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Research Article

Mainstreaming Mental Health Care in 42 Countries

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CONTENTS

Introduction

Methods

Results

Discussion

Conclusion

References

Abstract—Global consensus and national policies have emphasized deinstitutionalization, or a shift in providing mental health care from institutional to community settings. Yet, psychiatric hospitals and asylums receive the majority of mental health funding in many countries, at odds with research evidence that suggests that services should be delivered in the community. Our aim is to investigate the norms, actors, and strategies that influence the uptake of deinstitutionalization internationally. Our study is informed by prior literature on management and implementation science. The success and failure of mental health care operations depend on identifying and overcoming challenges related to implementing innovations within national contexts. We surveyed 78 experts spanning 42 countries on their knowledge and experiences in expanding community-based mental health care and/or downsizing institution-based care. We also asked them about the contexts in which said methods were implemented in a country. We found that mental health care, whether it is provided in institutions or in the community, does not seem to be standardized across countries. Our analysis also showed that moving deinstitutionalization forward requires meaningful engagement of three types of actors: government officials, health care professionals, and local experts. Progress toward deinstitutionalization depends on the partnerships formed among these actors and with diverse stakeholders, which have the potential to garner resources and to scale-up pilot projects. In conclusion, different countries have adapted deinstitutionalization in ways to meet idiosyncratic situations and population needs. More attention should be given to the management and implementation strategies that are used to augment treatment and preventive services.

Keywords: deinstitutionalization, expert survey, health care management, implementation science, mental health systems

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INTRODUCTION

Health care management is a critical yet often overlooked element in strengthening health systems and, in turn, serving different populations with mental, neurological, and

substance use (MNS) disorders. MNS disorders accounted for 7.4%¹ and 13%² of disability-adjusted life years in 2010 and 2013, respectively. Access to mental health services is inadequate in many low- and middle-income countries (LMICs) despite the heavy burden of MNS disorders: with a treatment gap of up to 90% in LMICs versus 50% in high-income countries (HICs).³⁻⁵ A high treatment gap has dire economic consequences globally, with mental health cost estimates of 2.5 trillion USD annually in 2010, projected to rise to 6 trillion USD annually by 2030.⁶ National governments have responded by reconfiguring their mental health systems to meet professional norms, population needs, resource availability, and local circumstances.^{7-10,[a]} *Deinstitutionalization*, as defined by the US National Library of Medicine and in this study, is the process of shifting the locus of mental health care from institutional to community settings.¹¹ Deinstitutionalization now has strong global support, but the means to achieve this goal differ by country,¹²⁻¹⁴ so in this study we systematically compare 42 countries' experiences with deinstitutionalization.

Building managerial capacity in resource-poor settings is critical. The resources allocated to preventing and treating MNS disorders are not commensurate with their collective burden on society, especially in LMICs, which typically spend less than 3% of their health budgets on mental health.¹⁵ Of the mental health budget, over 80% is earmarked for mental hospitals.¹⁶ Sound resource allocation and decision making are needed in order to transform the overall mental health system.⁹

Concerns over budget misspending and infringement of human rights have stimulated a broad array of initiatives aimed at improving the quality of mental health care. Mental hospitals and asylums have been the dominant infrastructural model historically, yet they are the most costly provider facilities. Mental hospitals and asylums are often places where patients are secluded, restrained, and housed against their will in locked, crowded, and unhygienic conditions.¹⁷ Despite this, they tend to have high institutional inertia because they are historically rooted.¹⁸⁻²² Finally, they operate on a high marginal cost per service user—resources that could be better used for community-based services.²³⁻²⁵ Therefore, one of the key tenets of deinstitutionalization is for mental health care to be provided through service outlets accessible to the general population.²⁶⁻²⁸

Deinstitutionalization is, at its core, an intervention that disrupts the existing order of established national health systems. The World Health Organization (WHO) developed a Pyramid Framework to guide its member states on how to find the *optimal mix* of mental health services.²⁹ This

Pyramid Framework is organized such that the majority of mental health care would be provided through informal services and self-care and the minority through formal services. The range of services is based on service cost and frequency of need in each country. Long-stay facilities and specialist services impose the highest cost yet serve a small sub-set of the general population with severe and persistent mental illness. Indeed, research from HICs has shown the benefits of minimizing the number of long-term inpatient facilities and putting, in its stead, a mix of service outlets.³⁰⁻³² However, the overarching strategy to improve mental health care does not seem to be uniform across countries. A WHO–Gulbenkian Foundation joint report enumerated a myriad of methods used to either downsize institution-based services or to expand community-based services in LMICs.³³ Furthermore, the implementation of these methods requires adequate staffing and individual competency to translate and to deliver clinical knowledge.³⁴ Health workers and organizations alike have to meet the functional demands on them and to evolve their practice within the environments in which they are embedded.³⁵⁻³⁷

Our aim is to investigate the norms, actors, and strategies that influence the uptake of deinstitutionalization internationally. In this article, we pose two study questions. Then we elaborate on three emergent themes that we draw from to extend and build cross-cultural management and implementation science theories.

Research Questions

Much of the cross-national variation in mental health system reform can be explained by processes in which deinstitutionalization enters and unfolds within countries, though unfortunately there has been limited attention in the sub-fields of cross-cultural management and implementation science on deinstitutionalization. The WHO's 194 Member States voluntarily adopted the Mental Health Action Plan 2013–2020 during the 66th World Health Assembly.²⁶ However, countries do not generally make predictable, institutionalized responses to soft coercive pressures from international organizations.^{38,39,[b]} Countries have enacted mental health policy⁷ but not necessarily changed system structure¹⁸ to conform to the WHO's recommendations or to evidence-based guidelines. This is problematic given the scarce financial resources that flow through health systems and the complexity of daily operations of mental health care.

Management is recognized by the WHO as part of service delivery, one of the six building blocks necessary to strengthen health systems,⁴⁰ and is defined as the use of

human, financial, and technical resources to achieve predetermined objectives.^{41,42} It can be used to augment clinical interventions (i.e., medication, psychotherapy) by improving individual worker outcomes (e.g., motivation, turnover) and organizational outcomes (e.g., organization culture, effectiveness). Existing empirical evidence has demonstrated that efforts to build the management capacity in health facilities and of health teams can improve the performance of LMICs' health systems.⁴³⁻⁴⁶ This leads to the first research question: What managerial know-how has helped augment the implementation of deinstitutionalization interventions?

Implementation science provides a second lens to advance global mental health. Implementation science is the study of methods that are used to integrate evidence into policy or practice.^{47,48} Damschroder et al.'s⁴⁹ and Proctor et al.'s⁵⁰ frameworks are useful in differentiating the content of interventions (i.e., what they do), the implementation of those interventions (i.e., how it is done), and ways to make the interventions sustainable and scalable. Treatment and prevention packages for MNS disorders with high clinical efficacy and cost-effectiveness have been developed for LMICs,^{51,52} but it takes an average of 17 years for 14% of research to be translated into practice^{53,54} because the research conditions of implementation projects may deviate from the real-world context of service delivery.^{55,56} Based on this point, we address a second research question in this study: What are the factors behind the implementation of deinstitutionalization interventions in policy translation and in routine practice?

Our respondents reported barriers on multiple levels of analysis. We took stock of three factors that interact to influence implementation strategies: the external environment (i.e., finance mechanism, political administration); the structure of the organization (i.e., institution, community based); and the processes used by individuals (i.e., bottom-up versus top-down decision making). These multilevel effects could

either be aligned synergistically or compete with one another to frustrate the achievement of deinstitutionalization.

METHODS

We developed the survey and conducted sample recruitment in three phases. During phase 1 (July to December 2012), we reviewed the peer-reviewed and grey literature on deinstitutionalization as we developed our survey. We piloted the survey among three WHO staff members. In phase 2 (December 2012 to February 2013), we contacted 76 experts from a list provided by the WHO Mental Health and Substance Abuse Department. We asked them whether they have been involved in strategic work or management of expanding community-based mental health services and/or downsizing hospital-based care ("doer") or whether they have studied and commented on these areas ("observer"). We also asked them to provide two additional names of doers or observers for this study, a snowballing technique. We only invited doers to take our survey because they hold the judgment and tacit knowledge necessary to integrate organizational learning activities within the broader societal context. In phase 3 (February to May 2013), we emailed an English-language survey to 152 people. Survey respondents were asked to list up to five countries they have knowledge and experience about deinstitutionalization in and to complete the survey for one of the countries. Of them, 78 completed our survey and returned it electronically (52% response rate).^[c] The University of California at Berkeley Committee for Protection of Human Subjects approved our study protocol (#2012-07-4514).

We designed the survey so that deinstitutionalization could be compared across countries.⁵⁷ A comparative case study is appropriate because the responses reflect not only institutional logic but also societal logic in the pursuit of deinstitutionalization.⁵⁸ A copy of the survey is included in Appendix 1. The statements that were provided for questions 3a, 3b, 4a, and 4b

3a. Reflecting on your experiences, could you please share with us *methods*^a to expanding community-based mental health care and/or downsizing institution-based services that *you believe have been effective*?

3b. Please tell us *what went well* during the work on reorganizing and/or developing mental health services described in 3a.

Instructions: please describe in some detail (e.g., 200 words). If possible, please add references or attach any documents that describe any of your experiences relevant to the above.

4a. Reflecting on your experiences, please share with us *methods* to expanding community-based mental health care and/or downsizing institution-based services that *you believe have failed*?

4b. Please tell us *what did not go well* during the work on reorganizing and/or developing mental health services described in 4a.

Instructions: please describe in some detail (e.g., 200 words). If possible, please add references or attach any documents that describe any of your experiences relevant to the above.

^aFor examples of methods, please see question 5.

TABLE 1. Copy of Four Key Questions from the Survey

(repeated in Table 1) were entered and coded for this study. We also triangulated data collected from their written responses with published and unpublished documents they provided.

The primary author (GS) conducted the qualitative analysis with a research assistant. We used abduction,⁵⁹ or the process of finding explanations about deinstitutionalization based on associating data with ideas from management and implementation science theories. We indexed all surveys collected using HyperRESEARCH software (Researchware, Inc., Randolph, MA, USA). We familiarized ourselves with the data, independently compiled a list of codes, and then integrated the two lists of codes with due consideration to the two research questions. Each of us independently assigned codes to lines, paragraphs, or segments. We discussed discrepancies and settled them by consensus during meetings. Appendix 2 contains a list of the concepts, codes, and their definitions that we followed to analyze 46,230 words. We developed themes based on comparing statements and observations⁶⁰; each theme suggests a relationship among concepts, which link multiple codes.⁶¹ We draw on our findings to build and extend theory.⁶²

RESULTS

We summarize the descriptive statistics of the 78 respondents in Table 2. The respondents' average professional tenure, academic degree(s) held, and organizational affiliation(s) further demonstrated their qualification as experts on service provision for MNS disorders. We show in Figure 1 that our respondents represent 42 countries, which span all four World Bank country income groups and six WHO regions. Appendix 3 contains the same codes in Appendix 2 and their valence frequency. Three main themes emerged through our qualitative analysis: Theme 1 addresses the first research question and themes 2 and 3 address the second research question.

Theme 1: Disagreements about the Means to Deinstitutionalization

Shifting the locus of mental health care has become an important national goal as actors aim to improve population health by addressing mental health-related needs, improving their quality of care and health outcomes, and reducing costs. The tenets of deinstitutionalization are enshrined in guidelines, reports, and research articles. However, little is known about the norms, or patterns of social behavior, typical of actors who are developing new institutional arrangements that radically depart from existing ones.⁶³ What are the vocabularies, logics, and meaning structures that they have used in the pursuit of transforming mental health care in their

	N (%) rounded)	
Country income group (World Bank)		
Low	18	(23)
Lower-middle	28	(35)
Upper-middle	13	(16)
High	20	(25)
Geographic region (World Bank)		
East Asia and Pacific	16	(20)
Europe and Central Asia	20	(25)
Latin America and Caribbean	7	(9)
Middle East and North Africa	4	(5)
North America	1	(1)
South Asia	11	(14)
Sub-Saharan Africa	20	(25)
Geographic region (World Health Organization)		
African	20	(25)
Eastern Mediterranean	6	(8)
European	19	(24)
Americas	8	(10)
Southeast Asia	12	(15)
Western Pacific	14	(18)
Gender		
Male	57	(72)
Female	20	(25)
Highest degree obtained		
Bachelor's	6	(8)
Master's	13	(16)
Medical doctor	25	(32)
Doctorate	11	(14)
Other	9	(11)
Current affiliation		
Government	29	(37)
	Full-time	18 (62)
Part-time	9 (31)	
International NGO	16	(20)
	Full-time	6 (38)
Part-time	8 (10)	
National/local NGO	31	(39)
	Full-time	12 (39)
Part-time	17 (55)	
Academia	34	(43)
	Full-time	16 (47)
Part-time	17 (50)	
International organization	8	(10)
	Full-time	3 (38)
Part-time	4 (50)	
User or family association	6	(8)
	Full-time	4 (67)
Part-time	2 (40)	
Other	12	(15)
	Full-time	1 (8)
Part-time	11 (92)	
Other (in years)		
	Mean	Standard deviation
Age	52.7	±10.3; n = 77
Tenure	24.3	±11.4; n = 76

TABLE 2. Demographic Characteristics of Survey Respondents.
^aMore than one affiliation might apply

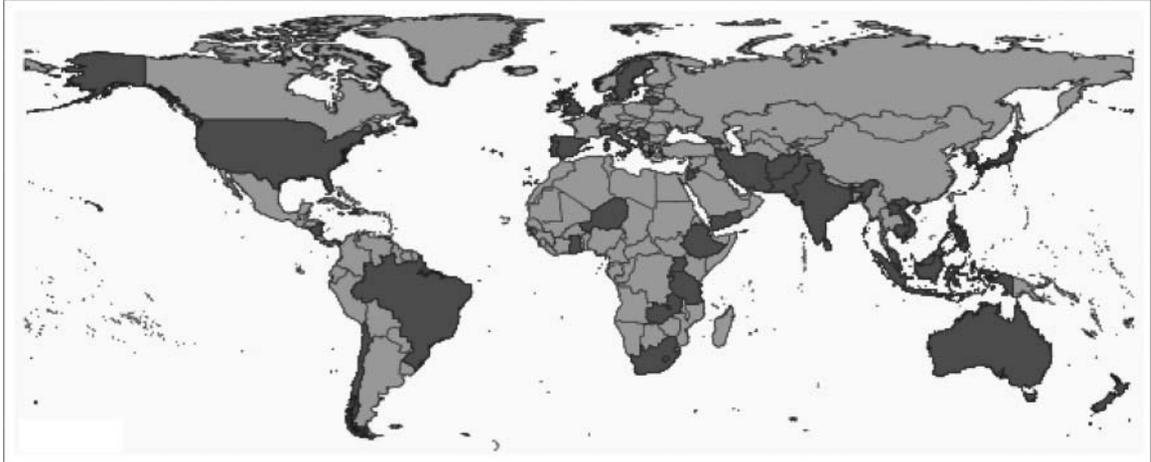


FIGURE 1. Countries Represented in the Survey

country? Here, we present a set of norms about institution-based care and another about community-based care that are common across countries.

Primacy of Downsizing or Closure of Institution

Respondents corralled around two main sets of methods: drastic downsizing or closure of psychiatric hospitals and improvements made to existing infrastructures. Their sentiment regarding a decrease in the centrality of psychiatric hospitals and asylums is stronger than other changes made within mental health systems.

The rationale for deinstitutionalization is clear:

The psychiatric hospitals were big and in quite bad conditions that they easily promote the feeling of urgency for a change among the “reformers.” (R8, Jordan)

Hundreds of such stable persons with mental illness are stuck in these institutions for years. On the other hand, those needing hospital care do not get admission, for want of beds. Over-crowding and inadequate budget allocation/support staff result in poor amenities and shoddy services in the institutions. (R32, Australia)

Respondents also expressed a dogmatic focus on either downsizing (seven respondents) or closure (five respondents):

When it came to downsizing mental hospitals it was felt that this is too simplistic a recipe which is not taking into account the fact that often these might be the facilities providing services in a whole region and the social safety networks are nonexistent. (R47, Pakistan)

The target must be closure, not downsizing, because implementation of community services by keeping mental

hospitals, albeit reduced in size, produces a costly two-tiered system. (R6, Italy)

The imperative is to develop alternative sources of clinical care while downsizing or closing psychiatric hospitals.

However, we observed a divergence in other formalized care. Mental health services can be decentralized and reconfigured by establishing community mental health centers or clinics (13 respondents), increasing the number of beds in psychiatric units of general hospitals (23 respondents), or integrating mental health care in primary care settings (27 respondents). But these measures did not necessarily have a focus on continuous quality improvement:

The fast process without careful planning has caused several shortcomings; that is, concerning buildings’ architecture, joining several services (old and innovative) into one facility without much space, lack of long-term care beds. (R57, Georgia)

Patients are abandoned as a result of budgetary, staff, and space constraints, as recounted to us by two other respondents from Lao and Nicaragua. The burden to overcome these constraints falls on managers, as is the case for a psychiatric nursing program in Ethiopia, yet managers are underqualified to be serving patients with mental health needs:

The hospital management had no particular knowledge or training in MH [mental health] services organization or MH services needs. This made it often difficult to discuss new needs and demands from the Department of Psychiatry. (R31, Portugal)

The standardization of care requires the following know-how, according to our respondents: discharge planning (eight respondents); case management (two respondents); new

admission procedures (11 respondents); referral and back referral process (13 respondents); and financial and administrative autonomy. Setting up a network of care requires a concerted effort to overcome the key barriers respondents identified.

Imperative for Community-Based Services

The development of “shadow community services,” as a UK respondent said, is paramount for those living in the community. Another respondent stated why clinical services that provide medication and psychotherapy are not enough:

Community services are a tripod of clinical, disability support (usually NGO [nongovernmental organization]) and stable accommodation; not just clinical services. (R33, Australia)

Institution-to-community transition programs should also encompass rehabilitative services (14 respondents) that would address comorbid conditions and psychosocial problems and wrap-around services (18 respondents) that would support employment and housing needs. Furthermore, 28 respondents described outreach efforts involving nurses, community health workers, and/or multidisciplinary care teams. Providers provided consultations, diagnoses, and treatment in hard-to-reach, especially rural, areas by traveling on motorcycles or providing mobile clinics.

Even though these interventions are often not formalized—for instance, as Assertive Community Treatment^[d]—they have helped health care providers sharpen clinical assessments and improve the quality of case management through closer interactions with individuals and with families. Community outreach also has other tangible results, such as increasing the number of patients who visited health centers for treatment in Uganda. Likewise, other respondents reported improvements in case detection, readmissions, first aid, and disease monitoring. Moving from being an early adopter of deinstitutionalization to mainstream reformer seems to require creative responses to challenging contexts. But respondents did not clearly specify what the requisite community-based services are from the potpourri of responses reported.

Theme 2: Committed Engagement by Key Actors

Deinstitutionalization involves collective effort by state and nonstate actors for a considerable amount of time and frequently under trying circumstances.^{14,64} We find that buy-in, engagement, and ownership from three types

of actors—government officials, health care practitioners, and researchers—are necessary for improvements to mental health care delivered nationwide and to population health.

Limited Political Support

Mental health systems are often configured according to the formalized structures of the government. Therefore, respondents spoke at length about the need for political leaders to have “will,” “vision,” “commitment,” and “ownership.” These respondents gave summaries as to why political support is crucial in their country:

With no political will, things don’t go ahead. Besides, at the ministry of health level this [deinstitutionalization] is never a great priority and if problems and conflicts emerge, they will prefer to avoid them. . . . With this I say, decisions must be supported at the highest possible level, involving most levels possible, and with the enough political and budgetary support. (R52, Chile)

Mental health policies, laws, and action plans cannot be implemented without the support of leaders, or attempts to do so may be delayed.

Leadership from sub-national governments is likewise needed in order to make transformational change:

The decentralization of government system in the Philippines in the mid-90s is a major hindrance in advocating for health programs, especially the mental health. The lack of control and/or supervision over the local government units by the Health Department made it very hard to promote the community mental health program. . . . A good number of local chief executives considers MH not their concern because of other more pressing problems. (R75, Philippines)

Respondents from six other countries also reported similar resistance in their mental health reform processes.

Professional Resistance

Deinstitutionalization fundamentally challenges the status quo and, therefore, health care providers and managers can perceive it to be inimical to their interests. They generally viewed the downsizing or closure of hospitals as threats to their financial stability, power, and prestige.⁶⁵ Therefore, they have acted as a powerful contingent in obstructing change, sometimes with the assistance of labor unions:

The first attempt to expand service in a community and downsize Accra Psychiatric Hospital in 1998 was met with a strong resentment from the psychiatric nursing staff who didn't want to leave the hospitals for the community care. (R9, Ghana)

Administrative and clerical staff of mental hospital remained very hostile towards the closure throughout whole process. (R6, Italy)

Professional resistance is a hindrance to the deinstitutionalization process.

Health care practitioners can be staunch opponents of deinstitutionalization, given the radical challenge it can pose to the entrenched biomedical model:

The hardest thing in the process was battling very rigid attitudes of the professionals and their reluctance for any changes in the way of their work. Inability to allow for the inclusive way of thinking as a consequence of the long-term exposure to the medical model of disability embodied in the professionals. (R11, Serbia)

Deinstitutionalization was likewise viewed as a challenge to the biomedical approach in Indonesia, India, Sri Lanka, and Vietnam. Respondents noted that general health practitioners resented the entry of mental health into their practice, partly due to the undesirable addition to their workload and training. Physicians were skeptical of the participation of non-physicians (e.g., nurses, community health workers) in mental health care. Professional resistance is amplified by the chronic shortage of qualified mental health workers.⁶⁶

Although interest groups in favor of the status quo tended to be more powerful than those in favor of reform, respondents did report some positive responses and efforts to promote reform. Attitudes of practitioners were not unanimously negative. In Italy, practitioners made strong commitments to deinstitutionalization and gave administrative and political support. In Spain, dedicated practitioners pressured biomedical institutions to change through strikes and formation of professional societies. In Chile, Hospital Psiquiátrico Sanatorio el Peral favored a community mental health approach, and a network of allied mental health practitioners was formed as a result. In Rwanda, hospital administrators and government officials showed support for the provision of mental health service in the post-genocidal context. In Ethiopia, health care practitioners worked with international NGOs to provide psychosocial support and to make referrals to specialist care in some rural communities.

Evidence-Lite Decision Making

An epistemic community is a network of local researchers who are involved in the process of deinstitutionalization in their country.^{68,69} Respondents generally agreed on the utility of research in furthering deinstitutionalization.

Local experts helped find the means to achieve deinstitutionalization, once this policy goal had been selected. Alone or with colleagues, local experts conducted many types of research: epidemiology research in Ethiopia, needs assessments in the Philippines and in Cambodia, situation analyses in Ethiopia and Tanzania, and quality improvement research in Rwanda. These experts went about gathering facts in a formalized and technical manner, as was the case in Rwanda:

It was felt that the team should have a greater commitment to a "change management process" focusing on the care of patients, starting with increased focus on quality improvement at the district hospital level, and with greater emphasis on measurable outcomes. This improvement at the hospital level was expected to trickle down to the health centers as patients are followed by the team to the community. (R79, Rwanda)

However, knowledge that would inform future implementation of deinstitutionalization was not always gleaned from places where pilot programs were implemented:

Unfortunately, there are no mechanisms to study, evaluate and share these models within the country. Some of these models have almost disappeared without us learning from them. Poor research and reporting too could be factors. (R30, Sri Lanka)

Detailed analysis of the attributes and needs of the patients and systematic investigations to characterize the needs of the community were lacking, according to two respondents from the UK and Haiti. Furthermore, none of our study data seemed to indicate that monitoring and evaluation were conducted routinely. Makers of mental health policy did invoke scientific evidence in Australia, Jordan, Albania, Zambia, Haiti, and Uganda.

Theme 3: Partnership Formation as a Key Implementation Strategy

Deinstitutionalization often happened under severe resource constraints, so the dispersal of an innovation ultimately requires context-appropriate strategies to be coupled with imported technical specifications. Actors formulated and reformulated implementation strategies to suit different

environments over time.⁶⁹⁻⁷¹ Their objectives are not only to introduce new interventions but to sustainably improve the quality of mental health care. Our respondents viewed the establishment of strong relationships as a cornerstone for prompting and sustaining progress.

Cooperation from all levels of government was cited as an enabling factor to deinstitutionalization. Respondents described top-down decision making within their mental health system:

The health system has too many interphases at national, provincial and district level. The translation of legislation and policies is not consistent at all these levels. (R66, South Africa)

Though national governments tended to be responsible for the translation of mental health policy, plans, and law, they did not control the actions of lower, sub-national-level governments.⁷²

Secondarily, deinstitutionalization is not merely a matter of concern for the health sector:

In short, there is a general (false) belief that the burden of mental health issues is solely for the mental health services (in the health department), and each of the related departments tends to work in a vertical column approach without having horizontal connections or inter-sectoral coordination. (R67, Sri Lanka)

Other respondents discussed the value of collaboration with education, social services/welfare, agriculture, information, law enforcement, and courts within the public sector.

With bottom-up planning, respondents referred to a scale-up of successful pilots from a jurisdiction to a broader sub-national level. An example from Jordan offers inspiration for the possibility of change:

The small project was about the development of the first community mental health center, as recommended from a comprehensive needs assessment. Staying initially away from the psychiatric hospitals, and establishing first a successful experience of an alternative model of care such as the community mental health services brought visible and exciting results with a small financial investment. This decision allowed also to not immediately and directly threaten the leadership and the exclusive role of the psychiatric hospitals and of the psychiatrists and therefore to not raise their strong resistance at the initial stage of the project. (R8, Jordan)

Wagner et al.⁷³ and Berwick⁷⁴ consider health care delivery to be a process where top-down mandates and bottom-up innovations occur iteratively and cyclically. Respondents'

accounts, however, suggested that this was not often the case, due to disruptions in either direction or to a lack of feedback.

With regard to health care practitioners, a respondent from Malaysia suggested the benefit of building a "network of like-minded mental health professionals." Such a network grew out of a professional training program in Portugal. Relationships among service providers were often formalized into networks (Malaysia, Portugal), coalitions (Australia), alliances (Sri Lanka), steering committees (Jordan), community-based partnerships (Laos), and systems (Indonesia).

NGO advocacy is regarded as a crucial force: "Without NGO's nothing moves—they are the motor of change" (R63, Georgia). Furthermore:

Consumer advocates were often able to speak with a voice of lived experience and tell the story in a way which really facilitated wider within sector and within the community understanding. (R77, New Zealand)

The number of respondents who cited positive experiences (eight) in partnership outnumbered the number of ambivalent (seven) and negative (one) experiences.

Although involving diverse "local champions" (R8, Jordan) makes planning processes lengthier and more laborious, our respondents found that the buy-in was ultimately worth the time and effort invested. Interorganizational networks can promote innovations and sustain momentum in countries with few resources dedicated to mental health.⁷⁵⁻⁷⁸

DISCUSSION

Deinstitutionalization is inherently a coordinated effort across individuals, organizations, and sectors. Despite several decades of attempts to make mental health care more widely available in the community, progress has been uneven and slow, especially in LMICs.^{7,8} The manner in which it is implemented differs by country, so the granular information we presented about its characteristics, the role of key actors, and the influence of partnerships is valuable.⁷⁹

Respondents offered three distinct yet interacting actors responsible for mental health system transformation: government officials, health practitioners, and researchers. These are the actors that enable cross-national isomorphism.^{38,80} These actors have to come to a consensus on the appropriate deinstitutionalization goals (e.g., changes to institution- and/or community-based care) and means to attain those goals (i.e., managerial know-how), which vary significantly between countries. Respondents found it challenging to rally

support from senior leaders, but the payoff to mobilizing support at the highest and broadest levels was ultimately worth the effort. “Soft” political skills such as social astuteness, interpersonal influence, networking ability, and communication of sincerity can be vital for successful advocacy.⁸¹ The health workforce—health care providers and managers—must be committed to change because they can either be an asset or an obstacle to reform. As such, the health workforce and professional associations need to be consulted, motivated, organized, and equipped for change.⁸² Local experts analyzed risks and brokered knowledge as part of their influence on policymaking.⁸³ The formation of partnerships among these three forces is ultimately important in overcoming resistance, gaining financial investment, and pursuing evidence-based innovations through implementation. Future research might examine the mechanisms to elicit key actors’ commitment and the optimal configuration of partnerships’ professional networks that would drive activities around deinstitutionalization progress and sustainable community-based alternatives.

This survey has four main limitations. First, snowball sampling might mean that respondents shared the WHO’s goal for deinstitutionalization. However, we would not have had a broad geographical reach without these links, and many respondents did not have formal ties to the WHO. Second, we invited a wide range of mental health experts, but women, service users, and experts from the Americas and Eastern Mediterranean regions were underrepresented in our sample. Third, we surveyed in English only, but we were able to obtain responses from senior professionals fluent in English. Fourth, we provided respondents with a definition of deinstitutionalization that entailed shifting from one goal (i.e., downsize institutions) to another goal (i.e., expand other care outlets). However, we wrote the survey questions to be open-ended and piloted the survey because we recognize that there are other goals. Furthermore, we validated the survey responses we obtained by triangulating them against published and unpublished documents. The themes that arose from the data are thus intertwined and, in many cases, interdependent in practice.

Our respondents displayed a nuanced understanding of the complexity of deinstitutionalization. The majority of them, due to similarities in training or professional socialization, highlighted a scientific approach and were aware of current global norms. Our respondents emphasized the need for iterative learning for global norms to fit local circumstances. In this way, projects fielded in isolated locations were informed by a large reservoir of tacit knowledge.⁸⁴

CONCLUSION

LMICs vary in the extent to which they have enacted deinstitutionalization. Our results support the notion of *equifinality*, which is a concept from general systems theory that there are multiple paths to the same outcome or common end state.^{85,86} Societies have idiosyncratic institutional arrangements for coordinating mental health services. Top-down forces such as WHO guidelines and national policies precipitated deinstitutionalization in a country like Nicaragua, whereas bottom-up pilot projects were crucial in engendering change in a country like Jordan.⁸⁷ Many respondents were sensitive to the institutional context and social bonds that facilitated deinstitutionalization within a country and across countries.

Deinstitutionalization is disruptive, but it can be innovative too. Future researchers might examine further mechanisms of shifting the locus of mental health care, finding the optimal mix of services, and then involving providers to offer a continuum of care.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

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AUTHOR CONTRIBUTIONS

G.S. and J.E. designed the study and fielded the survey. G.S. subsequently performed the analysis. All authors were involved in the drafting of the article, and all authors read and approved the final article.

NOTES

- [a] This study is designed to focus on governments because they are the primary funders and providers of mental health services in LMICs. We did not preclude organizations of other ownership statuses from our analysis because a shift in the role that governments, especially HICs, have played in mental health system reform has been documented elsewhere.⁸⁸ In addition, consistent with the new public management literature,⁸⁹⁻⁹¹ many services that were formerly provided directly by governments are increasingly being provided by nongovernmental organizations that are either nonprofit or private entities as a way of improving efficiency and cost-effectiveness.
- [b] Coercion is a potential mechanism of policy diffusion,⁹² specifically mental health policy diffusion.⁷ Coercion can be hard or soft.⁹³ Hard coercion typically involves a manipulation of economic incentives or military force. Soft coercion can be hegemonic ideas and policy leadership. International organizations, governments, and nongovernmental actors can exercise either form of coercion. We contend that the WHO exercises soft coercion through the provision of information and expertise that shape its member states' mental health policy choices and changes they make to the mental health system structure.
- [c] Two respondents filled out the same survey for the same country, whereas a third respondent completed our survey for different two countries. We accepted these surveys as is.
- [d] Assertive Community Treatment (ACT) was developed in the early 1970s as a response to the closure of psychiatric hospitals. ACT is a clinically effective approach to managing the care of severely mentally ill people in the community.⁹⁴ ACT is a team-based approach aiming at keeping ill people in contact with services, reducing hospital admissions, and improving outcomes, especially social functioning and quality of life.

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