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Moving psychiatric deinstitutionalisation forward: A scoping review of barriers and facilitators

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Abstract

Psychiatric deinstitutionalisation (PDI) processes aim to transform long-term psychiatric care by closing or reducing psychiatric hospitals, reallocating beds, and establishing comprehensive community-based services for individuals with severe and persistent mental health difficulties. This scoping review explores the extensive literature on PDI, spanning decades, regions, socio-political contexts, and disciplines, to identify barriers and facilitators of PDI implementation, providing researchers and policymakers with a categorization of these factors.

To identify barriers and facilitators, three electronic databases (Medline, CINAHL, and Sociological Abstracts) were searched, yielding 2250 references. After screening and reviewing, 52 studies were included in the final analysis. Thematic synthesis was utilized to categorize the identified factors, responding to the review question.

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Author Contribution statement

M.l and M.C conceived the idea for the project. J.U and C.M developed the framework to conduct the systematic search, which J.G performed. J.U and J.G, established the eligibility of articles under the supervision and with the contribution of C.M. J.G and J.U extracted the data of the selected articles. J.G, J.U and C.M coded the article contents and created the categories iteratively through rounds of revision and adjustment. J.U and C.M produced an early draft of the manuscript. F.T reviewed several versions of the manuscript. The final manuscript was discussed and improved by all the authors. C.M and J.U coordinated the development of the manuscript.

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The analysis revealed that barriers to PDI include inadequate planning, funding, and leadership, limited knowledge, competing interests, insufficient community-based alternatives, and resistance from the workforce, community, and family/caregivers. In contrast, facilitators encompass careful planning, financing and coordination, available research and evidence, strong and sustained advocacy, comprehensive community services, and a well-trained workforce engaged in the process. Exogenous factors, such as conflict and humanitarian disasters, can also play a role in PDI processes.

Implementing PDI requires a multifaceted strategy, strong leadership, diverse stakeholder participation, and long-term political and financial support. Understanding local needs and forces is crucial, and studying PDI necessitates methodological flexibility and sensitivity to contextual variation. At the same time, based on the development of the review itself, we identify four limitations in the literature, concerning ‘time’, location’, ‘focus’, and ‘voice’. We call for a renewed research and advocacy agenda around this neglected aspect of contemporary global mental health policy is needed.

Introduction

Starting during and after World War II in Western Europe and North America, psychiatric deinstitutionalisation (PDI) is widely considered a central element of the modernization of psychiatry. It involves two broad components: (i) the closure or reduction of large psychiatric hospitals and (ii) the development of comprehensive community-based mental health services aiming to promote social inclusion and full citizenship for people living with severe mental illness A broad international consensus supports the need for a shift in mental health care, away from long-term institutionalisation and towards comprehensive and integrated community-based and community-shaped services (Campbell & Burgess, 2012; Thornicroft et al., 2016; WHO, 2013, 2021a)

Significant economic, social, and cultural forces have precipitated the development of PDI, including public awareness of the dehumanizing effects of prolonged institutionalisation in often poor conditions, the high cost of maintaining large, long-stay institutions, and pharmaceutical developments such as the introduction of psychotropic medication (Salisbury et al., 2016; Turner, 2004; Yohanna, 2013). For several decades, advocacy movements across the mental health and disability fields have demanded the protection of patients’ human rights, including the right to live independently in the community (Hillman, 2005; Mezzina et al., 2019). The UK, Italy, and Finland among other countries are generally regarded as good examples of PDI (Barbui et al., 2018; Turner, 2004; Westman et al., 2012). In the global south, while varying in approach and scale, Brazil, Chile, Sri Lanka and Vietnam have received praise for their efforts to move away from centralized psychiatric institutions (PAHO, 2008; Cohen & Minas 2017).

Despite the consensus and the declarations by many governments, PDI remains a complex, and fragile endeavour. Progress towards PDI varies greatly across and within countries (Hudson, 2019). In some regions, the majority of resources are still invested on centralized, long term hospitalization (WHO and the Gulbenkian GMHP, 2014); in others, PDI has been delayed with the balance of mental health care shifting in favour of hospital-focused care

(Sade et al., 2021); and in other cases, poor management of the PDI process has resulted in tragedy (see for example Moseneke's 2018 account of the Esidimeni tragedy in South Africa).

Understanding the factors that lead to or prevent the transition is crucial to inform the planning and implementation of PDI. Whilst these factors have been documented through the accounts of leaders and experts with hands-on experience, such as in the WHO's Innovation in Deinstitutionalisation report (WHO and the Gulbenkian GMHP, 2014), there has been no previous attempt to systematically scope the literature on barriers and facilitators to PDI.

This paper therefore reports the results of a Scoping Review examining the extent and range of available research regarding barriers and facilitators involved in PDI processes. We organised the specific barriers in seven groups, and the facilitators in six groups, totalling thirteen thematic groups. This categorization can be adapted to national realities and different levels of policy action around PDI, to guide research and policy efforts. The synthesis of this information allows us to establish a list of suggestions on ways to move forward.

Methods

Given that the literature on this topic has not been comprehensively reviewed, the Scoping Review (ScR) (Arksey & O'Malley, 2005) methodology was used. The goal of a ScR is "to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available (...), especially where an area is complex or has not been reviewed comprehensively before" (Mays et al., 2001, p. 194). For this review, a barrier to PDI was defined as any factor limiting or restricting the transition of care from long-term hospitalization to community-based services and supports. This may include, but is not limited to, issues related to the public-health priority agenda (Shen & Snowden, 2014); challenges in the implementation of mental health services in community settings (Kormann & Petronko, 2004; Saraceno et al., 2007); the resistance of workers employed by psychiatric institutions (Priebe 2002); and public and community responses, including stigma, paternalism and other sociocultural factors (Fisher et al., 2005; O'Doherty et al., 2016).

Correspondingly, we define a facilitator as any factor that fosters, promotes, or enables an adequate PDI process. These include the presence of well-organised social activism supporting the rights of persons with mental health problems (Anderson et al., 1998), the acceptance of mental illness as a human condition (Gostin, 2008), service paradigms that enhance social inclusion and citizenship (Fakhoury & Priebe, 2002; Saraceno, 2003) and political willingness (Saraceno et al., 2007).

This ScR was conducted following the Checklist for Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Review (PRISMA-ScR) (Tr¡cco et al., 2018). A review protocol was created and registered at the Open Science

Platform (doi: 10.17605/0SF.I0/XEBQW). See the protocol and PRISMA-ScR Checklist in Supplementary materials A and B, respectively.

Three electronic databases were searched in May 2020 - Medline, CINAHL and Sociological Abstracts. Previously published systematic reviews on adults with severe mental health impairment (Lean et al., 2019; Richardson et al., 2019), barriers and facilitators to healthcare access (Adauy et al., 2013) and the deinstitutionalisation process (May et al., 2019) informed our search strategy. The strategy combined terms across three dimensions: (i) adults with mental health impairment; (ii) barriers and facilitators related to health care delivery; and (iii) the deinstitutionalisation process. The search strategy was not limited by study design or country. Tailored searches were developed for each database (see Supplementary material C). Eligibility criteria was limited by studies in English and Spanish. All references obtained through the electronic database search and hand search were pooled in End Note 11 (reference manager) and then uploaded to Covidence (screening and data extraction tool).

Studies selected for inclusion met the criteria detailed in Table 1. Initial eligibility was independently assessed by JU and JG based on title and abstract. At the level of full-text screening, a random sampling of 10% of the selected studies was pilot-tested (with three reviewers) to ensure at least 80% of agreement. Differences in opinions were discussed, and a final decision on their eligibility was made after discussion with CM. A specific data extraction form was created to record full study details and guide decisions about the relevance of individual studies (Table 2). Two reviewers (JU and JG) extracted data and checked for accuracy with another reviewer (CM). Eligibility criteria was further specified to differentiate and exclude specialized substance abuse services involving the legal system. Studies on child institutionalisation and substance abuse were also excluded because of the distinct set of causes and challenges associated with these phenomena. Articles related to transinstitutionalisation, the transfer of users from psychiatric hospitals to other institutional settings were excluded unless they addressed PDI barriers and facilitators directly.

During the research process, inclusion criteria adopted a dimensional character, with studies clearly stating barriers and facilitators on one extreme and studies where they had to be inferred, on the other. Given that ScR methodology is defined as an exploratory strategy to map the state of research on a topic (Arksey & O'Malley, 2005; Peters et al., 2015), no attempts were made to assess the methodological quality of the included studies.

Thematic synthesis (Harden, 2010; Lucas et al., 2007; Thomas et al., 2004; Thomas & Harden, 2008) of the selected papers followed a three-stage process. Firstly, it involved free coding the content of the text, to identify barriers and facilitators. Secondly, grouping and organizing the codes into an inductively developed set of categories. Finally, CM examined the categories and their respective codes in the light of the review question to produce an initial set of categories. The match between codes (barriers/facilitators) and categories, and their relevance for the review question was further discussed and refined through rounds of collective revision. A table with examples of the data coding process is available (Supplementary Material D).

To consistently scope the academic production around PDI over several decades, this review includes publications up until May 2020, intentionally excluding the literature related to the Covid-19 pandemic. To properly assess the effects of the Covid-19 pandemic upon processes of Deinstitutionalisation -and on the reality of long-term psychiatric hospitals in general- a different research question, and a tailored design is required.

Results

The search strategy retrieved 2250 references. Nine more references were added after hand-searching reference lists and contacting relevant authors. After duplicate removal, 1915 references were screened by title and abstract, leaving 215 articles for full-text screening. Finally, 52 studies were included in the analysis. Search results and the reasons for excluding full-text articles are provided in the PRISMA flowchart (Figure 1).

Characteristics of the studies

Included studies were published between 1977 and 2019. This broad temporal scope responds to the fact that an important proportion of research was parallel to the implementation of PDI policies in Europe and the USA during the 1970s and 1980s. Studies were predominantly conducted in the USA (n=22), followed by the UK (n=7) and Canada (n=5). Figure 2 shows an overview of the geographical distribution of the included studies. Regarding the methodology, 25 publications were qualitative studies, 22 were quantitative, and 5 used mixed methods. We provide a summary of the studies' characteristics in Table 3 and descriptions of each study in Table 4.

It is important to consider that this is a general categorization based on the available literature, whose aim is to identify what has been reported as a barrier and as a facilitator in a systematically selected, diverse set of references. We applied thematic analysis to the entire set, and on that basis, we developed this initial categorization. We are not establishing the prevalence of each barrier/facilitator across the set or contrasting the characteristics of each barrier/facilitator across regions or within a specific stage in the PDI process. For specific information about the composition of the categories and codes, see table 5 for barriers and table 6 for facilitators.

Barriers to the process of psychiatric Deinstitutionalisation

Barriers to the process were organised under seven categories, summarized in Table 5 and described in detail below.

1 Planning, leadership, and funding—This category includes barriers related to design, implementation, monitoring and overall leadership of the process, and its interaction with other policy processes. One barrier is the lack of accountability from the government to carry out the reform properly, refusing responsibility for housing, social or medical needs and not including other agencies in patient discharge planning (Rose, 1979). The absence of clear operational goals may hinder performance evaluation.(Rosenheck, 2000). Charismatic and ideologically driven leadership is important at the beginning, although is vulnerable to political shifts, including elections and changes in government (PAHO, 2008).

Barriers related to funding included the lack of a clear policy that assured the reallocation of resources from hospitals to CMHS (Fakhoury & Priebe, 2002; PAHO, 2008) and a lack of funding to ensure the continuity of community services (McCubbin, 1994; Mechanic & Rochefort, 1990; PAHO, 2008). This to secure a synchronicity between downsizing psychiatric hospitals and the scaling up of psychosocial interventions.

2 Knowledge/Science—Conceptual barriers to promoting PDI were identified. Some authors consider that the lack of research on PDI processes (Bennett & Morris, 1981), paralyze or slow down policy planning and implementation (Shen & Snowden, 2014). At the conceptual level, reducing the concept of community care to narrow geographical proximity can limit the development of community-based interventions (Bennett & Morris, 1983).

Some authors criticised the inadequate transfer and use of certain service paradigms, such as the application of urban-centred interventions to rural locations (Kraudy et al., 1983) without previous identification of rural specificities, creating a disconnection between users and facilities (Schmidt, 2000).

3 Power, interests, and influences—Barriers related to the conflict between the interests and perspectives of different groups were grouped under this category.

Authors have discussed the impact of the privatization of mental health care in the wake of the closure of psychiatric hospitals. Market-driven decisions can re-create similar conditions to those in old psychiatric facilities (Rose, 1979). The rise of private hospitals in the United States and their reluctance to participate in non-profit services, such as working with existing public providers, influences access to and the nature of mental health care. Private for-profit hospitals may restrict access to care for uninsured patients (Dorwart et al., 1991). Additionally, private insurance in the United States often encourages unnecessary hospitalization and discourages psychosocial interventions and alternative forms of treatment (Freedman & Moran, 1984; Barton, 1983).

Furthermore, the low cost of hospitalization in some areas, as reported in Asia (Fakhoury & Priebe, 2002), does not provide an economic incentive to push for deinstitutionalization".

The dependence of psychiatric research and development on drug-companies is seen as a barrier. McCubbin stated that the vested interests of the pharmaceutical industry may influence psychiatric practice by selectively supporting medical schools, conferences, and journals, potentially tuning the vision of community mental health into a market opportunity (McCubbin, 1994).

Finally, the lack of relevance of mental health in the political agenda is a crucial, over-encompassing barrier to effective advocacy efforts (Mechanic & Rochefort, 1990; PAHO, 2008; Semke, 1999), as is the uncoordinated and fragmentary nature of these efforts (McCubbin, 1994; Mechanic & Rochefort, 1990; Rosenheck, 2000).

4 Services and support in the community—The slow development of community programmes forced patients to return to long-term institutions, risking chronification (Kaffman et al., 1996). There have been reports of problems caused by the sudden decrease

in psychiatric beds without corresponding increases in community-based services. This can result in unintended transfers of patients to other institution-based services and even imprisonment (Shen & Snowden, 2014). Inadequate training of community-based workers, discharge without community support (Shen & Snowden, 2014) and early release promoted by legislatively mandated PDI policies (Kleiner & Drews, 1992) are elements to consider.

The authors identified several barriers to adequate integration of discharged users into their communities, including the absence of jobs and income (Goering, 1984), inadequate housing (Grabowski et al., 2009), and insufficient public support (Manuel et al., 2012). Other barriers included challenging behaviors (Allen et al., 2007), old age (Barry et al., 2002), and pessimistic attitudes and feelings of disempowerment and hopelessness among patients (Chopra & Herrman, 2011). In addition, the decrease in disability pensions following an increase in earned income was also identified as a barrier to social integration, as it can discourage work (Chopra & Herrman, 2011)."

5 Workforce—Barriers related to the workforce in both institutionalized settings and community services were identified. Regarding human resources, authors mentioned staff shortages as a barrier for the transition towards community-based care (Fakhoury & Priebe, 2002; Rose, 1979; Shen & Snowden, 2014, Stelovich, 1979). Another barrier reported was the internal frictions and the existence of opposing views about care and rehabilitation (Kaffman et al., 1996; O'Doherty et al., 2016). More specifically, the psychiatric hospital workforce can delay or hinder the transformation of psychiatric institutions for fear of losing their livelihoods (Shen & Snowden, 2014; Swidler & Tauriello, 1995). Workers can express reluctance and scepticism regarding the feasibility of community living for institutionalized persons (Mayston et al., 2016; O'Doherty et al., 2016). This includes the development of unfair expectations toward family members, which alienated carers and hindered their willingness to accept responsibility (Barton, 1983).

On the other hand, service providers located in the community can be sources of stigma, expressed in the avoidance of formerly institutionalized patients (Barton, 1983), hopelessness towards treatment (Aggett & Goldberg, 2005), exclusion of users from constructing their treatment plan (Bryant et al., 2004) and fears stemming from the lack of restraining measures (Ash et al., 2015). Perceived racism at the hands of service providers can lead to mistrust in patients, causing them to either reject treatment or have poor adherence, which in turn can result in poorer outcomes, such as a longer hospital stays (Chakraborty et al., 2011).

6 Communities and the public—Factors limiting social inclusion, comprising attitudes towards persons with SMI and community responses to PDI processes, were grouped under this category. Lack of preparation and stigma (Aggett & Goldberg, 2005; Bredenberg, 1983; Chan & Mak, 2014; Fakhoury & Priebe, 2002; Manuel et al., 2012; Mechanic & Rochefort, 1990; O'Doherty et al., 2016; PAHO, 2008) leads to hostile attitudes toward service-users challenging social integration (Aggett & Goldberg, 2005; Bredenberg, 1983; Fakhoury & Priebe, 2002; O'Doherty et al., 2016, PAHO, 2008). The attribution of dangerousness to individuals with SMI and the public acceptance of social control

measures over recovery-oriented alternatives were also reported as barriers to PDI processes (Fakhoury & Priebe, 2002; Matsea et al., 2019)

7 Family/Carers—Authors highlighted the difficulties in maintaining relationships between caregivers and community services (Aggett & Goldberg, 2005; Barton, 1983; Yip, 2006; Lavoie-Tremblay et al., 2012; McCubbin, 1994; Mayston etal., 2016; O'Doherty et al., 2016). Previous experiences of failed treatments can lead to lack of cooperation and hostility towards services (Aggett & Goldberg, 2005). Professionals can be reluctant to cooperate and skeptical about the feasibility of community living (Mayston et al., 2016; O'Doherty et al., 2016). Families and caregivers may have concerns about community living and its suitability for people with high support needs (O'Doherty et al., 2016) and concerns about receiving the burden of care, and this can alienate them and hinder their willingness to accept responsibility.

Facilitators to the process of psychiatric Deinstitutionalisation

Facilitators in the process were organised under six categories summarized in Table 6 and described in detail below.

1 Planning, leadership, and funding—Factors related to organizational and managerial capacities required for the transition were grouped under this category. Authors stated that the presence of a central mental health authority increased the potential to ensure effective coordination. For example, Latin America and Caribbean countries have developed mental health units within the health ministry capable of overseeing coordination (PAHO, 2008). Coordination across countries in the initial phases of reform played a crucial role, by sharing technical support and experiences of implementation (PAHO, 2008). Authors highlighted the relevance of developing intersectoral coordination, which may act as a safety net for persons with serious mental health illness reducing acute episodes (PAHO, 2008).

Studies mentioned how increases in psychiatric population and fiscal strain on state mental hospitals drove governments to develop an alternative mental health strategy (McCubbin, 1994, Mechanic & Rochefort, 1990). The pressure on fiscal resources - partly linked to economic crisis-made the costs of mental health hospitals and their inefficiency more apparent (PAHO, 2008). Also, the direct transference of funds - from reduced hospital expenditure- to community-based services was mentioned as a factor that fostered the transference of patients from state hospitals to alternative placements in the community (Mechanic & Rochefort, 1990). Finally, the growth of disability insurance was understood as a facilitator of the process of discharging service users from psychiatric hospitals by contributing to their support in the community (Mechanic & Rochefort, 1990).

2 Knowledge/Science—Interdisciplinary research focusing on the legal and economic factors which influence PDI processes and practices was valued (Mechanic & Rochefort, 1990; PAHO, 2008). The elucidation of adverse effects of institutions on individual patients (Anderson et al., 1998; Bennett & Morris, 1983; Kleiner & Drews, 1992; Mechanic & Rochefort, 1990) together with the documentation of human rights violations in mental health hospitals helped in catalysing the reform process (Bennett & Morris, 1983;

PAHO, 2008). More generally, some authors stressed that conceptual clarity regarding the application of a biopsychosocial model to the mental health field (McCubbin, 1994) and the interpersonal aspect of mental health (Bennett & Morris, 1983; Kleiner & Drews, 1992) helped in the rolling up of the Deinstitutionalisation processes.

In the early stages of PDI in the USA, the allocation of research grants to state mental health hospitals developing pilot testing of outpatient treatment and rehabilitation helped in the shift of funds from mental hospitals into general hospitals (Weiss, 1990). The dissemination of early experiences of innovative policy implementation in mental health facilitated the adoption of Deinstitutionalisation practices in other regions (Shen & Snowden, 2014). Finally, the development of psychotropic medication and the reduction of psychiatric symptomatology helped to build trust in the implementation of less coercive management plans that were feasible to apply at the community level (Anderson et al., 1998; Bennett & Morris, 1983; Bredenberg, 1983; Freedman & Moran, 1984; Kleiner & Drews, 1992; Mechanic & Rochefort, 1990).

3 Power, interests, and influences—This category points to the role of social movements and organizations in influencing the development of Deinstitutionalisation processes. This includes advocacy actions and legal transformations.

Mental health professional groups and civil society organizations were seen as key agents contributing to overcome stigma and change the delivery of mental health services (Weiss, 1990). Some authors emphasized the importance of promoting the active involvement of civil society groups (Oshima & Kuno, 2016). Finally, authors highlight how the internationalization of mental health reforms puts increasing pressure on other countries to jump on the “bandwagon” to avoid appearing antiquated (Shen & Snowden, 2014).

Recognition of the rights of people with disabilities and their defence by civil rights movements fostered the development of new mental health laws promoting less restrictive therapeutic alternatives and broader transformations on mental health systems (Anderson et al., 1998; Freedman & Moran, 1984; Mechanic & Rochefort, 1990; PAHO, 2008; Shen & Snowden, 2014). These changes involved expanding the supply of options in the community (Anderson et al., 1998; Freedman & Moran, 1984; Mechanic & Rochefort, 1990; PAHO, 2008) and relocating investment from institutions to community services (Swidler & Tauriello, 1995). In some countries, an extensive and strong network of community-based organizations provided opportunities for community participation, facilitating the effective integration of patients into the community (PAHO, 2008). This was accompanied by the divulgation of reports showing mistreatment of patients in hospitals, pushing public sensitivity against asylums (Anderson et al., 1998).

4 Services and supports in the community—This category describes how the characteristics and distribution of community-based services and support for persons with SMI acted as facilitators in PDI processes.

Authors noted how policies around prevention in mental health, the integration of mental health services in primary health care centres (Kraudy et al., 1983; PAHO, 2008) and

the accessibility of services (Mayston et al., 2016), together with social support such as supplementary income, can sustain community inclusion (Lamb & Goertzel, 1977), giving sustainability to Deinstitutionalisation. Adequate coordination across community-based services allowed the adequate externalization of users with complex needs (Cohen, 1983; Conway et al., 1994; Evans et al., 2012). Scaled up outpatient facilities including local acute hospitals and intermediate facilities (Abas et al., 2003; Bennett & Morris, 1983) were key in allowing mental health systems to reduce their reliance on inpatient care and limiting beds in psychiatric settings (PAHO, 2008). Plans to end seclusion and to support mental health professionals towards a transformation in their clinical practice were identified as a facilitator to the transition (Ash et al., 2015).

Other facilitators included the continuity of care after discharge (Sytema et al., 1996) and specific actions such as: developing mobile teams and home interventions as they facilitate access to service for users who can't physically access needed services (John et al., 2010), mitigating self-stigma dynamics by allowing an active participation of users in their treatment through shared decision-making with professional staff (Chan & Mak, 2014; Matsea et al., 2019; Mayston et al., 2016) and supporting mechanisms for primary care workers such as a 24 hr hotline for assistance when it is required (Huang et al., 2017).

In terms of training, it is argued that a reform such as PDI requires the development of an educational infrastructure including local health training networks for continuing education and training needs, and targeting providers, service-users, volunteers, family members and others (Wasylenki & Goering, 1995). The incorporation of non-specialized, community-based workers trained on mental health prevention and promotion is also highlighted (Mayston et al., 2016).

Expanding user's freedom to choose among service options was a central facilitator. This includes models of self-directed care, where users are given a budget to choose between service options (Kalisova et al., 2018). Experiences from the US, Germany and England show that patients used their budget to pay for care from their relatives, avoiding the use of institutionalized settings and preventive care options, thus shifting from crisis intervention to early interventions (Alakeson, 2010). Self-directed care improved user's autonomy and has proved to be an effective preventive intervention (Alakeson, 2010).

5 Workforce—Facilitators related to community mental health services workforce were organised under this category. Strategies around training and skills include enhancing psychiatric aspects in health curriculum and provision of grants to complete training and research projects. This attracted students from other professions to the community mental health field (Weiss, 1990). Having previous experience in general medicine before training into psychiatry appeared to support a culture of community-based work and a strong collaboration with primary care teams (PAHO, 2008).

6 Exogenous factors—Factors indirectly affecting the feasibility of implementing Deinstitutionalisation policies were gathered under this category. This includes the role of exogenous shocks (e.g. conflict and humanitarian disasters) (Shen & Snowden, 2014) in bringing wider public attention to patients' living conditions. A study also mentioned how

the end of dictatorial regimes brought attention to human rights issues in psychiatric care, facilitating the process of Deinstitutionalisation in countries such as Argentina, Brazil and Chile (PAHO, 2008).

Discussion

A marked decline in interest on psychiatric institutions across the global mental health literature has been noted by Cohen and Minas (2017) being absent from important prioritization exercises like the Grand Challenges in Global Mental Health (Collins etal. 2011). The authors argue that although establishing high-quality community mental health services is crucial for improving the lives of people with severe mental disorders, an exclusive focus scalability overlooks ongoing deficiencies in treatment quality and human rights protections in psychiatric institutions. Given their role in human rights abuses experienced by people with mental disorders, PDI efforts should receive more attention.

In response to this call, this article organised the available evidence around PDI, to assist in planning and conducting contextually relevant studies about and for the process. Drawing on the review, the following section introduces a set of proposals while reflecting on the limitations and problems with the available literature.

Moving Psychiatric Deinstitutionalisation Forward

The transition from a system centred on long-term psychiatric hospital care to one centred on community-based services is complex, usually prolonged and requires adequate planning, sustained support and careful intersectoral coordination. The literature documenting and discussing PDI processes is vast, running across different time periods, regions, socio-political circumstances, and disciplines, and involving diverse models of institutional and community-based care. Based on this scoping review, we propose five key considerations for researchers and policymakers involved in PDI efforts:

1) *Needs assessment, design and scaling up.* An adequate assessment of the institutionalized population is required, to shape existing and new communitybased services around their needs and preferences. A thorough analysis of the correlation of forces required to unlock institutional inertia is crucial.

2) *Financing the transition.* A comprehensive and sustainable investment is necessary, and the different aspects of the transition should be adequately costed, including new facilities, support of independent living, training, new professional roles, and the reinforcement of primary health care.

3) *Workforce development.* The workforce should be aligned with the transition from the outset. Elements such as training, incentives and guarantees of job stability are required. Curricular changes in psychiatric training, including more emphasis on community-based care and recovery-oriented practices, are necessary.

4) *PDI implementation.* The implementation process requires political resolve, careful monitoring, and an ability to respond to unexpected challenges. PDI represents a crucial learning opportunity for further scaling up.

5) *Monitoring and quality assurance.* Results of the process need to be carefully assessed against clear operational goals. The perspectives of users, caregivers, and the workforce should be incorporated into the assessments. The development of an assessment strategy detailing clear outcomes that incorporate financial and organisational dimensions is advised. Thorough documentation of PDI process, including achievements and setbacks should be done to build a reliable and diverse evidence-base for action.

A multifaceted strategy, clear and strong leadership, participation from diverse stakeholders and long-term political and financial commitment are basic elements in the planning of PDI processes. Nonetheless, implementation dynamically responds to local conditions, widely differing across countries and regions. What appears as a barrier or a facilitator can vary according to a specific context.

Although this review focuses on the barriers and facilitators for processes of PDI, we recognise that outcomes are important, and they cannot be separated from processes. Misconceptions about outcomes can hinder PDI efforts, and failed processes can lead to negative outcomes.

Two misconceptions are common. The first suggest a strong correlation between decreasing psychiatric beds and increasing homelessness or imprisonment among people with mental health problems. However, in their analysis of 23 cohort studies, Winkler et al. (2016) found that homelessness and imprisonment occurred only sporadically, and, in most studies, cases of homelessness or imprisonment were not reported.

The second misconception considers that PDI can be negative for formerly institutionalised individuals. In his review on the impact of deinstitutionalisation on discharged long-stay patients, mainly diagnosed with schizophrenia, Kunitoh (2013) found that most studies reported favourable changes in social functioning, stability and improvements in psychiatric symptoms, and positive changes in quality of life and participant attitudes towards their environment, at various time-points. Deterioration following deinstitutionalisation was rare. This suggests that even long-stay patients, who commonly experience functional impairment due to schizophrenia, can achieve better functioning through deinstitutionalisation.

At the same time, failure at the level of process - including planning and implementation - can lead to negative and even fatal outcomes for patients. In South Africa, from October 2015 to June 2016, a poorly executed attempt to relocate 1,711 highly dependent patients resulted in 144 deaths and 44 missing individuals (Freeman, 2018). This tragedy stemmed from ethical, political, legal, administrative, and clinical errors. Reports examining this failure offer valuable lessons for PDI efforts globally (Wessels & Naidoo, 2021).

Limitations in the literature: Time, space, process, and voice

The literature on PDI is diverse, which makes synthesis endeavours difficult. Although promoted as a global standard in psychiatric and social care, the multiplicity of contexts in which the policy has been implemented limits the possibility of finding common ground. In their systematic review of the current evidence on mental health and psychosocial outcomes for individuals residing in mental health supported accommodation services, McPherson and colleagues (2018) noted how the variation in service models, the lack of definitional consistency, and poor reporting practices in the literature stymie the development of adequate synthesis.

Similarly, in a recent systematic review of psychiatric hospital reform in LMICs, Raja et al. (Raja et al., 2021 pp. 1355) expressed regret over the "dearth of research on mental hospital reform processes," indicating how poor methodological quality and the existence of variation in approach and measured outcomes challenged the extrapolation of findings on the process or outcomes of reform. Of the 12 studies they selected, 9 of them were rated as weak according to their quality assessment

Beyond the challenges posed to synthesis efforts and through conducting this review, we identified four wider problems affecting the literature documenting PDI planning and implementation. They are related to *time location focus, and voice.*

In terms of *time*, most of the work addressing PDI was developed at the end of the 1970s through the 1980s and early 1990s. After this, there are barriers and facilitators documented which indirectly relate to the development of communitybased services and their evaluation, with PDI as the "background" but not as the main object of attention. Also, the date of the search -May 2020- could potentially exclude studies that worked with data from the pre-COVID period.

When it comes to *location*, while there is a wealth of literature on the topic, it is important to note that much of it is based on the experiences of the USA and Western Europe. The documentation of PDI in regions outside of the 'global north' is typically limited to personal testimonies from process leaders, which may lack systematicity and are usually published in languages other than English. This can restrict their accessibility and dissemination.

In terms of *focus*, most studies have a clinical orientation, evaluating various outcomes that are directly or indirectly related to PDI. However, the process itself, has received little attention. An exclusive emphasis on outcomes can obscure the administrative, legal, and political complexities of carryng out a psychiatric reform, this, hinder the dissemination of important lessons.

Finally, it’s worth noting that important *voices* are often missing from available studies and reports on PDI processes. While some studies do consider the experiences and engagement of caregivers, healthcare workers, and patients, they are still in the minority. This can create a skewed understanding of the impact of PDI, as these individuals play crucial roles in shaping the process and its outcomes. The same goes for the different communities where patients have developed their lives after PDI.

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These limitations have significant consequences. It's unclear whether the evidence extracted from experiences in high-income countries in North America and Europe can directly inform processes in other regions, including low- and middle-income countries (LMICs). While it's possible to identify common pitfalls, barriers, and needs, this identification must be accompanied by up-to-date local research to ensure that the evidence is relevant and applicable to specific contexts.

The involvement of patients and communities affected by institutionalization in the design and implementation of research and policy should be central in a renewed PDI agenda. The recently launched Guidelines on deinstitutionalization, including in emergencies, by the United Nations Committee on the Rights of Persons with Disabilities represent a pioneering effort in this direction (OHCHR, 2022).

At the same time, qualitative and ethnographically oriented case studies are required to closely examine PDI efforts while remaining attentive to diversity and local creativity beyond global normative parameters of success and failure. Furthermore, reflexive, and flexible approaches to research synthesis are necessary to capture and assess the wealth of lessons learned from diverse engagements with deinstitutionalization across the globe.

This article offers a preliminary and general classification of barriers and facilitators that can inform the development of relevant research through various methodologies and other literature. The categories can be modified and customized based on the evidence from various settings. As far as we know, this classification is not yet present in the existing literatura

Conclusion

Institutional models of care continue to dominate mental health service provision and financing in many countries, leading to a continued denial of the right to freedom and a life in the community for individuals with mental health conditions and associated disabilities. The successful implementation of PDI requires detailed planning, sustained support and coordinated action across different sectors.

This review identifies the factors impacting PDI processes, according to the available literature. Barriers and facilitators are organised in fifteen thematic groups. The results reveal that PDI processes are complex and multifaceted, requiring detailed planning and commensurate financial and political support. We have offered five considerations for policymakers and researchers interested and/or involved in PDI efforts.

There are many lessons to be learned from the processes described in the literature, and many areas where research has been insufficient. Barriers and facilitators will differ in response to the legal, institutional, and political characteristics of each region and country. This categorization can be adapted to national realities and different levels of policy progress in PDI, to guide research and policy efforts. We call for methodological innovation and the involvement of affected communities as key elements of a renewed research agenda around this neglected aspect of mental health reform worldwide.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Data Availability Statement

The authors confirm that the data supporting the findings of this study are available within the article [and/or its supplementary materials.]

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Impact Statement

The transition from a mental health system centred on long-term psychiatric hospital care to one centred on community-based services is complex, usually prolonged and requires adequate planning, sustained support and careful intersectoral coordination. The literature documenting and discussing psychiatric Deinstitutionalisation (PDI) processes is vast, running across different time periods, regions, socio-political circumstances, and disciplines, and involving diverse models of institutionalisation and community-based care. This scoping review maps this literature, identifying barriers and facilitators for PDI processes, developing a categorization that can help researchers and policymakers approach the various sources of complexity involved in this policy process.

Based on the review, we propose five key areas of consideration for policymakers involved in PDI efforts: 1) Needs assessment, design and scaling up; 2) Financing the transition. 3) Workforce attitudes and development; 4) PDI Implementation and 5) Monitoring and quality assurance.

We call for a multifaceted transition strategy that includes clear and strong leadership, participation from diverse stakeholders and long-term political and financial commitment. Countries going through the transition and those who are starting the process need a detailed understanding of their specific needs and contextual features at the legal, institutional, and political levels.

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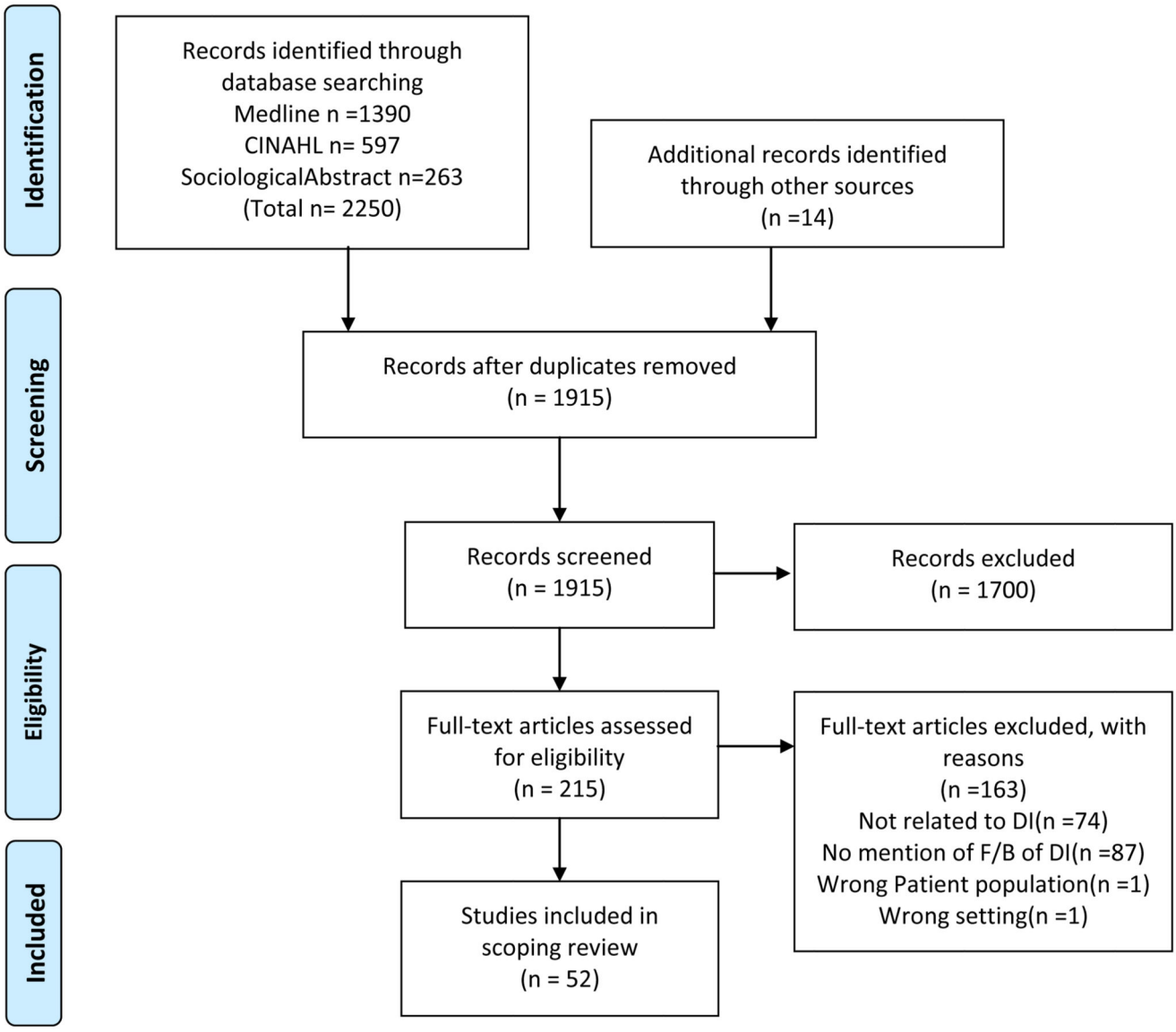
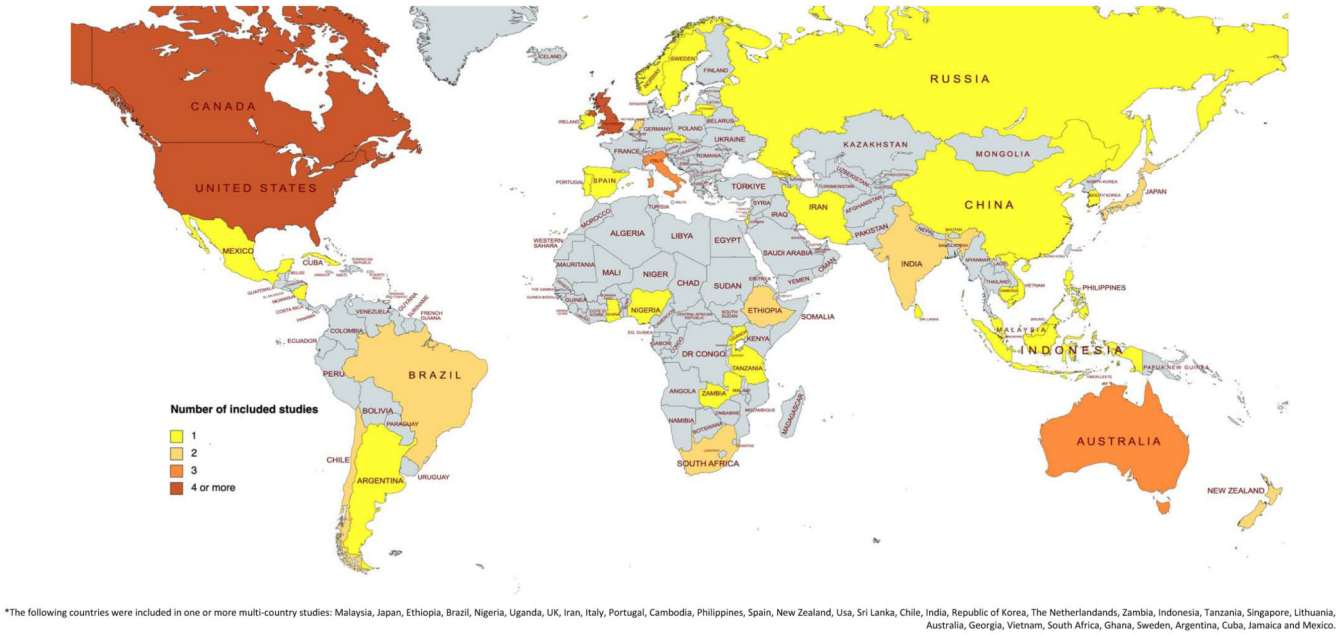


Figure 1. PRISMA 2009 Flow Diagram



*The following countries were included in one or more multi-country studies: Malaysia, Japan, Ethiopia, Brazil, Nigeria, Uganda, UK, Iran, Italy, Portugal, Cambodia, Philippines, Spain, New Zealand, Usa, Sri Lanka, Chile, India, Republic of Korea, The Netherlandands, Zambia, Indonesia, Tanzania, Singapore, Lithuania, Australia, Georgia, Vietnam, South Africa, Ghana, Sweden, Argentina, Cuba, Jamaica and Mexico.

Figure 2. Geographical distribution of included studies

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Table 1

Inclusion and Exclusion criteria

	Included	Excluded
Population	- Studies focused on adult users of long-term mental health services (stays longer than 60 days).	- Studies meeting the above criteria but where participants had a background of a long-term stay in Children Services facilities (children ward, orphans' asylum, group home or residency) or specialized substance abuse services.
Concept	Studies focused on providers, caregivers (family/friends) and users' account on barriers and facilitators of the psychiatric deinstitutionalization process. Studies focused on PDI processes were included regardless of the study aims. Studies focused on reporting outcome measures related with the community mental health system where only included if they involved a reform process in the context of PDI.	- No mention of any facilitator or barrier related to the process of PDI. - Studies where the researchers could infer the presence of a barrier o facilitator of PDI but no direct link with PDI processes were clearly set out by the authors were excluded.
Context	- Studies conducted in mental health setting.	- No description of the mental health services provided - No restrictions were placed on the location of intervention delivery (i.e. hospital, day services, community health centre, homes).
Type of Source	Published and unpublished (grey literature) sources including primary studies, textual papers, technical and governmental reports, calls to action, theoretical and political discussions, historical studies, book chapters and reviews.	
Language	- Studies wrote in English or Spanish	- All other languages.

* In the light of the potential differences that may affect the process of deinstitutionalization of Mental Health organizations from Social Services and Specialized Substance Abuse Services (like penal law involvement), this kind of interventions will be excluded.

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Table 2

Data Extraction Form

Study Information	Correspondence Author
	Title
	Year of Publication
	Country in which the study was conducted
	Aim of study
	Study Design
	Population description
	N° of participants
	Setting
	Provider type
Outcomes	Barriers to Psychiatric Deinstitutionalization
	Facilitators to Psychiatric Deinstitutionalization
Policy Advice	

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Table 3

Summary characteristics of included studies

		N° of studies
Setting	Community mental health	19
	Mixed	15
	Inpatient	10
	Residency	4
	Primary care centre	2
	Day Service	1
	Emergency Department	1
Provider	Public	30
	Other	16
	Private	5
	NGO	1
Language	English	52
	Spanish	0

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Table 4
Study Characteristics Of Included Studies

First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
ABAS 2003	New Zealand	To describe reasons for admission and alternatives to admission in a government funded acute inpatient unit	Inpatient Unit	Mixed Methods	Adult patients admitted to a psychiatric hospitalization in the South Auckland Health Mental Health Services	255 admissions to an acute psychiatric unit in Auckland	Public
AGGETT 2005	UK	To describe the work of a busy Community Mental Health Team with outreach clients. Barriers to collaborative work and some of the team's strategies to overcome them are delineated.	CMHC	Case series	Difficult to engage adult clients between 35 and 52 years old of a outreach community mental health team in an East London borough.	4 service users	Public
ALAKESON 2010	USA	To examine a range of innovative self-directed care programs in England, Germany, the Netherlands, and the United States.	CMHC	Narrative style	Home and community-based long-term care service users with physical and cognitive disabilities	Inapplicable	Public
ALLEN 2007	UK	To investigate predictors for out of area placements for people with challenging behaviors and also reports on their costs and basic characteristics.	Mixed	Descriptive Transversal	All people attending to services supporting children and adults with intellectual disability in a large area of South Wales in conjunction with health, education, unitary authority, voluntary and private sector commissioners and providers.	1458 people	Public
ANDERSON 1998	USA	To show the changes over 30 years in state institutional populations, interstate variability, movement of individuals into and out of state institutions, costs of state institutional care, and state institution closure as a result of social policy.	Inpatient Unit	Descriptive Longitudinal	Patients in institutions for mental disabilities and epileptics between 1950 and 1968	Inapplicable	Public
ASH 2015	Australia	To describe the implementation of recovery-based practice into a psychiatric intensive care unit, and report change in seclusion rates over the period when these changes were introduced (2011–2013).	Inpatient Unit	Mixed Methods	Consumers (average age 38 years) detained under the SA Mental Health Act. Eleven percent had been charged with or convicted of an offence with a custodial sentence. Common diagnoses were schizophrenia	63 people	Public

First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
					(32%), drug-induced psychosis (18%) and bipolar disorder (manic) (18%). The average length of stay was 11.5 days.		
BARRY 2002	USA	To examine the relationship between age, the use of health services and level of functioning in patients with schizophrenia across the adult lifespan	Mixed	Descriptive Transversal	Veterans with schizophrenia drawn from the VA National Psychosis Registry who received a diagnosis of schizophrenia during a VA clinical encounter between 1999 and 2000.	102.256	Other: not described
BARTON 1983	USA	To discuss the role of mental hospital in the health care system for the elderly	Inpatient Unit	Narrative style	Inapplicable	Inapplicable	Mixed
BENNETT 1982	UK	To describe factors that fostered the deinstitutionalization process in the UK and its consequences in psychiatric services.	Mixed	Narrative style	Inapplicable	Inapplicable	Public
BREDENBERG 1983	USA	To present available documentation regarding the implications of residential integration of geriatric ex-mental patients and the well elderly and make recommendations for future action.	Residency	Narrative style	elderly discharged mental health service users	Inapplicable	Other: not described
BRYANT 2004	UK	To identify how the experience of attending day services met the needs of people with enduring mental health problems	Day Unit	Thematic analysis	patient population.	39 people	Public
CHAKRABORTY 2011	UK	To compare measures of perceived racism, medication adherence and hospital admission between African-Caribbean and white British patients with psychosis	Mixed	Cohort study	participants aged 18–65 years; with a self-assigned ethnicity of Caribbean origin with either parents or grandparents born in the Caribbean; having a Research Diagnostic Criteria-defined psychotic symptom and in receipt of psychiatric services in north London, UK	110 people	Public
CHAN 2014	Hong Kong	To examine the mediating role of self-stigma and unmet needs in the relationship between psychiatric symptom severity	CMHC	Case series	Adults with schizophrenia spectrum disorders attending community mental health services in Hong Kong	400	Nonprofit organization

First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
		and subjective quality of life.					
CHOPRA 2011	Australia	To assess the long-term outcomes for the original cohort of 18 residents of the Footbridge Community Care Unit (CCU), a residential psychiatric rehabilitation unit at St Vincent's Mental Health Melbourne.	ED	Cohort study	14 schizophrenic and 4 people with schizoaffective disorder	18	Public
COHEN 1983	USA	To clarify conceptions about mental illness in later life and promote the development of mental health services for the elderly in the community.	Residency	Narrative style	senior people with mental health difficulties living in housing arrangements	Inapplicable	Other: not described
CONWAY 1994	UK	To report outcomes of community mental health services for people with schizophrenia who had shown very low levels of supported housing and structured day activity.	CMHC	Cohort study	patients from West Lambeth, London originally aged 20-65 years who satisfied the research diagnostic criteria for schizophrenia.	51 people	Other: not described
DORWART 1991	USA	To assess the effect of changes in ownership and types of inpatient settings on the structure of the mental health services system.	Inpatient Unit	Analytic transversal	All nonfederal psychiatric hospitals in the United States, including community mental health centers with inpatient units between October 1987 and May 1988	915 hospitals	Mixed
EVANS 2012	USA	To describe the conversion of partial hospitals into recovery-oriented programs as part of system transformation.	CMHC	Narrative style	Stakeholders involved in a transformation of mental health service in a hospital	Inapplicable	Other: not described
FAKHOURY AND PRIEBE 2002	UK	To provide an international overview of deinstitutionalization and review related issues as discussed in the current literature.	Mixed	Narrative style	Inapplicable	Inapplicable	Mixed
FREEDMAN 1984	USA	To identify and discuss the major policy issues related to the care of the chronically mentally ill, specifically the effects and implications of deinstitutionalization	CMHC	Case report	a 32-year-old schizophrenic who has spent more than 10 years in mental health institutions	Inapplicable	Public

First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
		for this particular population.					
GOERING 1984	Canada	To describe the 6-month and 2-year postdischarge outcome in each of five aftercare components for 505 subjects in a traditional system of service delivery.	Inpatient Unit	Cohort study	Adult people discharged from inpatient units in Toronto	505 participants	Public
GRABOWSKI 2009	USA	To estimate the cross-state variation in the proportion of nursing home admissions indicating a mental illness, and the proportion of persons with mental illness admitted to nursing homes.	Residency	Descriptive Transversal	Nursing home admissions in the USA during 2005	1.150.734 new admissions	Private
HUANG 2017	Singapore	To design a general practitioner–partnership programme in an institute in Singapore to facilitate the transition to community services and gauge the impact of the interventions chosen to improve uptake of referrals.	CMHC	Mixed Methods	Stable mental health service users referred to the GP from December 2014 to January 2016 partnership programme in a mental health institute in Singapore	238 service users	Private
JOHN 2010	India	To describe the successful management of a person with schizophrenia in the community through a primary care team in liaison with psychiatrist services.	CMHC	Case report	adult with psychotic symptoms living in an urban area of India	1 person	Public
KAFFMAN 1996	Israel	To report on an alternative community care program that has been developed and implemented in the Kibbutz Clinic for the treatment and rehabilitation of the severely mentally ill.	CMHC	Mixed Methods	adult people with a severe mental illness with poor functioning who participated in the program conducted in Telem, Israel, for at least 18 months and followed up for a minimum of 4 years.	124 patients	Private
KALISOVA 2018	Czech Republic	To assess the effect of the S.U.P.R. psychosocial rehabilitation programme on the quality of care at the longer-term inpatient psychiatric departments	Inpatient Unit	Experimental not randomized (‘before and after’ design)	All Czech psychiatric hospitals focused on longer term inpatients, mainly with a diagnosis of schizophrenia.	14 units for 499 patients with severe mental illness with complex needs	Other: not described
KAM-SHING 2006	China	To review and evaluate the implementation of	CMHC	Narrative style	Inapplicable	Inapplicable	Public

First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
		community mental health in the People's Republic of China					
KLEINER 1992	USA and Norway	To describe the experiences in the creation of innovative service delivery system which integrates psychiatric services with lay community support systems and patient social networks.	CMHC	Narrative style	Psychotic patients who had more than two years of cumulative hospitalization, and who could not be placed with relatives.	Inapplicable	Other: not described
KRAUDY 1987	Nicaragua	To assess the extent to which the new proposed model had been translated into a different way of delivering psychiatric care in Nicaragua	Primary Care Centre	Descriptive Transversal	children and adult patients attending one of the surveyed services for the first time irrespective of whether or not they had a psychiatric history.	342 patients	Public
LAMB 1977	USA	To assess the career of psychiatrically disabled people in the community	CMHC	Descriptive Transversal	Long-term psychiatrically disable people between 18 and 64 years old who live in the community in California with a psychotic diagnoses	99 people	Private
LAVOIE-TREMBLAY 2012	Canada	To describe how families and decision makers perceive collaboration in the context of a major transformation of mental health services and to identify the factors that facilitate and hinder family collaboration.	CMHC	Thamatic Analysis	family members of users of mental health services and key decision makers on the mental health service	54 family members and 22 decision makers	Public
MALLIK 1998	USA	To identify perceived barriers to community integration in people with psychiatric disabilities, in the areas of skills, environmental support, and community resources.	Inpatient Unit	Case series	People with psychiatric disabilities in the Alliance of Psychiatric Rehabilitation Program in Baltimore County, Maryland	42 people	Public
MANUEL 2012	USA	To explore the experience of women with severe mental illness in transition from psychiatric hospital care to the community.	Residency	Thematic analysis	women living in transitional residences on the grounds of two state-operated psychiatric hospitals in the New York City metropolitan area, awaiting discharge to both supervised and independent housing in New York City.	25 women	Public

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First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
MATSEA 2019	South Africa	To explore the views of different stakeholders about their roles as support systems for people with mental illness and their families in a rural setting.	CMHC	Content Analysis	Stakeholders comprising traditional health practitioners (faith and traditional healer), traditional leaders, church members, home-based care team and police officers from Mashashane, a rural setting in Limpopo Province, South Africa	41 stakeholders	Public
MAYSTON 2016	Ethiopia	To engage key stakeholders in participatory planning for a shift to mental health care integrated into primary care, and to explore their perspectives on acceptability and feasibility of the change.	CMHC	Framework analysis	key stakeholders (healthcare administrators and providers, caregivers, service-users and community leaders) living in Butajira town	11 service users, 27 caregivers, 15 health extension worker and 10 health center workers	Public
MCCUBBIN 1994	Canada	To reevaluate the recent tendency to attribute economic causes to deinstitutionalization and its subsequent “treatment in the community” mental health systems	Mixed	Narrative style	Inapplicable	Inapplicable	Mixed
MECHANIC 1990	USA	To provide a comprehensive overview of the causes, nature, and consequences of the practice of deinstitutionalization in the Unites States	Mixed	Narrative style	Inapplicable	Inapplicable	Mixed
O’DOHERTY 2016	Ireland	To document the views of family members of people with an intellectual disability regarding implementation of a personalized model of social support in Ireland.	CMHC	Grounded theory	parent, adult sibling or extended family member of a person receiving full-time residential supports from the agency	40 family members	Public
OSHIMA 2006	Japan	To explore how the introduction of community-based care has changed the role of psychiatric hospitals and families in caring for people with mental illness by examining the different types of living settings of clients treated for schizophrenia in Kawasaki as compared with a	CMHC	Descriptive Transversal	adults with a diagnosis of schizophrenia living in the community and hospitalized in Kawasaki and the rest of Japan	3.845 people living in Kawasaki and 448.000 living in Japan	Private

First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
		similar group of clients nationally					
PAHO 2008	Argentina, Brazil, Chile, Cuba, Jamaica and Mexico	To convey some of the more innovative experiences to reform mental health services implemented in Latin America and the Caribbean	Mixed	Narrative style	Inapplicable	Inapplicable	Public
RIZZARDO 1986	Italy	To analyse the impact of the reform on health care delivery by the general practitioner in an urban district in the Veneto region.	Primary Care Centre	Descriptive Transversal	General practitioners working in a psychiatric service run by the University of Padua by 1983	24 general practitioners	Other: University facilities
ROSE 1979	USA	To analyse deinstitutionalization policy on the sector of community mental health care and review its accomplishments and difficulties.	Mixed	Narrative style	Inapplicable	Inapplicable	Mixed
ROSENHECK 2000	USA	To review the relationship between mental health service delivery and the community in which it is embedded.	CMHC	Narrative style	Inapplicable	Inapplicable	Mixed
SCHMIDT 2000	Canada	To examine how psychiatric rehabilitation fits within a remote First Nations community.	CMHC	Thematic analysis	service providers, consumers and family members of aboriginal people with severe mental illness living in northern British Columbia.	10 stakeholders	Public
SEMKE 1999	USA	To explore system outcomes of interventions that were aimed at lowering high use of long stay state hospitals.	Mixed	Descriptive Transversal	adults living in the Washington state who experienced one psychiatric hospitalization of 30 days or more, or three or more psychiatric hospital admissions during a “pre-reform” period (1988) or after implementation of reform interventions (between 1991 and 1993)	2.646.307 high utilizers of state hospitals	Public
SHEN AND SNOWDEN 2014	USA	To examine whether the institutionalization of deinstitutionalization policy changed the supply of psychiatric beds in 193 countries from 2001 to 2011.	Inpatient Units	Echological study	Mental health systems as units	193 countries	Public
STELOVICH 1979	USA	To describe factors related to	Inpatient Unit	Narrative style	Psychiatric patients transferred to	Inapplicable	Public

First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
		deinstitutionalization leading to transfer mental health service delivery from civil mental health hospitals to prison facilities.			prison facilities in Massachusetts		
SWIDLER 1995	USA	To describe the political processes leading to the Community Mental Health Reinvestment Act passage, the obstacle overcome by legislative negotiators and implementation issues.	Mixed	Narrative style	Inapplicable	Inapplicable	Public
SYTEMA 1996	Italy and Netherlands	To compare the treatment of severely mentally ill patients in a community mental health service without the back-up of a mental hospital with the treatment provided in an institution-based system in which mental hospital are still predominant.	Mixed	Cohort study	Patient with schizophrenia that contacted a service at least once in 1988 or in 1989 in Groningen (The Netherlands) or South-Verona (Italy)	812 patients	Mixed
WASYLENKI 1995	Canada	To describe the authors' involvement in three service delivery projects in Ontario and discuss how, by assuming multiple roles, they were able to ensure that planning and policy development were informed by current knowledge.	Mixed	Narrative style	Inapplicable	Inapplicable	Public
WEISS 1990	USA	To analyze deinstitutionalization policies implemented in 1946 and 1963 in USA	Mixed	Narrative style	Inapplicable	Inapplicable	Public
WHO 2014	Malaysia, Japan, Ethiopia, Brazil, Nigeria, Uganda, UK, Iran, Italy, Portugal, Cambodia, Philippines, Spain, New Zealand, Usa, Sri Lanka, Chile, India, Republic of Korea, The Netherlandands, Zambia, Indonesia, Tanzania,	To capture lessons learnt from those who have been involved directly with deinstitutionalization and/or expanding community-based services and identify innovative strategies and methods associated with success of this process.	Mixed	Mixed Methods	mental health experts involved directly with deinstitutionalization and/or expanding community-based services	78 people	Public

First Author And Year	Country	Aim of study	Setting	Study Design	Type of end user or participant	Number of participants	Provider Type
	Singapore, Lithuania, Australia, Georgia, Vietnam, South Africa, Ghana, Sweden						

* CMHC: Community Mental Health Centre; ED: Emergency Department

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Table 5
Barriers to the process of psychiatric deinstitutionalization

Category	Descriptive themes	References
1. Planning, leadership, and funding	Mental Health Policy: Responsibility/ accountability	Rose, 1979
	Reform fragility: charismatic leadership	PAHO, 2008
	Reform fragility: Lack of synchronization between bed reduction and development of CBMHSs	Freedman & Moran, 1984; Shen & Snowden, 2014
	Reform fragility: Unaccountability of failure	Freedman & Moran, 1984; Rose, 1979; Rosenheck, 2000
	Funding: Continuity of community care	McCubbin, 1994; Mechanic & Rochefort, 1990; PAHO, 2008
	Funding: Hospital funds not reallocated to CMHS	Fakhoury & Priebe, 2002; PAHO, 2008
2. Knowledge / Science	Conceptual limitations and ambiguities	Bennett & Morris, 1983; Fakhoury & Priebe, 2002; Freedman & Moran, 1984; Mallik et al., 1998; McCubbin, 1994
	Evidence: Lack of evidence on DI processes	Shen & Snowden, 2014
	Lack of research and innovation on alternatives to institutionalization	Bennett & Morris, 1983
3. Power, interests, and influences	Irrelevance of Mental Health in the political/ policy agenda	Mechanic & Rochefort, 1990; PAHO, 2008; Semke, 1999
	Market factors fostering re-institutionalization	Barton, 1983; Dorwart et al., 1991; Fakhoury & Priebe, 2002; Freedman & Moran, 1984; Rose, 1979
	Uncoordinated and fragmentary advocacy actions.	McCubbin, 1994; Mechanic & Rochefort, 1990; Rosenheck, 2000
	Vested interests: Pharmaceutical	McCubbin, 1994
4. Services and supports in the community	Centralized System	Kleiner & Drews, 1992
	Patients: Challenging behaviours	Allen et al., 2007
	Patients: Old Age	Barry et al., 2002
	Services: Hospital centric models and practices	Bennett & Morris, 1983; Kaffman et al., 1996
	Early discharge	Kleiner & Drews, 1992; Stelovich, 1979
	Services: Lack of services and support in the community	Fakhoury & Priebe, 2002; McCubbin, 1994; Oshima & Kuno, 2006; Weiss, 1990
	Housing: Inadequate, insufficient	Grabowski et al., 2009; Mechanic & Rochefort, 1990; PAHO, 2008
	Dependence on disability benefits and/or pensions	Chopra & Herrman, 2011; Freedman & Moran, 1984; Manuel et al., 2012
	Patients: Disempowerment / Fatalism	Chopra & Herrman, 2011
	Insufficient Public Support	Manuel et al., 2012
	Patients: No money	Goering, 1984
	Clashing views on DI within the Workforce	Kleiner & Drews, 1992; PAHO, 2008
5. Workforce	Shortages in general	Fakhoury & Priebe, 2002; Schmidt, 2000; Shen & Snowden, 2014; WHO, 2014
	Shortages of specific professions	Ash et al., 2015

Category	Descriptive themes	References
	Inadequate training	Barton, 1983; Mayston et al., 2016; PAHO, 2008; WHO, 2014
	Moral concerns and fears	Ash et al., 2015; Kleiner & Drews, 1992; PAHO, 2008
	Pessimism	Aggett & Goldberg, 2005; Cohen, 1983; Kleiner & Drews, 1992
	Practices of exclusion	Bryant et al., 2004; Chakraborty et al., 2011
	Stigma in workforce	Barton, 1983; Semke, 1999
	Vested interests: Workforce	Shen & Snowden, 2014; Swidler & Tauriello, 1995
6. Communities and the public	Communities are hostile towards users	Aggett & Goldberg, 2005; Bredenberg, 1983; Fakhoury & Priebe, 2002; O'Doherty et al., 2016; PAHO, 2008
	Communities are ill prepared to integrate users	Bredenberg, 1983; Fakhoury & Priebe, 2002
	Public acceptance of social control	Allen et al., 2007; Fakhoury & Priebe, 2002; Swidler & Tauriello, 1995
	Stigma & self-stigma	Aggett & Goldberg, 2005; Chan & Mak, 2014; Fakhoury & Priebe, 2002; Manuel et al., 2012; Mechanic & Rochefort, 1990; O'Doherty et al., 2016; PAHO, 2008
7. Family / Carers	Broken ties between families and services	Aggett & Goldberg, 2005
	Lack of support and/or unfair expectations towards families	Barton, 1983; Yip, 2006; Lavoie et al., 2012; Mechanic & Rochefort, 1990; Oshima & Kuno, 2006
	Scepticism and Opposition from families	McCubbin, 1994; Oshima & Kuno, 2006

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Table 6
Facilitators to the process of psychiatric deinstitutionalization

Category	Descriptive themes	References
Planning, Leadership and Funding/ Economic aspects	Centralized governance of the process	PAHO, 2008
	Austerity and fiscal pressure	PAHO, 2008
	Disability insurance	Mechanic & Rochefort, 1990
	Economic incentives for DI	Mechanic & Rochefort, 1990
	Fiscal strain on state mental hospital	Mechanic & Rochefort, 1990; O'Doherty et al., 2016
	International policy networks and advocacy	PAHO, 2008
	Intersectoral alliances and coordination	PAHO, 2008
Knowledge/Science	Available evidence about alternatives	Weiss, 1990
	Conceptual Clarity	Freedman & Moran, 1984; Kleiner & Drews, 1992; McCubbin, 1994
	Documented Experience	Shen & Snowden, 2014
	Evidence of human rights violations	PAHO, 2008
	Intellectual cross fertilization towards CBSs	Mechanic & Rochefort, 1990; PAHO, 2008
	Knowledge of effects of institutions on individual patients	Anderson et al., 1998; Bennett & Morris, 1983; Kleiner & Drews, 1992; Mechanic & Rochefort, 1990
	Psychopharmacological developments	Anderson et al., 1998; Bennett & Morris, 1983; Bredenberg, 1983; Freedman & Moran, 1984; Kleiner & Drews, 1992; Mechanic & Rochefort, 1990; Weiss, 1990
Power, interests and influences	Human rights legislation	Anderson et al., 1998; PAHO, 2008
	Influence of civil rights movements	Mechanic & Rochefort, 1990; PAHO, 2008
	Legal limitations to commitment/coercion	Freedman & Moran, 1984; Mechanic & Rochefort, 1990;
	Legal push towards community-based treatments	Freedman & Moran, 1984
	Legal standards for facility construction/operation	Anderson et al., 1998
	MH Legislation	Freedman & Moran, 1984; PAHO, 2008; Shen & Snowden, 2014
	Advocacy from professional organizations/groups	Weiss, 1990; WHO, 2014
	International policy pressure	Shen & Snowden, 2014
Services and supports in the community	Service-user movements and demands	Anderson et al., 1998; Kleiner & Drews, 1992
	Comprehensive & structured network of CB services	Cohen, 1983; Conway et al., 1994; Evans et al., 2012; Lamb & Goertzel, 1977
	Continuity of care	Sytema et al., 1996
	Income for patients	Alakeson, 2010
	Individualization of care in the community	Kalisova et al., 2018
	Integration of mental health in PHC	Evans et al., 2012; John et al., 2014; Kraudy et al., 1987; PAHO, 2008
	Limit readmission by closing beds	PAHO, 2008
	Recovery-based services in a psych ICUs	Ash et al., 2015
	Scale up of outpatient services	Abas et al., 2003; Bennett & Morris, 1983

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Category	Descriptive themes	References
	Self-directed support: Autonomy in the use/ selection of services	Alakeson, 2010
	Shared decision making and service user involvement	Chan & Mak, 2014
	Supporting PHC expertise to raise service-user confidence	Huang et al., 2017
	Social Help	Lamb & Goertzel; 1977
Workforce	Anti-stigma practice	Huang et al., 2017; Matsea et al., 2019; Mayston et al., 2016
PHC training	PAHO, 2008	
WF training	Wasylenki, 1995, Weiss, 1990	
Exogenous factors	Exogenous shocks (disasters, war)	Stelovich, 1979
	Re-democratization	Rizzardo et al., 1986