were relocated to community-based services in that territory, enabling concrete alternatives at the point of discharge rather than simple cost savings. Over time, this approach translated into a major rebalancing of expenditure, with community services receiving more resources than psychiatric hospitals since 2006 (*111, 146*). Between 2002 and 2024, more than 40 thousand psychiatric hospital beds were closed and replaced with community-based services such as CAPS, SRTs and mental health beds in general hospitals (*111*). By 2024, Brazil operated 952 SRTs with capacity for more than 7 300 residents. Regional gaps remain significant, however, with nearly threequarters of SRTs concentrated in the country's southeast.

Chile: national plans and budget targets

In Chile, successive national mental health plans sought to shift resources by setting targets for a growing share of the mental health budget to go to community services; and by using hospital bed reductions and outpatient coverage as key indicators for investment decisions. An evaluation of service development between 1990 and 2017 shows significant reductions in long- and short-stay beds in psychiatric hospitals, consistently followed by substantial growth in outpatient mental health centres, day hospitals, protected housing, and psychiatric beds in general hospitals (*147, 148*)

However, evidence from 2014 to 2018 suggests that, despite bed reductions in psychiatric hospitals, a third of public mental health funding still went to these facilities to support long- and mid-stays (*149*).

Coordinate with external authorities

- Ensure all resource transfers align with broader mental health system goals. Work with **health authorities** – and legal advisors where needed – to meet regulatory requirements for downsizing or closure (*150*).
- Involve **system planners and finance authorities** early to agree how dual running costs will be funded, how long the transition period is expected to last, and what conditions must be met before hospital budgets can be reduced (see Develop a transition plan and budget).
- Coordinate across **funding agencies** to manage the shift from a consolidated institution budget to a mixed economy of services and supports drawing on multiple funding streams (*23*).
- Work with **local service managers** to ensure community capacity can absorb reallocated resources and increased demand for mental health care.

Responsibly downsize operations

- **Phase reductions** in operating costs in line with actual decreases in resident numbers and parallel growth in community provision. Avoid closing capacity faster than alternative supports can safely take over.
- Adjust **service contracts** (food, cleaning, maintenance) in line with reduced resident numbers, while maintaining standards of care.
- Address key **operational issues**, including secure handling and transfer of health records and responsible disposal or relocation of equipment and medicines.
- Monitor for **unintended consequences** (e.g. staffing gaps or service disruptions) and respond quickly.
- In cases of full hospital closure, plan a final, coordinated, **block discharge** when the last few residents remain, ensuring each person has a suitable transition, complete recovery and discharge plans, and all supports in place.

Box 4.12. Practical tips for reallocating resources

- **Prioritize essential services:** focus early resources on housing, medicines and basic psychosocial support.
- **Leverage community assets:** partner with NGOs, faith groups and informal networks to extend care beyond formal services.
- **Seek external support:** apply for grants, seek philanthropic partners and advocate for extra transitional funding from health authorities and national treasury.
- **Phase transitions carefully:** match the pace of downsizing to available community capacity to avoid gaps in care.

Fig. 4.6. Examples of repurposed pyschiatric hospitals

The final step in the progressive reallocation of resources for DI is repurposing of hospital infrastructure. Rather than leaving former psychiatric hospitals abandoned or underused, many regions have transformed these spaces into vibrant community assets.

Austria
Maria Gugging, Tulln

Institute of science and technology

- Research
- Art centre
- Memorial for victims of medical crimes

Sri Lanka
Mulleriyawa, Colombo

National institute

- General hospital
- Supported living for women
- Psychosocial rehabilitation

Brazil
Instituto Municipal Nise da Silveira, Rio de Janeiro

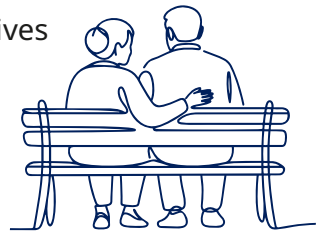
Multiuse community space

- Outpatient services
- Art and culture
- Training
- Research
- Museum

Italy
San Giovanni, Trieste

Community hub

- Health management
- Art and culture
- Social cooperatives
- Public park
- Education
- Research



Sources: Museum Gugging, 2025 (*151*); Rio de Janeiro City Hall, 2025 (*152*); Foot, 2014 (*80*).

LEADERSHIP • PARTNERSHIP

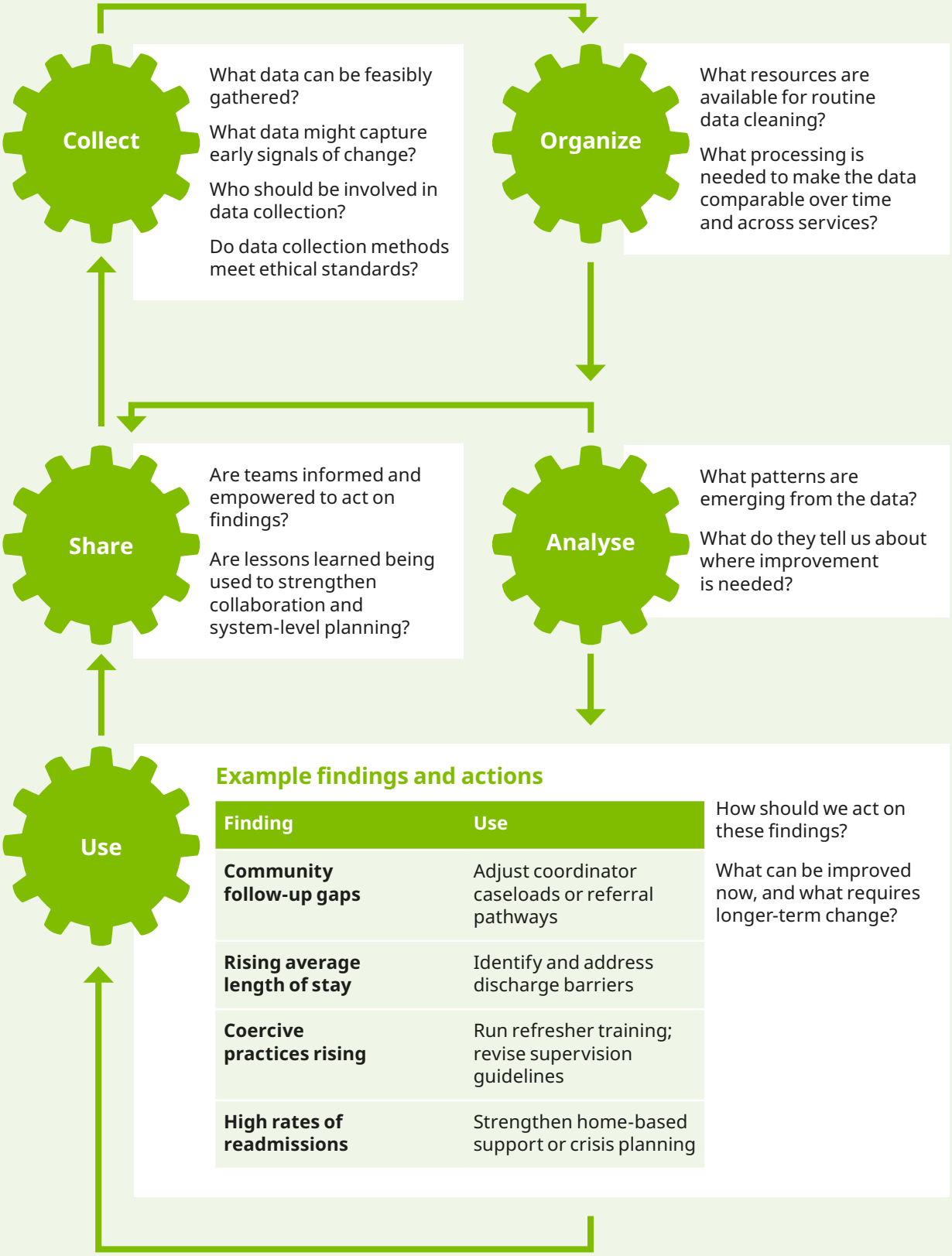
4.7 Monitor and evaluate

M&E keeps DI transparent, accountable and adaptive by measuring performance, tracking progress, identifying challenges and informing timely adjustments. Hospital leaders have a dual role: leading internal monitoring within the hospital while contributing to system-level evaluation alongside external partners.

M&E must function as a real information loop – not a one-way reporting system – so that data collected at the frontline are analysed, shared back to service users and stakeholders, and used to drive improvement, rather than disappearing upward in the system (*153*). PWLE and families should be active participants in this process – not only as respondents, but as partners in deciding what gets measured and how it gets measured and interpreted.

All activities should be guided by the M&E plan.

Fig. 4.7. Typical M&E cycle



Example findings and actions

Finding	Use
Community follow-up gaps	Adjust coordinator caseloads or referral pathways
Rising average length of stay	Identify and address discharge barriers
Coercive practices rising	Run refresher training; revise supervision guidelines
High rates of readmissions	Strengthen home-based support or crisis planning

4.7.1 Key actions and processes

Routinely collect, organize and analyse data

- Track what is **feasible**, prioritizing indicators for hospital performance, care quality and outcomes for people discharged to community settings (see Annex 5 for example indicators).
- Use **mixed methods**, combining quantitative data (e.g. admissions, length of stay, discharges, referrals) with qualitative information (e.g. first-person accounts, peer-led feedback, reflective conversations, focus groups, in-depth interviews and experience-based co-evaluation) (see Fig. 4.8).
- Involve **partners and stakeholders** – including PWLE and families – as co-developers of evaluation frameworks, and active participants in data collection, analysis and interpretation. Consider establishing an independent monitoring committee with PWLE and family representation.
- Use M&E as an opportunity to improve data recording practices across hospital and community services. Ensure all data collection complies with **ethical standards**, including protection of residents' privacy through anonymization where appropriate.

Use data for continuous improvement

- Review internal data regularly to identify **trends, gaps and opportunities**. Expect fluctuations.
- Use findings to guide decisions and **refine workflows**. For example:
  - if readmissions rise, strengthen community follow-up;
  - if there is an increase in coercive practices, revisit staff training, supervision and support.
- Share insights with staff to foster a positive **learning culture**, not punitive monitoring. Use dashboards or noticeboards to share progress and celebrate successes.
- Align with **regional or national reporting frameworks**, contributing to shared indicators, reporting formats and timelines.

Fig. 4.8. Useful data sources for M&E

Feedback

Surveys, questionnaires and interviews of residents, families, hospital staff and community partners on care quality, training and satisfaction.

Observation data

Audits, site visits and staff performance reviews to assess quality of care.

Outcome data

Health and social outcomes for individuals who have transitioned to community-based care.

Data sources for M&E

Research findings

Studies or evaluations conducted by external partners or academic institutions.

Administrative data

Admissions, discharges, length of stay, number of beds, staffing levels, and financial reports.

Grievance reports

Complaints, incidents of abuse, neglect or coercion, and safeguarding concerns.

Practical tips on collecting grievance reports

- Provide multiple, confidential ways for residents and family members to report concerns (e.g. anonymous forms, locked boxes, external ombudspersons).
- Ensure residents understand their rights and how to report safely.
- Train staff to respond respectfully and without retaliation.
- Monitor trends and act promptly on findings.

Share lessons learned

- Communicate **findings and actions** to health authorities, community partners and service users.
- Participate in **learning exchanges**, policy dialogues and advocacy efforts.
- Highlight successful practices and **innovations** to inspire wider system change.

CASE STUDY

Box 4.13. Brazil: national inspections to assess hospitals and strengthen rights

Brazil's National Programme for the Evaluation of Hospital Services in Psychiatry [Programa Nacional de Avaliação do Sistema Hospitalar/Psiquiatria (PNASH)] was created as a federal strategy to assess all psychiatric beds financed by the public system, including those purchased from private and philanthropic hospitals through service contracts (*154*).

With a view to improving the lives of people living in psychiatric hospitals, PNASH inspections evaluated infrastructure, bed numbers, living conditions, care practices and compliance with human rights standards. Results were directly linked to government contracts: hospitals that failed to meet basic requirements could lose public accreditation and financing (*155*).

In many cases, the results of a PNASH inspection acted as a trigger for DI (*156*). For example, at Paracambi Hospital, where resistance to reform was very strong, the development and implementation of a DI plan was only possible after the hospital failed a PNASH evaluation and the public sector took over its management.

For hospitals that remained open, PNASH functioned as a mechanism for structured quality improvement. Repeated evaluations were used to identify rights violations and prompt corrective plans and gradual reductions in long-stay beds. Over time, PNASH contributed both to the improvement of hospital care and to the strategic closing of thousands of psychiatric beds deemed ineffective or harmful.

Additional source: Pedro Gabriel Delgado, Universidade Federal do Rio de Janeiro, Brazil, interviewed on 23 May 2024.

Box 4.14. Practical tips for M&E

- Use what you already have: start with existing records (e.g logbooks, discharge forms) before creating new tools.
- Keep it simple: use paper-based forms or basic spreadsheets if digital systems are unavailable.
- Prioritize key indicators: focus on a small set of high-impact indicators that reflect progress and rights.
- Involve PWLE in indicator selection: include rights-based indicators –on dignity, autonomy, social connection and quality of relationships – alongside service or process indicators (see Annex 5).
- Collaborate with local partners: NGOs, universities or community groups may help with data collection, analysis or training.
- Act on findings: even basic data can guide improvements – focus on learning, not perfection.

Conclusion

5

DI involves both mental health service reforms and an ethical commitment to the right of every person, regardless of the complexity of their needs, to live freely, with dignity, as a full member of their community.

This guide has set out what hospital leaders and senior policy-makers can do to make that commitment real: from understanding the context and building a shared vision, to planning individual transitions, strengthening community services, rethinking admissions and redirecting resources. The actions described here are both practical and informed by the principle that the purpose of mental health care is not to manage people in institutions but support them as they build lives of their own choosing.

Progress is rarely linear. There will be resistance, setbacks and moments when the momentum for change can waver. Beds may empty slowly. Community services may need much improvement. Staff may feel uncertain. Families may be afraid. But these are not reasons to stop – they are the very reasons why this guide has been developed.

Three messages are worth reiterating. First, PWLE – including residents and, with residents' consent, families and carers – must be partners, not objects, in every phase of DI, from governance and planning to training, evaluation and the everyday work of transition.

Second, resources must follow people. Savings from bed closures must be protected and reinvested in community services and the wider conditions that make community life possible – housing, social connection, peer support, meaningful occupation.

Finally, downsizing hospitals and building community services must happen together: beds should only be reduced as real alternatives appear, so that people are not simply discharged out of sight but welcomed into services and communities that are ready for them.

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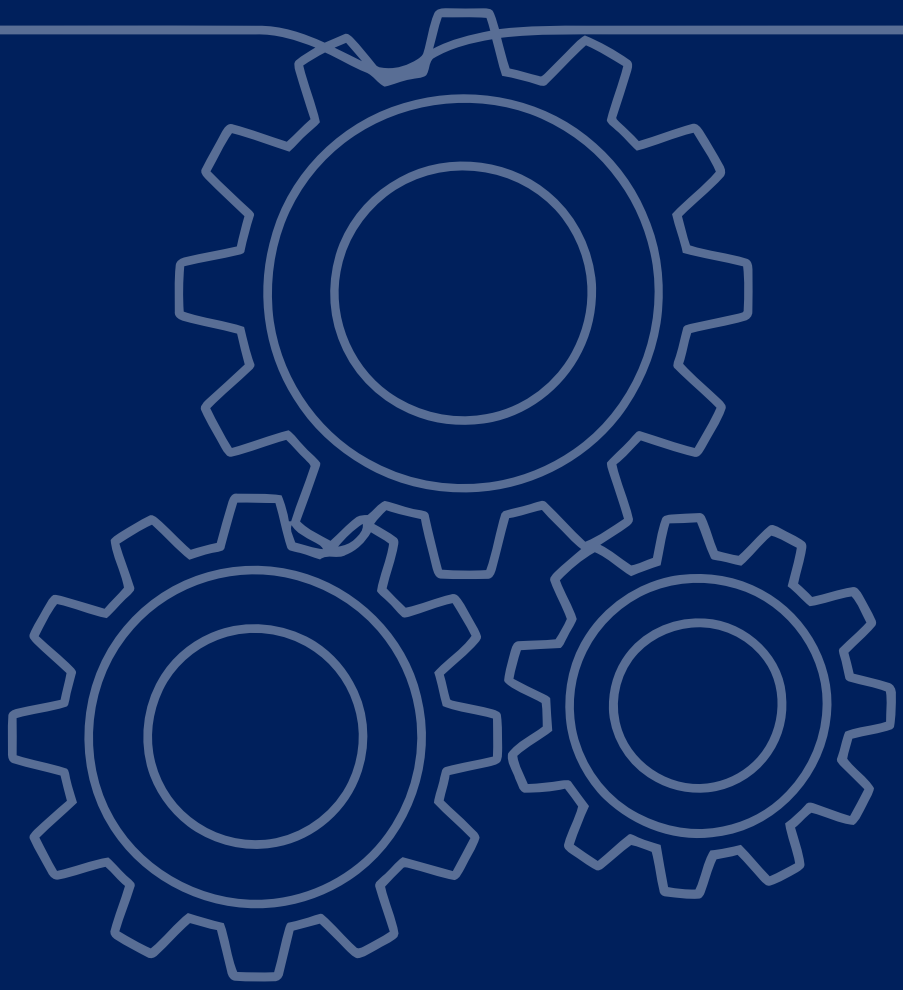
Annexes



Annex 1. Methods for developing this guide

Desktop review

A review was conducted of peer-reviewed articles and grey literature on deinstitutionalization (DI) published from 2000 to 2024 (in English, Portuguese and Spanish), including academic publications, technical reports, government documents, World Health Organization (WHO) documents and international standards and guidelines.

Targeted interviews

Ten semi-structured interviews were held with leaders involved in planning or managing DI efforts across diverse regions.

Peer review

An initial concept and detailed outline for the guide was developed by the WHO technical team and sent for development review, first by WHO staff and then by experts in DI implementation and community-based mental health care (including representatives from WHO Collaborating Centres, nursing associations, organizations of people with lived experience and other external experts). In total, 56 external invitees submitted a review, providing feedback on framing, structure and priority messaging, and proposing case studies and other technical inputs.

Feedback from the development review was used to produce an advanced draft of the guide, soliciting technical inputs from experts as necessary. The advanced draft was sent for a second, more targeted review by WHO staff and global experts in DI, focusing on hospital directors, senior decision-makers and people with lived experience. In total, 41 external invitees submitted a targeted review, providing feedback on technical accuracy of the content, and clarity and relevance for the audience. This feedback was used to finalize the guide.

External reviewers and contributors submitted declarations of interest and confidentiality statements. These were reviewed by the WHO technical team, which found no significant conflicts of interest.

Engagement of people with lived experience

People with lived experience of mental health conditions or mental health systems, particularly institutional care, were primarily engaged as peer reviewers. Four people with lived experience (out of 12 invitees) submitted feedback during the development review; all four also submitted a second review during the targeted review. Focused engagement with the Global Mental Health Action Network's Expert by Experience Action Group on deinstitutionalization led to a further 12 group members submitting a targeted review.

Case study development

Case studies were identified and developed through literature review or in consultation with external experts. All draft case studies were submitted for clearance by local partners and/or WHO regional teams for relevance and accuracy.

Annex 2. Key questions in deinstitutionalization (DI)

This annex presents a set of frequently asked questions reflecting common areas of uncertainty, debate and concern that arose during the development of this guide. They draw on extensive international feedback, as well as broader research and policy experience. They are not intended to resolve all differences, but to clarify what is at stake in key decisions and inform context-sensitive implementation.

Q1. Does DI require full closure of psychiatric hospitals?

DI is often associated with the full closure of psychiatric hospitals, and in some contexts this has been a central objective. Yet countries vary in how their health systems are organized, and what resources and policy environments they are working within, and different pathways are possible.

Sometime countries pursue progressive downsizing, repurposing, or transformation of hospital services as part of a broader shift towards community-based, rights-based and recovery-oriented care. What matters is not only the physical closure of buildings, but whether long-term institutional care is reduced and replaced by services that enable autonomy, inclusion and community living.

This guidance focuses on the direction of change – away from institutional dependence and towards community-based systems – while recognizing that the pace of that transition is gradual and its form may vary across contexts.

Q2. How do we know if we are truly moving away from institutional care?

Reducing reliance on psychiatric hospitals is important, but it is not sufficient. Institutional practices, such as rigid routines, limited autonomy, or segregation from community life, can persist in settings such as small residential facilities or community programmes. DI therefore means a change not only in location, but in how care is organized and experienced.

Progress can be assessed by looking at changes in infrastructure (such as bed numbers and locked-door wards), and changes in how care is provided and experienced – including reduced coercion, greater individual choice, participation in community life, and person-centred support.

Monitoring both structural and experiential change helps ensure that reform does not reproduce institutional practices in new settings.

Q3. How can new forms of institutionalization in the community be avoided?

A common risk in DI is that institutional practices are reproduced in new settings, even after people leave psychiatric hospitals, for instance through social stigma and discrimination. Smaller facilities, supported housing, or community programmes can still be restrictive if they limit autonomy, separate people from community life, or rely on rigid routines and control.

Avoiding this requires attention not only to where people live, but to how support is organized and delivered. Community-based services should promote choice, participation, privacy, social inclusion and meaningful control over everyday life.

Q4. Should countries wait until community services are fully developed before starting DI?

A common concern is that DI should only begin once comprehensive community services and supports are in place. While strong community capacity is essential, waiting for ideal conditions can delay reform indefinitely.

In practice, community services and DI often develop together. Early steps – such as improving conditions within hospitals, strengthening discharge planning, enhancing quality of care, and building partnerships with community actors – can create the conditions for further change.

At the same time, rapid or unplanned discharge without adequate support can cause harm. Careful sequencing is vital: progressing step by step, and ensuring that each transition is supported by appropriate services and safeguards.

Q5. What should come first: closing beds or building community services?

DI does not succeed through bed closures alone, nor through community service expansion alone. Both need to happen together.

Closing beds too quickly without planning and adequate alternatives in place can lead to neglect, houselessness, repeated crises, re-hospitalization, or transfer to other institutions. Expanding community services without reducing reliance on psychiatric hospitals can simply add capacity without changing the overall model of care.

This guide emphasizes parallel action: progressively reducing long-stay institutional care while simultaneously developing community-based services, housing and supports. The right sequencing will vary by context, but the two processes need to remain closely linked.

One practical approach is to create zones within large institutions by catchment area, grouping residents from the same localities together in both long- stay wards and acute crisis admission wards. As new community-based services open in those catchment areas and individuals are transferred, the corresponding institutional wards can be closed – and their human and financial resources redirected to the new district services.

Q6. Who should lead DI?

DI requires coordinated leadership at multiple levels and across sectors – no single actor can drive it alone. Many of the conditions that enable DI – social care policies, financing, legal frameworks, housing, housing and service planning – lie beyond the health sector.

There should be a government mental health authority responsible, among other things, for setting standards, monitoring progress and developing financial planning systems to develop and manage services through transition.

At the facility level, hospital leaders have a central role in changing practices, reallocating resources, building partnerships and supporting discharge.

In practice, successful DI depends on collaboration across hospitals, community-based mental health services, social care, housing authorities, people with lived

experience (of mental health conditions or mental health systems, particularly institutional care) (PWLE), families and community actors, coordinated across geographically defined areas. Different stakeholders may contribute at different points or in different domains. What matters is that leadership is coordinated, credible and consistently aligned with the goal of moving away from institutional care towards care in the community.

Q7. What kinds of resistance should be expected during DI?

Resistance is common in DI and should be expected. It may come from staff, families, communities, service managers, or hospital residents themselves. It can reflect concerns about safety, continuity of care, loss of scarce resources or the availability of alternatives. It may also reflect deeper attachments to existing roles, routines or institutional models of care.

Treating resistance only as opposition is unhelpful. It often signals uncertainties, structural tensions and fears that need to be addressed.

Understanding the source of resistance helps shape an effective response. Some concerns call for practical solutions, such as stronger discharge supports, clearer communication or job security measures. Others require dialogue, awareness raising, training, and opportunities to build trust in new ways of working.

Q8. How should success in DI be understood and measured?

Success in DI is not captured by a single indicator. Reductions in bed numbers or long stays are important, but they do not by themselves show whether people's lives have improved.

A fuller picture of success includes improved quality of life, stable housing, social inclusion, avoidance of coercion, reduced stigma, greater autonomy and continuity of care. It is also important to consider how people with lived experience, families and communities themselves understand the outcomes of reform.

Monitoring and evaluation should combine quantitative indicators with qualitative information and direct feedback from those directly affected. Measuring DI means looking not only at what has changed in the system, but also at what people are able to do and experience afterwards.

Q9. How can negative outcomes from DI be avoided?

Negative outcomes occur when DI is reduced to rapid discharge or bed closure without adequate planning, services, funding and follow-up. People may be exposed to houselessness, neglect, repeated crises, rehospitalization or transfer to other settings that reproduce institutional practices.

These risks can be addressed by planning DI as a transformation of the whole care system. This means ensuring that people have access to safe housing, continuity of physical and mental health care, social care, crisis response and practical assistance with daily living – before and after discharge. It also requires financial planning, including transitional funding to cover the period when psychiatric hospital services are being scaled back and community alternatives are being developed.

Discharge should be gradual, person-centred and based on individual needs, strengths and preferences. Each person should have a clear recovery and discharge plan, developed with their involvement, supported by trained staff and community partners, and, where relevant and with consent, family engagement and supported decision-making arrangements. Families and carers may also need information, support and respite.

Follow-up after discharge is essential. Services should check whether people are receiving necessary support, whether their living situation remains suitable and whether new needs or risks are emerging.

Q10. How can DI be pursued in settings with very limited resources?

DI is more challenging where community mental health services, social care, housing and welfare systems are extremely limited.

In these settings, hospital leaders and policy-makers may not be able to create new services immediately, but they can take practical steps to:

- **Improve care practices inside the hospital.** In every setting, reform can begin by reducing institutional practices, including improving freedom of movement, increasing residents' autonomy, and strengthening discharge planning so that each admission is treated as time-limited and oriented towards community return.
- **Build staff capacity progressively.** Staff can be supported to adopt recovery-oriented approaches, with a clear expectation that long-term institutional care is a last resort.
- **Map and mobilize existing community assets.** Even where formal community mental health services are scarce, hospital teams can identify organizations of PWLE and people with disabilities, peer support networks, primary health facilities, nongovernmental organizations, community groups, family organizations, and social protection, housing or livelihood programmes. Simple referral pathways, discharge planning links and follow-up arrangements can be established with these actors.
- **Reorient staff roles towards the community.** Small teams or designated outreach staff can conduct home visits after discharge, support families with basic psychoeducation and problem-solving, and liaise with primary care. Where travel is difficult, schedules phone calls or collaboration with community health workers are practical alternatives.
- **Begin with carefully supported individual transitions.** Early progress may involve a small number of well-planned discharges for residents whose needs can realistically be met with the available supports, rather than large-scale moves. These early experiences generate learning, build confidence among staff, families and communities, and provide evidence can help advocate for further investment.
- **Develop a basic data system** to monitor progress on key indicators e.g. admissions, discharges, length of stay.

Over time, hospital leaders and policy-makers can also look for ways to redirect resources from long-stay institutional care towards community-based supports, while ensuring that no one is discharged before essential supports are in place for the person.

Annex 3. Selected further reading on DI[1]

Mental health policy and strategic action

Overall policy guidance

- Guidance on mental health policy and strategic action plans: module 1. Introduction, purpose and use of the guidance. Geneva: World Health Organization; 2025 (https://iris.who.int/handle/10665/380465).
  Licence: CC BY-NC-SA 3.0 IGO.
- Guidance on mental health policy and strategic action plans: module 2: key reform areas, directives, strategies, and actions for mental health policy and strategic action plans. Geneva: World Health Organization; 2025 (https://iris.who.int/handle/10665/380466).
  Licence: CC BY-NC-SA 3.0 IGO.
- Guidance on mental health policy and strategic action plans: module 3: process for developing, implementing, and evaluating mental health policy and strategic action plans. Geneva: World Health Organization; 2025 (https://iris.who.int/handle/10665/380467).
  Licence: CC BY-NC-SA 3.0 IGO.
- Guidance on mental health policy and strategic action plans: module 4: country case scenarios. Geneva: World Health Organization; 2025 (https://iris.who.int/handle/10665/380468).
  Licence: CC BY-NC-SA 3.0 IGO.
- Guidance on mental health policy and strategic action plans: module 5: comprehensive directory of policy areas, directives, strategies and actions for mental health. Geneva: World Health Organization; 2025 (https://iris.who.int/handle/10665/380469).
  Licence: CC BY-NC-SA 3.0 IGO.
- Improving health systems and services for mental health. Geneva: World Health Organization; 2009 (https://iris.who.int/handle/10665/44219).

Human rights and legislation

- A community for all: implementing Article 19. New York: Open Society Foundations; 2011 (https://www.opensocietyfoundations.org/publications/community-all-implementing-article-19).
- Mental health, human rights and legislation: guidance and practice. Geneva: World Health Organization and United Nations; 2023 (https://iris.who.int/handle/10665/373126).
  Licence: CC BY-NC-SA 3.0 IGO.
- MiNDbank [website]. Pune; Keshav Desiraju India Mental Health Observatory; 2026 (https://mindbank.cmhlp.org/).

[1] Additional resources beyond the list of references; all hyperlinks accessed 29 June 2026.

Box A3.1 WHO QualityRights (selected resources)

- QualityRights in mental health [e-training course]. In: WHO Academy [website]. Geneva: World Health Organization; 2026 (https://whoacademy.org/coursewares/course-v1:WHOA+0016_QR_EN+2024?source=edX).
- Transforming services and promoting human rights: WHO QualityRights training and guidance: mental health and social services: course guide. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329611). Licence: CC BY-NC-SA 3.0 IGO.
- WHO QualityRights assessment tool kit: assessing and improving quality and human rights in mental health and social care facilities. Geneva: World Health Organization; 2012 (https://iris.who.int/handle/10665/70927).

Finance for DI

- EU funds checklist to promote independent living and deinstitutionalization. Brussels: European Expert Group on the transition from institutional to community-based care and Hope and Homes for Children; 2021 (https://deinstitutionalisation.com/2021/05/28/eu-funds-checklist-to-promote-independent-living-and-deinstitutionalisation/).
- From institutions to community living. Part II: funding and budgeting. Vienna: European Union Agency for Fundamental Rights; 2017 (https://fra.europa.eu/sites/default/files/fra_uploads/fra-2017-independent-living-part-ii-funding-budgeting_en.pdf).

Community-based services

- Comprehensive mental health service networks: promoting person-centred and rights-based approaches. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/341646) Licence: CC BY-NC-SA 3.0 IGO.
- Mezzina R. Innovations in mental health services delivery: international experiences and trends. Washington D.C.: World Bank Group; 2025 (https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099062625151528872).
- World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/356119). Licence: CC BY-NC-SA 3.0 IGO.

Stakeholder engagement

Engaging PWLE

- Voice, agency, empowerment: handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/342704).
  Licence: CC BY-NC-SA 3.0 IGO.
- Toolkit for developing a multisectoral action plan for noncommunicable diseases. Module 2: establishing stakeholder engagement and governance mechanisms. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/353159).
  Licence: CC BY-NC-SA 3.0 IGO.

Stakeholder mapping tools

- Global mental health policy influence toolkit. London: Overseas Development Institute and Mental Health Innovation Network; 2015 (https://www.mhinnovation.net/sites/default/files/content/document/Policy%20Influence%20Toolkit%20for%20MHIN%20-%20final_0.pdf).
- Stakeholder analysis matrix template. Sydney: Tools4dev; 2025 (https://tools4dev.org/resources/stakeholder-analysis-matrix-template/).
- Stakeholder mapping guide. In: Implementation guide for the medical eligibility criteria and selected practice recommendations for contraceptive use guidelines. Geneva: World Health Organization; 2018 (https://cdn.who.int/media/docs/default-source/reproductive-health/contraception-family-planning/stakeholder-mapping-tool.pdf).

Discharge planning

- Person-centred recovery planning for mental health and well-being self-help tool. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/329598).
  Licence: CC BY-NC-SA 3.0 IGO.

Strengthening competencies

- Foundational helping skills training manual: a competency-based approach for training helpers to support adults. Geneva: World Health Organization and United Nations Children's Fund; 2025 (https://iris.who.int/handle/10665/381678).
  Licence: CC BY-NC-SA 3.0 IGO.
- iSupport for dementia: training and support manual for carers of people with dementia. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/324794).
  Licence: CC BY-NC-SA 3.0 IGO.
- Supporting people with mental health, neurological and substance use conditions: a job aid for community health workers. Geneva: World Health Organization [in press].

Annex 4. Transition plan template[1]

1. Goals and objectives

State the overall goal and specific objectives for DI.

DI goal:	Based on the shared vision with stakeholders
Objectives:	• Specific objective 1
	• Specific objective 2
	• Specific objective 3

2. DI sites and populations

List the psychiatric hospital units, wards, long-stay populations or geographical catchment areas included in the DI transition.

Facilities involved:	
Populations affected:	
Community service areas/ districts involved:	

3. Infrastructure, support systems and service readiness

Describe mechanisms to ensure readiness for DI.

Community service infrastructure required:	e.g. housing, outpatient clinics, general hospital units or beds, crisis services, education/skilling services
Hospital infrastructure changes needed during transition:	
Transport, equipment, information systems:	
Continuity-of-care pathways:	

[1] To be adapted for context. For users in the World Health Organization (WHO) Region of the Americas, please note that data generated through this template can directly inform national reporting for the Pan American Health Organization (PAHO) Strategic Plan 2026–2031, specifically on:

- outcome indicator 3.1.5. Number of countries that have decreased the rate of persons in long-stay mental hospitals; and
- output indicator 3.1.4.c. Number of countries and territories implementing a national strategic plan for deinstitutionalization of long-term psychiatric hospital care.

Users are encouraged to share completed templates with their national mental health authority.

4. Human resources

Specify workforce needs and role descriptions.

Staff/external partner	**Role description in context of DI**	**Role status** (relocate, redeploy, retrain, recruit)	**Training needs**

5. Collaborative activities with stakeholders

List joint activities with different stakeholder groups and sectors.

Community-based mental health services:	e.g. joint activities with community mental health teams or general hospitals
Social services:	
Housing services:	
Psychosocial rehabilitation programmes:	
People with lived experience (of mental health conditions or mental health systems, particularly institutional care) and family organizations:	
Local authorities:	
Nongovernmental organizations (NGOs):	
Other services:	

6. Safeguarding and resident involvement

Describe how residents and families will be informed, involved and protected throughout the DI process.

Information sharing	e.g. individual and group briefings, accessible leaflets and posters, Q&A sessions
Supported decision-making	e.g. decision aids, involvement of trusted supporters, access to peer supporters, use of advance directives
Participation in planning and review	e.g. oversight committee membership, resident councils, discharge planning, participatory monitoring and evaluation
Safeguarding measures	e.g. named safeguarding lead, simple risk-reporting forms, staff training on rights, referral pathways to independent protection bodies
Feedback and complaints	e.g. confidential complaints box, hotline or messaging line, response timelines, corrective action targets
Independent advocacy and peer support	e.g. contracts with advocacy NGOs, on-site legal advice sessions, peer support worker involvement

7. Implementation activities plan

Outline the key activities required to meet DI objectives, along with estimated timing and costs. (See section below for pre-filled example).

Activity	Timing (start/end)	Responsible person/agency	Resources required
e.g. Conduct rapid situation analysis, assess individual needs, train staff etc.	e.g. continuous, Month 1–2	e.g. continuous, Month 1–2	e.g. staff time, access to records, private space, templates

8. Prevention of new long stays

Plan measures for preventing new long-stay admissions during DI.

Admission criteria	e.g. XX months target for maximum stay of new admissions
Early review triggers	e.g. all admissions reaching XX months to be reviewed by discharge planning team
Diversion pathways and protocols	e.g. criteria and referral routes to divert admissions to community-based alternatives

9. Risk mitigation

Anticipate risk of transinstitutionalization and other obstacles and define mitigation actions.

Risk	Likelihood	Impact	Mitigation strategy
e.g. residents are moved to other institutional settings	e.g. medium to high	e.g. high – perpetuates segregation and institutional practices	e.g. exclude large institutions as discharge options, prioritize community-based services and supported housing, review discharge options for quality of care, monitor post-discharge placements

10. Communication plan

Specify how updates, decisions and changes will be communicated to key audiences.

Audience	Key messages	Method
e.g. long-stay residents, families, staff, community providers, local authorities, public (where appropriate)	e.g. what is changing or why, how people will be supported, where to get information	e.g. one-to-one or group meetings and briefings, workshops, newsletter, public updates, helplines

Additional component [to complete with support of health authorities]

Resource reallocation plan

Map the period of dual running costs, track when hospital funding can be released, and plan the progressive transfer of resources to communities.

Estimated duration of dual running period (when institutional and community services are operating simultaneously):	e.g. XX months from first discharge wave
Estimated monthly cost of dual running period:	
Sources of funding to support dual running period:	e.g. ring-fenced government allocation, external grant, redeployed internal budget
Criteria for releasing hospital funds for transfer:	e.g. occupancy reduced by x%/full ward closure; community mental health centre operational; housing placements confirmed for x residents; follow-up arrangements confirmed; crisis service operational.
Safeguards to protect released funds:	e.g. dedicated budget line, joint oversight with finance authority
Scope of community reinvestment:	e.g. list of clinical services and psychosocial supports
Responsible person/agency for monitoring resource transfer:	

Annex 5. Example indicators for DI

The monitoring and evaluation framework should track both implementation progress and the effects of DI on health systems and individuals. Three types of indicators are commonly used.

1. People-level indicators

These capture the effects of DI on long-stay residents, families, hospital staff and communities over time. For residents transitioning to community living, measures should include both quantitative and qualitative dimensions.

2. System-level indicators

These measure the systemic effects of DI on hospital- and community-based mental health services and social supports, typically using numerical data.

3. Process indicators

These track whether key activities are being completed on time and as planned. They help identify implementation challenges or bottlenecks early.

Tables A5.1 – A5.3 provide sample indicators and potential means of verification. Indicators from all three groups should be chosen to best fit the DI plan in each setting, ideally using a SMART framework to guide selection.[1]

[1] Aim to set clear, well-defined indicators by making them SMART: **S**pecific (clearly defined and focused), **M**easurable (able to be quantified or assessed), **A**chievable (realistic given available resources), **R**elevant (directly linked to the goals of the DI plan), and **T**ime-bound (with a defined timeframe for measurement.

Table A5.1 Sample people-level measures

People-level measures	Means of verification
Autonomy	Autonomy measurement tools; first-person narratives/self-reports; interviews; focus groups discussions
Daily functioning	WHO Disability Assessment Schedule (WHODAS 2.0) (*1*); medical records; first-person narratives/self-reports
Engagement in work (including supported employment) or education activities	Hospital information system, reports or documentation; medical records; first-person narratives/self-reports; interviews; focus group discussions
Family burden or satisfaction	Family satisfaction and family burden measurement tools; first-person narratives/self-reports; interviews; focus group discussions
Health care providers' attitudes[a]	Healthcare providers' attitudes measurement tools; individual or group interviews; first-person narratives/self-reports
Experiences of coercion (service-user reported)	structured self-report questionnaire at 3 and 12 months post-discharge (e.g. QualityRights interview tool, Theme 4 (*2*)); focus group discussions
Quality of life	WHO Quality of Life questionnaire (e.g. WHOQOL BREF) (*3*); first-person; follow-up reports; narratives/self-reports; interviews; focus groups discussions
Recovery, well-being	WHO-5 Well-Being Index (*4*); recovery measurement tools; first-person or recovery narratives/self-reports; interviews; focus groups discussions
Service user satisfaction and experience	Service user satisfaction and experience measures; Recovery and discharge plans; first-person narratives or self-reports; interviews; focus groups discussions
Social connectedness	Social connectedness or inclusion measurement tools; medical records; first-person narratives/self-reports; interviews; focus group discussions
Social support	Social support measurement tools; social service access records; first-person narratives/self-reports; interviews; focus group discussions
Housing stability (at 3 months and 12 months post discharge)	Housing tenancy records; case manager visit notes; self-report at follow-up

Notes: a Pre–post changes in healthcare providers' attitudes can also be measured through the WHO e-QualityRights platform and its associated training programmes. See: QualityRights in mental health [e-training course]. In: WHO Academy [website]. World Health Organization; 2026 (https://whoacademy.org/coursewares/course-v1:WHOA+0016_QR_EN+2024?source=edX).

Table A5.2 Sample system-level indicators

System-level indicators	Means of verification
Hospital-based mental health care	
Government spending on psychiatric hospitals as a proportion of total government mental health spending (target declining trend year on year)	Health information system; national or local government mental health or health financing reports
Number of beds (per 100 000 population)	Health or hospital information systems; national or local government mental health reports
Number of long-term beds (per 100 000 population)	
Number of adults admitted to the hospital in the last 12 months	As above; hospital admissions records
Number and proportion of involuntary admissions in the last 12 months	
Number and proportion of people living in the hospital for 6 months or longer (long-stay residents)	Health or hospital information systems; national or local government mental health reports
Average length of stay	As above; hospital reports
Number of people discharged in the last 12 months	As above; hospital discharge records
Number and proportion of long-stay residents discharged in the last 12 months	
Community-based mental health care	
Government spending on community-based services as a proportion of total government mental health spending (target increasing trend year on year)	Health information system; national or local government mental health or health financing reports
Number and location of new inpatient and crisis beds in secondary care services in a selected area (e.g. surrounding community, catchment area, district)	Health information system; national or local government mental health reports; service mapping reports
Number and types of non-residential community-based mental health services in the area	
Number of housing supports in the area	
Number of primary healthcare centres in the area	
Psychiatric hospital expenditure	
Total budget available to hospital	Administrative or financial reports
Amount and proportion of the total budget ringfenced/allocated for community services	
Additional funds allocated for community services and supports	

Table A5.3 Sample process indicators

Process indicators	Means of verification
Plan	
Situation analysis • Health information system; national or local government mental health or health financing reports • Situation analysis, hospital census and rapid needs assessment completed • Number and proportion of people living in the hospital for 6 months or longer (long-stay residents) • Priority needs for community living identified (from rapid needs assessment) • Number and description of available community-based services	Situation analysis or needs assessment reports; service mapping report
Multistakeholder engagement in DI planning • Health or hospital information systems; national or local government mental health reports • DI or transition plan co-designed with stakeholders, with people with lived experience (of mental health conditions or mental health systems, particularly institutional care) (PWLE) meaningfully involved at all stages of planning (not only in consultation) • Number of PWLE associations, organizations or individuals involved • Number of transition planning meetings held	Oversight committee membership; planning meeting notes, reports and attendance list

Process indicators	Means of verification
Prepare	
Recovery and discharge planning • Number and proportion of long-stay residents with recovery and discharge plans completed or reviewed • Number of long-stay residents, family members or persons of trust involved in developing recovery and discharge plans • Consent procedures and support decision protocols established • Number of long-stay residents who made or were supported to make decisions about their care arrangements • Number and proportion of long-stay residents who potentially can transition to live independently or with families or other trusted persons in the community • Number and proportion of long-stay residents who might require supported housing • Number and proportion of long-stay residents who require intensive community support for complex needs	Medical records versus persons's life story; Recovery and discharge plans; medical records; hospital information systems; first-person narratives or self-reports
Care coordination • Care coordination or shared care mechanisms or protocols established • Number of case reviews or coordination meetings held with family members, community-based teams • Number of PWLE or peer support workers involved in care coordination and description of their roles	Case review or care coordination meeting notes; attendance list; PWLE/peer worker narratives
Workforce development • Training needs assessed • Number (and type) of training activities carried out • Number, cadres and proportion of health providers trained in rights-based, recovery-oriented care	Training needs assessment survey or consultation; hospital or training reports; training attendance lists

Process indicators	Means of verification
Provide	
Enhancing quality of care **A. Care standards** • Quality care standards, protocols and decision-making tools established and shared with staff • Number of training sessions conducted with health care providers to operationalize care standards • Number and proportion of long-stay residents screened for physical health problems (including sensory impairments) in the last 6 months • Improvements in meeting long-stay residents' basic needs (see Box 4.8) **B. Oversight mechanisms** • Number of mental health review board/tribunal meetings conducted in the last 12 months • Number and outcomes of internal audits or evaluations carried out • Number of external regulatory oversight or inspection visits in the last 12 months • Number of reported human rights violations or serious adverse events (disaggregated by death, abuse, coercion, mechanical or physical restraint, seclusion, involuntary treatment) reported each month • Involvement of PWLE in external oversight or inspection commissions	Hospital policies and procedures; shared care protocols; meetings notes; QualityRights toolkit; Ombudspersons, inspections or accreditation reports; first-person narratives or self-reports; grievance mechanism reports; hospital ethics committee reports; medical records
Gradual transition • If a transitional facility has been established: number and proportion of long-stay residents who moved there, and their average length of stay • Number and proportion of long-stay residents who transitioned to independent living or back to family home • Number and proportion of long-stay residents who moved into community-based, supported housing • Number and proportion of long-stay residents who remain in hospital • Average length of transition process per person • Number and proportion of discharged residents with a documented follow-up contact (within 30 days and 90 days after discharge) • Number and proportion of new admissions to community mental health services or general hospital mental health units	Health or hospital information system, reports or documentation; case manager records; community mental health service registers; first-person narratives or self-reports
Preventing new long stays • Number and proportion of people admitted for 6 months or more in the last 12 months • Average length of stay	Health or hospital information system, reports or documentation
Admissions and discharge practices • Number and proportion of long-stay residents who moved to community living in the last 3 months • Number of people re-admitted within 3 months	

Process indicators	Means of verification
Reducing institutional practices[a] • Number and proportion of long-stay residents with free access to personal belongings, telephone or internet, indoor and outdoor spaces • Number and proportion of long-stay residents with unrestricted visits from family/friends • Number and proportion of residents engaged in meaningful occupation, employment, education, or activities outside the hospital • Number and proportion of long-stay residents under continuous surveillance (security cameras in private spaces) • Number and proportion of residents who can wear their own clothes, have daytime leave arrangements, and can participate in activities of their own choice.	Hospital policies and procedures; grievance mechanism reports; notifications or register for reporting episodes of seclusion, coercion or restraint; first-person narratives from staff, residents and families (See QualityRights Toolkit for more examples of indicators)

References

1 Üstün T, Kostanjsek N, Chatterji S, Rehm J, editors. Measuring health and disability: manual for WHO Disability Assessment Schedule (WHODAS 2.0). Geneva: World Health Organization; 2010 (https://iris.who.int/handle/10665/43974).

2 WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities: interview tool. Geneva: World Health Organization; 2012 (https://iris.who.int/handle/10665/374253).

3 WHOQOL-BREF: introduction, administration, scoring and generic version of the assessment. Field trial version, December 1996. Geneva: World Health Organization; 1996 (https://iris.who.int/handle/10665/63529).

4 The World Health Organization-Five Well-Being Index (WHO-5). Geneva: World Health Organization; 2024 (https://www.who.int/publications/m/item/WHO-UCN-MSD-MHE-2024.01).
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Annex 6. Example continuity-of-care checklist

Conduct joint review of recovery and discharge plan

Bring residents, hospital staff, community care teams, and chosen supporters, including families, together to jointly go through the recovery and discharge plan and ensure shared understanding of needs and strengths, planned treatments and supports, and agreed community-living arrangements.

Schedule follow-up appointments

Ensure there are booked appointments (not just referrals) with community mental health services and, as relevant: peer support, social services, specialist physical health appointments, local clubs or activities for social inclusion. Identify transport arrangements and who will accompany the person (if applicable).

Ensure medicine supply

Confirm supply provided on discharge (quantity and duration). Identify pharmacy location and opening hours, prescriber name and contact details for urgent queries.

Support family and peers

Ensure families, peers and chosen support person understand the person's needs, recovery and discharge plan, and their own role, and have access to social supports without shifting responsibility onto them inappropriately.

Arrange logistics of discharge

Include transport plan, accompanying person, personal belongings checklist, food security, and phone access and credit.

Designate a service for long-term follow-up after discharge

With the person's consent, ensure that a service is responsible for staying in contact after discharge and regularly checking that their housing, livelihood, health, social, and safety needs continue to be met in the community.

Connect with peer support

Identify a peer support worker or organization to be introduced to the person before the discharge, where available.

Key documents to share with the person being discharged

- Needs assessment summary
- Recovery and discharge plan
- Treatment summary
- Crisis plan and advance directive, if applicable
- Legal documents (e.g. ID)
- Benefits documentation
- Housing agreement/tenancy information
- Contact sheet with relevant phone numbers (hospital team, community providers, family/chosen supporters)
- Written summary of rights as a community-based mental health service user, including how to raise a complaint.

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