OUT OF SIGHT, OUT OF MIND

THE HUMAN RIGHTS CASE FOR ENDING INSTITUTIONALISATION IN MENTAL HEALTHCARE

UNITED FOR GLOBAL MENTAL HEALTH

INDEX

Executive summary 3

What is an institution? 4

Understanding institutionalisation 7
- How many people live in institutions and how long do they spend there?
- Why are people with mental health conditions being placed in institutions?

Institutions and the violation of human rights 12
- Involuntary admissions, treatment and coercion
- Seclusion, restraint and abuse
- Physical, psychological and sexual abuse
- Neglect and unsanitary living conditions
- Stigma, discrimination and community marginalisation

The impact of institutionalisation on care providers 20
- Families and caregivers
- Mental health professionals and the workforce

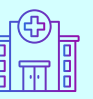
Ending institutionalisation using a human-rights-based approach 24
- Transitioning from institutions to community-based care
- Repurposing existing institutions using a person-centred approach
- Using a human-rights-based legislative and policy framework
- Recognising the crucial role of the mental health workforce
- Comprehensive planning and enabling sustainability

Recommendations from people with lived experience of institutionalisation 39

Methodology 40

Acknowledgements 42

8.4 million people are admitted to mental hospitals every year - more than people in prison for committing crimes.



66% of all government funding for mental health goes to mental hospitals

Less than 20% of mental health budgets are spent on primary and community based care in most countries

13% of people stay in institutions more than 1 year

7% of people stay in institutions more than 5 years

60% of people in institutions are male

EXECUTIVE SUMMARY

An estimated 8.4 million people are admitted to mental hospitals across the world every year. They are placed in these institutions for a variety of reasons, not all to do with having a mental health condition. And there are many more people who end up in other formal and non-formal institutions, including community-based institutions, who do not appear in the World Health Organisation (WHO) data. This means that, in any given year, there are more people in institutions for their mental health than there are people in prison for committing crimes.[1] People with mental health conditions are part of society and communities – they are mothers, fathers, sisters, brothers, grandparents, grandchildren, neighbours, colleagues. Institutionalisation removes them from those relationships and sources of support, sometimes for years at a time.

1 Global Prison Populations and Trends, A Focus on Rehabilitation (UNODC 2024)

Institutions as per the 2025 WHO guidance on mental health policy and strategic action plans:

Wherever the term 'institution' is used in this report, it is referring not only to long-stay mental hospitals or similar psychiatric institutions, which are traditionally classified as asylums, but all places where the practices and consequences associated with institutionalisation exist. These include some forensic hospitals, community and residential care homes, and prayer camps. This report presents a human-rights and evidence-based case against institutionalisation. It is designed to help parliamentarians and ministry officials bring about institutional reform, and implement legislation and policies to end institutionalisation.

It also provides first-hand accounts of the actual problems people face in institutions and sets out the changes those with lived experience want to see. It details implementable recommendations for reform based on those of the WHO, the UN Committee on the Rights of Persons with Disabilities (UNCRPD) and the Office of the High Commissioner of Human Rights (OHCHR).

The report echoes the WHO's calls for countries to systematically shift away from institutions to integrated networks of community-based care, where rights-based, recovery-oriented care is practised. It also calls for support to help individuals reintegrate into their communities and lead full lives, free from stigma and discrimination.

We recognise that the journey to reform is different in every context. In low-income countries, for example, incremental and financially feasible measures are likely to be necessary, while external financing is secured to support more resource intensive reforms.

Our research – including surveys and interviews with people who have lived or worked in institutional care – reveals those in institutions may face involuntary admissions and treatment, coercion, seclusion and restraint (involving inhumane practices, such as shackling and chaining). These problems – as well as the reported physical, psychological and sexual abuse, unsanitary living conditions, and neglect and understaffing – can all be addressed through rights-based policy reforms.
To end institutionalisation, we must find ways to help people with mental health conditions recover and connect. Once people are released from institutions back into the community they often face stigma and discrimination. They frequently struggle to establish social relationships, or find accommodation or employment. Through education, we can create a supportive society that recognises all of us experience mental ill health at certain points in our lives, but mental health conditions are not what define us.

When treating mental health conditions, institutions usually adopt a reductionist biomedical approach. They fail to address key factors promoting recovery, such as individual self-determination, free will, and the social determinants of mental health, as well as essential supports like community integration, social inclusion, and person-centred planning—critical elements of recovery that are rarely prioritised or adequately provided within institutional settings.

With the support they need to manage their mental health condition, people can return to living in their communities and, where possible, be reunited with their families. Ending institutionalisation recognises the important role families, friends, caregivers and the wider community can play in a person's mental health.

And helping people recover, return to society and live productive lives is also arguably a far more fulfilling role for health workers. Working in an environment where they witness or enforce seclusion and restraint, and see patients housed for the long-term without recovering, is demoralising. Health workers in frequently understaffed institutions are often overburdened and insufficiently trained. These are not ideal conditions in which to provide human-rights based, person-centred care.

Health workers play a crucial role in institutional care. So addressing the challenges they face can be a vital part of systemic institutional reform. It can also be an effective way to deinstitutionalise.

Governments can take several measures to end institutionalisation, as recommended by the WHO, including under objective 2 of the WHO Comprehensive Mental Health Action Plan (2013-2030)[2] WHO guidance and technical packages on community mental health services[3] as well as the WHO guidance on mental health policy and strategic action plans[4], by the WHO/OHCHR Mental Health, Human Rights and Legislation: guidance and practice[5], and by the UNCRPD Guidelines on Deinstitutionalisation,[6] such as:

2 WHO Comprehensive Mental Health Action Plan 2013-2030
3 https://www.who.int/publications/i/item/guidance-and-technical-packages-on-community-mental-health-services
4 https://www.who.int/publications/i/item/9789240106796
5 https://www.who.int/publications/i/item/9789240080737
6 CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies (2022)

- Gradually shifting care away from institutions towards a holistic approach to mental health care – as we're seeing in Brazil, for example. This shift would see a growing reliance on the entire health system, with a focus on networks of community-based care – supported by primary, secondary and, where needed, short-stay inpatient care, including in community centres (CAPs). All of this care would be provided in a rights- and evidence-based manner.

- Repurposing existing institutions (which are often based in a national capital or large city) toward community-based care using a human-rights-based, person-centred and recovery-oriented approach.

- Having a strong legislative and policy framework that strengthens community-based mental health care, calls for the end of institutionalisation, and protects the human rights of people with mental health conditions, including the right to make decisions about their care. Italy, Argentina and Indonesia offer some progressive examples other countries can learn from.

- Recognising the crucial role of the health workforce, and addressing shortages of staff and relevant skills in the mental health workforce through training and support, as we're seeing in Lebanon.

- Giving families and caregivers adequate financial and social assistance, helping them navigate and access appropriate services, providing them with relevant information and working to address the stigma they may face. This can involve offering support and, where appropriate, working with their loved ones to develop treatment and recovery plans.

- Ensuring community-based alternatives, as well as appropriate care pathways at primary and secondary levels, are developed as institutions are closed.

The fight to end institutionalisation can only be won by amplifying the voices of people who have experienced institutional care and the civil society organisations advocating for them. This report captures these perspectives from people living in 21 different countries across the globe, through a series of video interviews, quotes and survey responses. Their recommendations for ending institutionalisation are to:

1. **Prioritise human dignity in all mental health care settings and train professionals accordingly**
2. **Review and reform mental health legislation and policies to bring them in line with international human rights standards**
3. **Develop a separate operational plan and budget for ending institutionalisation**
4. **Increase government budgets for mental health service reforms, and invest in evidence- and community-based services**
5. **Implement a system of accountability for human-rights abuses in all care settings**
6. **Empower people with mental health conditions to participate in the process of ending institutionalisation, and promote their reintegration into the community with help finding paid work, as well as social support and mental healthcare**
7. **Train families and caregivers to provide care at home with the right support from mental health services**
8. **Fight stigma and discrimination against people with mental health conditions**
9. **Strengthen data collection on institutions and alternatives**

The report calls for the building of more supportive communities, the strengthening of the family unit, the empowering of the mental health workforce and the creation of a flourishing primary- and community-care centred health system. It demands the recognition and protection of the rights of people who have been locked away, out of sight and out of mind. It calls for an end to institutionalisation.

UNDERSTANDING INSTITUTIONALISATION
WHAT IS AN INSTITUTION?

Sociologist Erving Goffman defines the 'total institution' as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life".[7] He points out this "does not appear to align with the recovery oriented approach to health at all."

Building on Goffman's definition,[8] a synthesised review of the concept of institutions[9] found four defining features:

1. physical constructs that enable isolation
2. legislation and policy frameworks that limit rights and autonomy
3. a relationship of dependency between the staff member and the person
4. the behaviour exhibited by the person who has been 'institutionalised'.

The last of the characteristics concerns the phenomenon of 'institutionalism'. This is when social isolation or limited access to the outside world, coupled with the regimented lifestyle of an institution, may lead to individuals losing independence and a sense of responsibility to such an extent they are unable to manage life outside of the institution.[10] In other words their behaviour is changed. As a consequence, the end of long stays in any form of institution often result in readmission the same or to another institution, rather than recovery and reintegration into the community.[11]

7 Erving Goffmann - Asylums 1968
8 Goodman, Benny. (2012). Erving Goffman and the total institution. Nurse education today. 33. 10.1016/j.nedt.2012.09.012.
9 Chow, W.S., Priebe, S. Understanding psychiatric institutionalization: a conceptual review. BMC Psychiatry 13, 169 (2013)
10 Wing JK, Brown GW. Social treatment of chronic schizophrenia: a comparative survey of three hospitals. J Ment Sci. 1961;107:847
11 Finkel D, Bülow PH, Wiliñska M, Jegermalm M, Torgé CJ, ErnsthBravell M,Bülow P. Does the length of institutionalization matter? Longitudinal follow-up of people with severe mental illness 65 years and older: shorter-stay versus longer-stay. Int J Geriatr Psychiatry 2021;36(8):1223-1230.

It is worth noting that Goffman's definition of a total institution did not specify any particular type of care facility or time duration. And the four characteristics above do not only apply to mental hospitals – the type of facility on which countries most often submit data to the WHO. The institutionalisation of people with mental health conditions and psychosocial disabilities can take place anywhere these characteristics exist, including:

- long-stay institutions for children with disabilities
- social institutions
- prisons
- forensic hospitals
- rehabilitation centres for alcohol and substance use
- prayer camps and other faith-based healing centres
- group and nursing homes, homeless shelters and other residential and community support services and settings.[12]

There is ongoing debate on what constitutes institutions and institutionalisation. The latest WHO definition is included below.

THE WORLD HEALTH ORGANISATION'S DEFINITION OF AN INSTITUTION:

"Institutions are living environments where residents are separated from the broader community, are often isolated, and lack control over their lives and decisions affecting them. Such settings also often prioritize institutional over individuals' needs. Institutions may include standalone psychiatric hospitals, social care homes, and other facilities where people experience these restrictions. Even small, community-based facilities can be considered institutional if they impose rigid routines, restrict autonomy, and fail to promote genuine community inclusion."

WHO Guidance on mental health policy and strategic action plans 2025[13]

In this report, whenever the term 'institution' is used, it refers to anywhere a person with mental health conditions or psychosocial disabilities is subjected to these features of institutionalisation. It is not the place where care takes place, but whether the care is human-rights based, person-centred and recovery oriented, with a pathway to integration into the community, which determines whether a place is an institution or not.

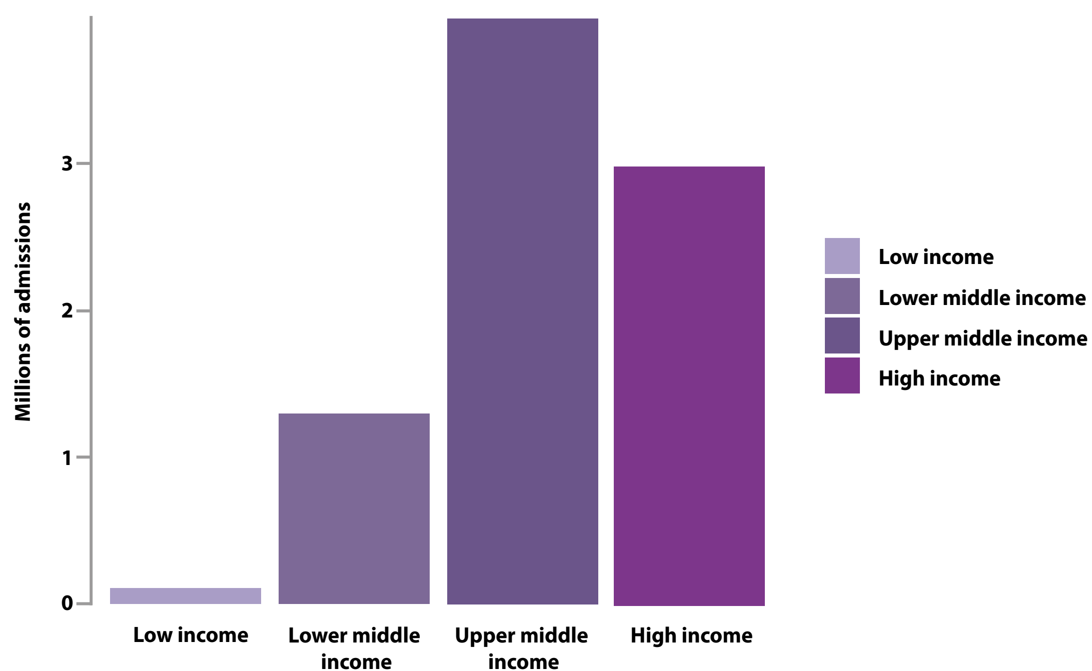
12 Summary overview of types and characteristics of institutional and community-based services for people with disabilities available across the EU - European Union Agency for Fundamental Rights 2017
13 Guidance on mental health policy and strategic action plans, module 2 (WHO 2025)

HOW MANY PEOPLE LIVE IN INSTITUTIONS AND HOW LONG DO THEY SPEND THERE?

Data submitted to the WHO's Mental Health Atlas project by member states shows approximately 8.4 million people – of whom 60% are men – are admitted to mental hospitals every year. This is likely to be a conservative estimate, which does not account for the many other settings where people with mental health conditions and psychosocial disabilities are institutionalised.

The number of admissions to mental hospitals in upper-middle- and high-income countries is three to four times higher than in lower-middle- and low-income countries.

Total admissions to mental hospitals by country income group, with imputed data



Source: WHO Mental Health Atlas 2020 data.
Notes: These figures are calculated by imputing missing data based on the median by income group. These ratios are then multiplied by the 2019 population.

Data is not readily available on how long people with mental health conditions or psychosocial disabilities stay in the different types of institutions discussed above. But WHO Mental Health Atlas 2020 data suggests 13% of all inpatients stay in mental hospitals for more than one year. Around half of those stays are more than five years, although how much longer than five years is not specified.

In 2019, the UK's *Guardian* newspaper reported a patient being held in a secure ward for more than 21 years, while another was kept there for almost 17 years.[14] In 2024, the BBC reported that an autistic woman was held in a mental health hospital in the UK for 45 years.[15] In India, according to a 2019 study, over 10% of all the country's mental health inpatients stayed in an institution for more than 25 years, while the mean stay was 9.6 years.[16]

WHY ARE PEOPLE WITH MENTAL HEALTH CONDITIONS BEING PLACED IN INSTITUTIONS?

In 2025, UnitedGMH conducted a set of surveys and interviews,[17, 18] gathering insights from national civil society organisations and people with lived experience of institutionalisation across 21 countries.

Participants revealed that people with mental health conditions or psychosocial disabilities were often institutionalised for reasons extending beyond clinical need. These include:

- community or family stigma surrounding mental health
- poverty
- lack of a caregiver or support network
- homelessness
- experiences of abuse or neglect
- sexual or gender-based violence
- substance-use challenges
- property, inheritance, and other financial disputes
- family or marital conflict

In some contexts, people – particularly those from LGBTQ+ communities – were institutionalised so they could be subjected to conversion therapy.[19] Although framed as therapeutic interventions, such practices seek to alter a person's sexual orientation or gender identity, and often result in harm and prolonged institutional stays.

These findings point to the complex social and structural issues that can drive institutionalisation – many of which are not directly related to the provision of mental health care. They reinforce the importance of community-based approaches that address stigma and the broader social determinants of mental health.

14 https://www.theguardian.com/society/2019/apr/23/nhs-mental-health-patients-locked-in-secure-ward-rehabilitation-years
15 Autistic woman wrongly locked up in mental health hospital for 45 years - Carolyn Atkinson and Ben Robinson (BBC 2024)
16 Angothu, Hareesh1,*; Philip, Sharad2; Jayarajan, Deepak1; Rachana, Arun3; Jagannathan, Aarti4; Prasad, M. Krishna5. Prolonged hospitalization of people with mental disorders in state-funded tertiary care psychiatric hospitals and unaccounted public health implications. Archives of Mental Health 24(1):p 8-13, Jan–Jun 2023. | DOI: 10.4103/amh.amh_72_22
17 National Perspectives on the Institutionalisation of people with Mental Health Conditions (UnitedGMH 2025)
18 Interviews of Individuals with Lived Experience of Institutionalisation (UnitedGMH 2025)
19 Sarah Golightley, 'I'm Gay! I'm Gay! I'm Gay! I'm a Homosexual!': Overt and Covert Conversion Therapy Practices in Therapeutic Boarding Schools, The British Journal of Social Work, Volume 53, Issue 3, April 2023, Pages 1426–1444, https://doi.org/10.1093/bjsw/bcad049

According to the WHO, more than 70% of government mental health spending in many low- and middle-income countries is directed towards mental hospitals.[20] Redirecting resources toward holistic, community-based services instead could more effectively and sustainably address both care needs and the underlying social factors to which our findings point.

INSTITUTIONS AND THE VIOLATION OF HUMAN RIGHTS

Stories of human rights abuses and the dehumanisation of people in institutions are common.[21] This section explores some of these abuses and why they occur, relating lived experience accounts of people who have suffered them first hand.w

Involuntary admissions, treatment and coercion

Forced admissions and treatment of people with mental health conditions still happens in institutions, even though it is against the UN Convention on the Rights of Persons with Disabilities.[22] It can lead to a wide range of abuses, many of which are detailed in the following sections.[23]

Supported decision making vs. substituted decision making[24]

Substitute decision-making

Regimes where legal capacity is removed from a person, even if this is in respect of a single decision; a substitute decision-maker is appointed to make decisions on behalf of the person concerned; or decisions are made by another person based on what is believed to be in the "best interests" of the person concerned, as opposed to being based on the person's own will and preferences.

Supported decision-making

Regimes comprising various support options which allow a person to exercise legal capacity and make decisions with support. While supported decision-making regimes can take many forms, under such regimes, legal capacity is never removed or restricted; a supporter cannot be appointed by a third party against the will of the person concerned; and support must be provided based on the will and preferences of the individual.

20 WHO Mental Health Atlas 2020
21 Sugiura K, Mahomed F, Saxena S, Patel V. An end to coercion: Rights and decision-making in mental health care. Bull World Health Organ. 2020;98(1):52-58. doi:10.2471/BLT.19.234906
22 Szmukler G. Compulsion and "coercion" in mental health care. World Psychiatry. 2015;14(3):259-261. doi:10.1002/wps.20264
23 Gartrell N. Bringing ethics alive: Feminist ethics in psychotherapy practice. London: Routledge; 2014. 10.4324/9781315783994
24 Mental Health, Human Rights and Legislation (WHO, OHCHR, 2023)

The argument behind involuntary admissions and treatment, and consequently substituted decision making, is the protection of people from serious harm or from harming others, and in some cases to provide people in a crisis with life-saving treatment they might otherwise refuse.[25, 26, 27] This argument comes with the caveat that such an intervention must be short-term, regulated, human-rights based and person-centred. It must be complemented by measures that allow for supported decision making when the person is able to make decisions regarding their care.

The World Health Organisation (WHO) and the Office of the High Commissioner for Human Rights (OHCHR)[28] recommend governments put in place mechanisms to eliminate coercion and replace substituted decision making with informed consent and supported decision making.

For example, the WHO has recommended providing service users full information on their treatment and having supporters in place to assist in communication either ways. It also includes advance plans/directives[29], co-created individual care, recovery and wellness plans, retraining of staff on de-escalation and negotiation techniques, having response teams in place to resolve conflicts, establishing complaints mechanisms to report coercion etc[30].

Countries should work towards putting these WHO recommendations into practice to help create a human-rights-based, recovery-oriented model of mental health care.

25 Freeman et al, 'Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities,' The Lancet Psychiatry, Volume 2, Issue 9, 2015, Pages 844-850,ISSN 2215-0366,https://doi.org/10.1016/S2215-0366(15)00218-7.
26 Carney T. Involuntary mental health treatment laws: The 'rights' and the wrongs of competing models? In: McSherry B, Weller P, editors. Rethinking rights-based mental health laws. Sydney: Hart Publishing; 2010. pp. 257–74.
27 Chieze M, Clavien C, Kaiser S and Hurst S (2021) Coercive Measures in Psychiatry: A Review of Ethical Arguments. Front. Psychiatry 12:790886. doi: 10.3389/fpsyt.2021.790886
28 CRPD/C/5: Guidelines on deinstitutionalization, including in emergencies (2022)
29 The Practice of Freedom - Human rights and the Global Mental Health Agenda; Roberto Mezzina, Alan Rosen, Michaela Amering, Afzal Javed (2018)
30 Guidance on mental health policy and strategic action plans, Module 2 (WHO 2025)

CASE STUDY: TIZAA HANNAN LEGEND, GHANA

No one should be made to feel like a prisoner on account of their mental health. And no one should be subjected to inhumane conditions or human rights violations, as the account of Tizaa Hannan Legend from Ghana illustrates:

"I was taken there against my will. This was because my family felt they needed to do so to preserve my mental health. It was not pleasant. I have always felt like a prisoner in the institution. It was not designed to rejuvenate you to be able to come back and deal with daily life stresses. I think it should be more accommodating, welcoming and friendly but that is a big dream I don't think will happen soon."

SECLUSION, RESTRAINT AND ABUSE

Restrictive practices in institutional settings are common across the globe. They include seclusion, restraint using straps, belts and cage beds, and being involuntarily subdued with medication.[31]

Where physical restraint of people with mental health conditions is occurring

Source: https://www.researchgate.net/figure/Countries-where-restraints-are-used_fig1_51507386

The people with lived experience we surveyed gave some shocking accounts of institutional care. They described patients being locked in dark and cold seclusion rooms, often naked, lying on the same floor as their toilet or without any amenities at all. They reported patients being overmedicated to 'subdue' them, as well as the use of drugs and chemicals as a form of coercion or punishment for disobedience. Several of those we interviewed said they were not allowed to get in touch with their families or have any kind of contact with the outside world. Their phones and most of their other personal belongings were taken away.

The National Survivor User Network conducted a survey of 65 service users who had been subjected to restraint in England. It found they often felt subjected to an unnecessary use of aggression, shaming, humiliation and re-traumatisation, in some cases for victims of sexual or physical abuse. As a result, they said their engagement with the services was characterised by increased fear, suspicion and wariness.[32]

31 Savage, Martha K et al. 'Comparison of coercive practices in worldwide mental healthcare: overcoming difficulties resulting from variations in monitoring strategies.' BJPsych open vol. 10,1 e26. 11 Jan. 2024, doi:10.1192/bjo.2023.613
32 Rose D, Perry E, Rae S, Good N. Service user perspectives on coercion and restraint in mental health. BJPsych Int. 2017;14(3):59-61. Published 2017 Aug 1. doi:10.1192/s2056474000001914

CASE STUDY: TERVER SIMON CHIESHE, NIGERIA

Dr Terver Chieshe is a medical doctor and clinical psychologist from Nigeria. He is Chief Medical Officer for the Comprehensive Community Mental Health Program of the Methodist Church Nigeria. He is also a poet, songwriter, singer and published author.

"It's been 35 years since my first admission in a psychiatric ward. I had an eight-year journey being in and out of institutions. My first institutional admission was in January 1990. I was institutionalised for three weeks, after which my home became my institution. My hands and feet were chained…

"After I got back from the institution, I could not go to school and my classmates all graduated. I wasn't permitted to start my internship or take my final exams. I went back to school the next year and had a relapse… I had no way out. One day, when everyone had gone to work, I unchained myself, took a bath, changed my clothes, and took a bus to go and apply for a job. When I got the job, I was free."

As an advocate, he feels that healthcare workers need to listen and empathise with their patients. "They don't listen to you at all. They treat you like a mere case. You have psychosis, bipolar, schizophrenia but you are not a person."

Terver also faced abuse and disrespect, which almost crushed his spirit. But he held onto his sense of self. "I am an artist, a poet, a songwriter and a published author. But the nurse called me names and abused me. It was too much for me. They stigmatise you so badly. When I complained, they chained me to a bed and I suffered a broken rib. I treated myself until my rib was healed."

Terver wrote songs and books about his experience, and kept looking for his purpose. "My mind is vexed, my heart is broken as I live in this silly world where people fight for wealth and power. But we can also fight for love and peace. People are not even aware when they call someone a 'madman', that person has intellect, knowledge and wisdom.

Restraint and community exclusion also take place in community and home-based settings. A Human Rights Watch report found that 60 out of the 100 countries it researched had evidence of people with mental health conditions, some as young as 10, being shackled. Carika, a young Indonesian woman from central Java, was the victim of 'Pasung' – an archaic practice of restraining people with mental health conditions. She was locked in a cramped and filthy goat shed for four years, and only released when her story received press attention. It is estimated there are 18,000 other people suffering in similar ways in Indonesia today.[33] Similarly, Robin Hammond, a human rights journalist, in his project 'Condemned'[34] documented how people with mental health conditions were locked up in dilapidated conditions, restrained and forced to live out their entire lives this way.

PHYSICAL, PSYCHOLOGICAL AND SEXUAL ABUSE

Institutions are often the scene of abuse. A study from Australia, New Zealand and the UK in 2022 found a third of all mental institution inpatients, including children and adolescents,[35] have suffered physical assault.[36] Bullying, humiliation and emotional abuse are also frequently reported.[37] The organisation Rape Crisis England & Wales reported 4,000 'sexual safety' incidents in institutions in the UK alone, within an eight-month period in 2023.[38] It was a shocking illustration of how common sexual assaults can be in inpatient facilities.

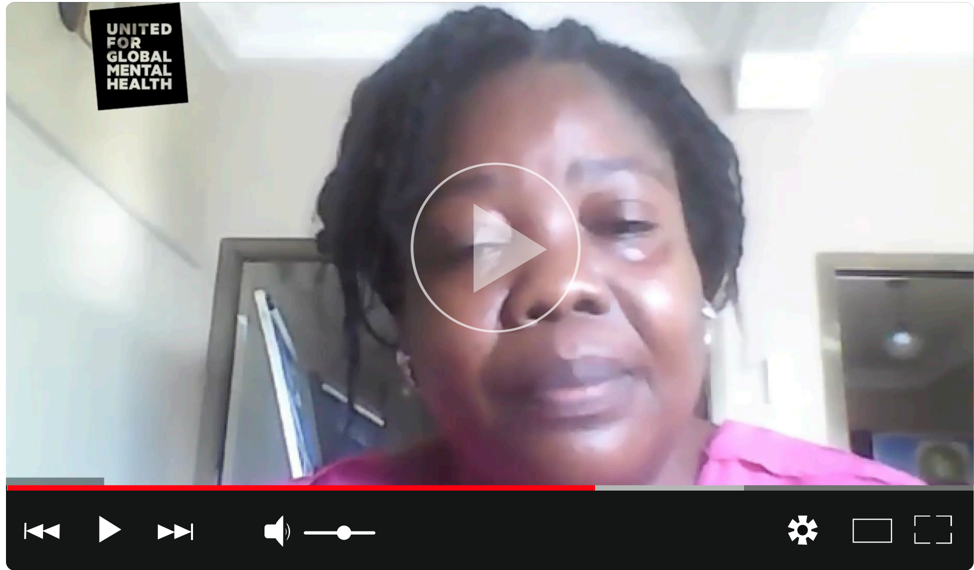
Such assaults take place for a variety of reasons, but the most significant factor is the vulnerability of people with mental health conditions living in institutions. Sexual assaults in such facilities are rarely reported. Victims are reluctant to come forward and, because of their mental health condition, when they do come forward their accusations are often dismissed. The lack of monitoring and low staffing levels contribute to the frequency of these incidents.[39] Inpatients' limited contact with the outside world increases their vulnerability, as does their lack of legal protection in jurisdictions where their evidence does not carry the same weight as someone considered 'normal'.[40]

Abuses in institutions have been regularly reported since the 1960s.[41] It is high time policymakers took the actions and devoted the financial resources necessary to tackle them.

33 Asher, L., Fekadu, A., Teferra, S. et al. "I cry every day and night, I have my son tied in chains": physical restraint of people with schizophrenia in community settings in Ethiopia. Global Health 13, 47 (2017). https://doi.org/10.1186/s12992-017-0273-1
34 Robin Hammond; Condemned - Mental Health in African Countries in Crisis
35 Hoffmann, U., Clemens, V., König, E. et al. Violence against children and adolescents by nursing staff: prevalence rates and implications for practice. Child Adolesc Psychiatry Ment Health 14, 43 (2020). https://doi.org/10.1186/s13034-020-00350-6
36 Jenkin, G., Quigg, S., Paap, H., Cooney, E., Peterson, D., & Every-Palmer, S. (2022). Places of safety? Fear and violence in acute mental health facilities: A large qualitative study of staff and service user perspectives. PloS one, 17(5), e0266935. https://doi.org/10.1371/journal.pone.0266935
37 Who gets believed: abuse in mental health services - Amy Wells (2022)
38 Alarming scale of sexual violence and abuse on mental health wards - Rape Crisis England & Wales 2024
39 Barnett, B. (2020). Addressing Sexual Violence in Psychiatric Facilities. Psychiatric Services, 71(9), 959–961. https://doi.org/10.1176/appi.ps.202000038
40 Paula Reavey, Rachel Wilcock, Steven D. Brown, Richard Batty, Serina Fuller, Legal professionals and witness statements from people with a suspected mental health diagnosis, International Journal of Law and Psychiatry, Volume 46, 2016, Pages 94-102, ISSN 0160-2527, https://doi.org/10.1016/j.ijlp.2016.02.040.
41 1. Hide L. Mental Hospitals, Social Exclusion and Public Scandals. In: Ikkos G, Bouras N, eds. Mind, State and Society: Social History of Psychiatry and Mental Health in Britain 1960–2010. Cambridge University Press; 2021:60-68.

BEATEN AND ABUSED

In this powerful film clip, Ms Augusta, who works with the Mental Health Coalition Sierra Leone, shares how she was subjected to beating and abuse at an institution. When she reported her abuse, it was brushed aside by the institution's management, who claimed it was necessary to curb her allegedly violent behaviour. The fracture she sustained to her knee affects her mobility to this day. Such stories are common in institutions, and far too often ignored. And yet Sierra Leone's mental health law still endorses institutionalised care.



NEGLECT AND UNSANITARY LIVING CONDITIONS

In September 2024, the South African Human Rights Commission investigated three patient deaths at a mental hospital in the Northern Cape, allegedly because of poor conditions. They found a lack of electricity, lighting, functioning toilets and warm water. Patients were exposed to extreme cold, amid broken windows, holes in the ceiling and a lack of blankets.[42]

Unfortunately, this fits the description of many institutions around the world, according to the results of UnitedGMH's survey of people with lived experience and CSOs working with them. They mentioned poor food, water shortages, and sanitation and hygiene problems – with women lacking access to sanitary pads. Social isolation and restricted movement were also common themes people with lived experience identified. They talked about how difficult it was to be disconnected from their families and the outside world for extended periods. These problems aren't just confined to mental hospitals. They can exist in community settings and traditional healing centres too. Wherever such problems exist, there is usually a lack of funds, staff, transparency and empathy. They can be addressed with reforms that will help people recover and reintegrate into the community.

42 State of Northern Cape's Mental Hospital Not Healthy - Noordkaap Bulletin, Charne Kemp 2024

STIGMA, DISCRIMINATION AND COMMUNITY MARGINALISATION

Our conversations with people with lived experience and the civil society organisations supporting them shed light on community attitudes. Often people living in or released from institutions are written off and treated as outcasts and lesser humans by the community. They are frequently considered 'dangerous', 'difficult' or 'dirty', and a threat to mainstream society. Mental illness can be seen as a sign of personal weakness or something shameful that should be hidden. The ability of people with mental health conditions to live independently, make a living, marry and start a family, and lead a meaningful and peaceful life in society is often seen as doubtful.

Many experience discrimination in the workplace. They are considered less capable and are not hired or are let go. They are shunned or 'othered' by superiors and colleagues, and face ridicule or abuse for their condition.[43] They confront practical challenges, such as a potential lack of recent work experience or training or long-term institutionalisation from an early age, putting them at a major disadvantage in a highly competitive job market. People who have been institutionalised are seen as incompetent and dangerous, even though there is clear evidence they are far more likely to be the victims of violence than its perpetrators.[44]

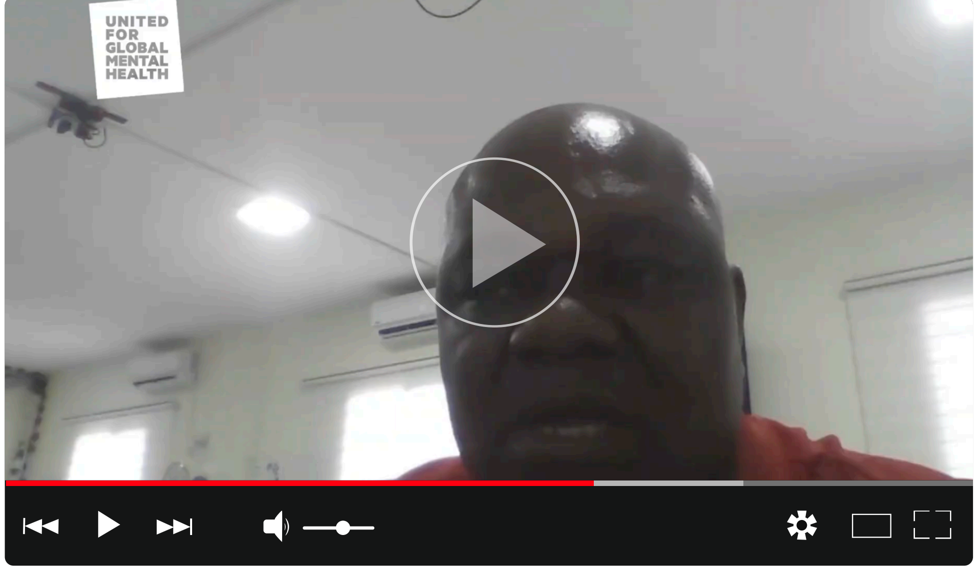
Stigma also exists among mental health workers in institutions. They may treat people as 'non-humans' or 'sub-humans' or somehow 'different' through restrictive or controlling behaviour. This could include limiting patients' contact with each other and the outside world, restricting their access to possessions and rejecting or avoiding those who are 'difficult to treat'.[45] Sometimes this negative treatment can be more extreme, including abuse, ridicule, beating, humiliation and isolation.[46]

43 Van Bortel T, Wickramasinghe ND, Treacy S, et al. Anticipated and experienced stigma and discrimination in the workplace among individuals with major depressive disorder in 35 countries: qualitative framework analysis of a mixed-method cross-sectional study. BMJ Open. 2024;14(6):e077528. Published 2024 Jun 19. doi:10.1136/bmjopen-2023-077528
44 Ghiasi N, Azhar Y, Singh J. Psychiatric Illness and Criminality. [Updated 2023 Mar 30]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK537064/
45 Mental health-related stigma in health care and mental health-care settings, Henderson, Claire et al. The Lancet Psychiatry, Volume 1, Issue 6, 467 - 482
46 'Toxic culture' of abuse at mental health hospital revealed by BBC secret filming - Panorama Team and Joseph Lee, BBC News

CUTTING THROUGH THE MISCONCEPTIONS

The story of Benjamin Ballah, from Cultivation for Users Hope in Liberia, cuts through all the myths about people with mental health conditions. Once shackled, institutionalised and shut out of employment, he now runs his own organisation and business employing people with mental health conditions. He works with the government and his organisation's imprint is on every aspect of recent mental health progress in Liberia.

His incredible journey, which highlights how humans we institutionalise and shun are full of potential, is well worth watching:



INSTITUTIONALISATION FROM THE PERSPECTIVE OF CARE PROVIDERS

This section looks at the negative impact of institutions on two key contributors of care: families and caregivers, and the mental health workforce.

FAMILIES AND CAREGIVERS

In the absence of community-based care, family members and caregivers often take responsibility for caring for people with mental health conditions. In many cases, they assume this role without adequate support, guidance or access to mental health services. The cumulative impact of these responsibilities – ranging from emotional distress to physical exhaustion to financial hardship – can lead families to seek institutional care. The decision to institutionalise a family member with a mental health condition is also often driven by factors such as a concern

for their safety, social stigma and the limits of informal care.[47] In some cases, families have to give up caregiving to keep their job or return to work.[48]

Many caregivers report withdrawing from their social circles because of the overwhelming nature of their responsibilities, isolating them from the emotional support they might need.[49] Families and caregivers can feel a mixture of both relief and guilt after choosing to institutionalise someone who was in their care.

The shift towards community-based care has redefined the expectations placed on families. They are expected to fulfil increasingly complex roles, including coordinating treatment plans, managing medication and engaging with mental health services – frequently without the necessary training or support.[50] This creates severe challenges in their professional lives – increasing their stress levels, reducing their attendance and productivity, and ultimately affecting their financial stability.

In this evolving landscape, it is essential that the needs and experiences of caregivers are integrated into the design and implementation of deinstitutionalisation strategies. The success of such reforms hinges not only on providing effective community-based services for patients, but also on alleviating the burden of caregivers. This includes providing them with:

- **formal support structures, such as respite care**
- **financial and emotional assistance**
- **psychoeducational programmes to build understanding and awareness**
- **access to crisis-intervention resources to help stabilise those most at risk**

It is difficult, tiring and stressful for caregivers to navigate complex mental health conditions and care decisions, so providing them with adequate training and support is a priority.[51]

Ending institutionalisation must not involve a mere transfer of responsibilities from institutions to families. Rather, it must be underpinned by comprehensive, sustainable frameworks that empower and support caregivers as a critical – yet vulnerable – part of mental health care provision.

47 Prieto-Ursúa, María & Sanchez-Izquierdo, Macarena & Caperos, José. (2017). The family caregiver after the institutionalization of the dependent elderly relative. Educational Gerontology. 43. 10.1080/03601277.2017.1386403.
48 Chee Wee Tew, Li Feng Tan, Nan Luo, Wai Yee Ng, Philip Yap; Why Family Caregivers Choose to Institutionalize a Loved One with Dementia: A Singapore Perspective. Dement Geriatr Cogn Disord 1 January 2011; 30 (6): 509–516. https://doi.org/10.1159/000320260
49 Mokgothu, M. C., Du Plessis, E., & Koen, M. P. (2015). The strengths of families in supporting mentally-ill family members. Curationis, 38(1), 1258. https://doi.org/10.4102/curationis.v38i1.1258
50 Ong HS, Fernandez PA, Lim HK. Family engagement as part of managing patients with mental illness in primary care. Singapore Med J. 2021;62(5):213-219. doi:10.11622/smedj.2021057
51 Jacqueline Botura Bessa, Maria Angélica Pagliarini Waidman (2012). Family of people with a mental disorder and needs in psychiatric care https://doi.org/10.1590/S0104-07072013000100008

THE MENTAL HEALTH WORKFORCE

Mental health professionals – including nurses, psychiatrists, psychologists, and inpatient care staff – form the backbone of mental health care. Their work is often conducted under high pressure, and takes a significant emotional, physical and psychological toll.

Institutional settings are frequently under-resourced and overburdened, leaving staff to manage complex cases with limited support. Professional nurses, for instance, often face excessive workloads, staff shortages and administrative inefficiencies, which contribute to chronic fatigue, burnout and low morale.[52]

Psychiatric facilities often lack the basic infrastructure to provide humane and therapeutic care, such as privacy for consultations, clean and safe wards, and functioning equipment. This all adds to the stress on mental health professionals.

Poor team cohesion and even conflict between staff can make working life even harder. Studies show that in some cases conflict among colleagues or with supervisors can undermine staff wellbeing even more than patient-related stress. These tensions among health workers and the feelings of hurt and isolation they often create increase rates of attrition in the mental health workforce.[53]

Low morale among mental health workers is a recurring theme. It often results from:

- **a lack of autonomy**
- **bureaucratic constraints**
- **the emotional strain of dealing with patient relapse or chronic illness.**

Mental health workers frequently talk about a disconnect between the ideals of therapeutic care and the realities of institutional protocols, which restrict their ability to provide person-centred, compassionate care.[54]

Mental health professionals have a crucial role to play in addressing these issues and driving the deinstitutionalisation process. It is essential they are fully involved in reforming mental health care, and in planning and implementing the move from institutional to community-based care.

52 Mulaudzi, Ndivhuwo P., Mashau, Ntsieni S., Akinsola, Henry A., & Murwira, Tinotenda S.. (2020). Working conditions in a mental health institution: An exploratory study of professional nurses in Limpopo province, South Africa. Curationis, 43(1), 1-8. https://doi.org/10.4102/curationis.v43i1.2081
53 Ignatenko, Valerie, 'Psychologists working in state psychiatric hospitals: An exploration of factors related to work engagement' (2015). Graduate Theses, Dissertations, and Problem Reports. 5855. https://researchrepository.wvu.edu/etd/5855
54 Totman, J., Hundt, G. L., Wearn, E., Paul, M., & Johnson, S. (2011). Factors affecting staff morale on inpatient mental health wards in England: a qualitative investigation. BMC Psychiatry, 11, 68. https://doi.org/10.1186/1471-244X-11-68

ENDING INSTITUTIONALISATION USING A HUMAN-RIGHTS-BASED APPROACH

As we have established, institutionalisation can and often does result in a variety of human rights abuses. It also exposes care providers, such as family members and mental health professionals, to significant challenges.

It is time to bring institutionalisation to an end, but we recognise there are many differing opinions on what that might look like. Some would argue that any form of institutional care should be stopped immediately; others would make the case for a gradual phase out. There are also those who would say institutions – where they mean residential care, and substituted decision making – are acceptable in some circumstances.

United for Global Mental Health believes institutionalisation – as defined in the WHO's guidance on mental health policy and strategic action plans[55] – is harmful and should be stopped. Long-term mental health support should not mean a long-term inpatient stay at an institution. Instead, such support should focus on rehabilitation and recovery, and aim to result in people living freely in society. Serious criminal practices such as violence, coercion and sexual assault should not be tolerated let alone permitted inside an institution. Children should not be housed or treated alongside adults. Mental health conditions range widely – from eating disorders to maternal mental health issues – and specialist care is needed for each, rather than the generalised approach often adopted in institutions.

Clearly, simply closing down psychiatric hospitals is not a remotely adequate solution to the problems of the current care model. What is needed are system-wide reforms that shift the centre of care to community-based services, which are grounded in a human-rights-based, person-centred approach. Such services must focus on helping the person recover from their condition, provide them with ongoing care where needed and ultimately result in their full participation in the community and everyday life – as is the objective with any other form of treatment or care.[56]

The following sections will explore ending institutionalisation based on these principles. The process of reform is complex and differs according to the context. It is also influenced by a variety of factors such as political will, funding, social stigma, lack of research on institutions and a shortage of human resources. These recommendations – based on those of the WHO, the UNCRPD and other renowned experts in the field – can be adapted to specific countries according to their needs, challenges and resources.

55 Guidance on mental health policy and strategic action plans: Module 2. Key reform areas, directives, strategies, and actions for mental health policy and strategic action plans - (WHO 2025)
56 Lamb, H. R., & Bachrach, L. L. (2001). Some Perspectives on Deinstitutionalization. Psychiatric Services, 52(8), 1039–1045. https://doi.org/10.1176/appi.ps.52.8.1039

TRANSITIONING FROM INSTITUTIONS TO COMMUNITY-BASED CARE

The WHO Comprehensive Mental Health Action Plan 2013-2030[57] recommends adopting a recovery-based approach, with people as equal partners in their care. It suggests systematically shifting care away from long-stay mental hospitals towards non-specialised health settings i.e. primary care settings. It calls for:

- **the development of integrated community-based mental health and social care services**
- **the integration of treatment into general hospitals and primary care**
- **continuity of care between different providers and levels of the health system.**

It also suggests a system of social care involving the development of day-care centres, support of people living with their families and supported housing (i.e. accommodation with access to care services).

The Deinstitutionalisation Guidelines of the UN Committee on the Rights of People with Disabilities[58] also call for the development of community support services to allow people with psychosocial disabilities to live independently, carry out daily activities and participate in society.

If implemented with a human-rights-based approach, community-based services can be:

- **more efficient**
- **allow for early – rather than crisis – intervention**
- **reduce treatment gaps and increase service coverage**
- **promote better mental health outcomes.**

And by using an approach that involves the community and does not foster segregation and 'othering', it is possible to dispel misconceptions and reduce stigma and discrimination.[59, 60]
The recently launched WHO Guidance on Mental Health Policy and Strategic Action Plans outlines concrete policy directives, strategies, and actions that policy makers can take to facilitate deinstitutionalization. These are summarised in Module 5 (see excerpt below), while Module 2 of the WHO Policy Guidance provides a detailed explanation of each directive, strategy, and action.

57 WHO Comprehensive Mental Health Action Plan 2013-2030
58 Guidelines on Deinstitutionalisation, including in Emergencies (UNCRPD 2022)
59 The Lancet Commission on ending stigma and discrimination in mental health Thornicroft, Graham et al. The Lancet, Volume 400, Issue 10361, 1438 - 1480
60 Mosaic Toolkit to end stigma and discrimination in mental health - (WHO 2024)

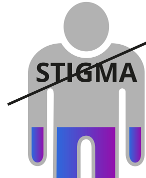
WHY COMMUNITY-BASED CARE SHOULD BE PRIORITISED OVER INSTITUTIONAL CARE

Community-based care:

Improves health outcomes and quality of life

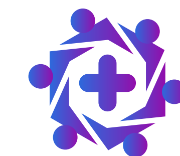
Protects human rights by reducing coercion, abuse and neglect

Does not isolate people, but focuses on their inclusion



Is less stigmatising because of the community's involvement

Respects the agency of the individual



Increases access to care for more people than often distant and limited institutions

To prevent community-based services becoming institutions, it is important to move away from both the physical facilities and the abusive practices within those facilities that led to the human rights abuses discussed above.

Historically, Brazil has been the home of some of the most heart-wrenching stories from institutions. But now the government is adopting nationwide system reforms to prevent those abuses, as the case study below shows.

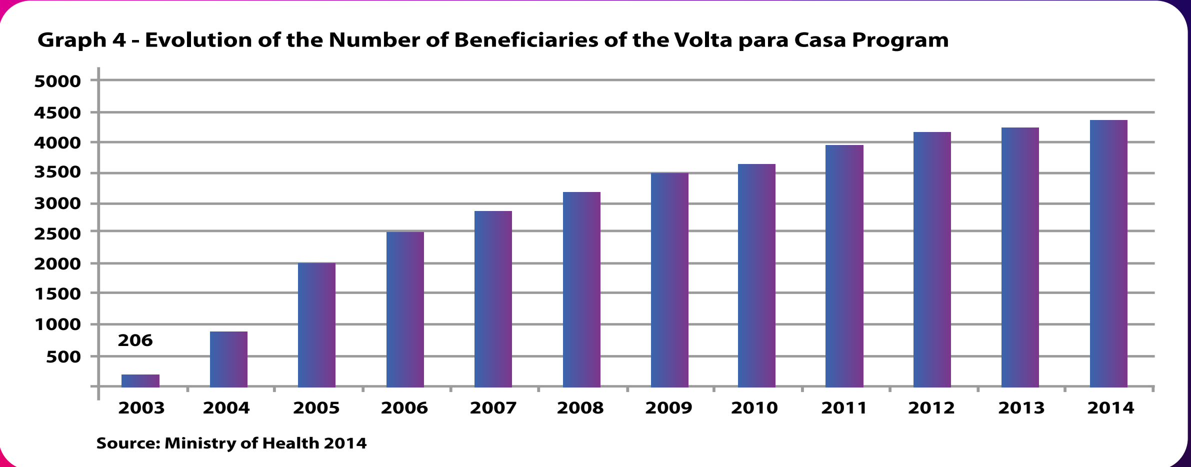
CASE STUDY: EMPOWERING RECOVERY, RECONNECTING TO COMMUNITY

Brazil has a history of people with mental health conditions living in institutions for extended periods of time. In the early 2000s, for example, around **a quarter of inpatients in a southern psychiatric hospital had been there for more than 40 years**!

In 2001, the **Brazilian Psychiatric Reform Law** shifted the focus. It **prohibited the establishment of new beds in psychiatric hospitals**, and set up financing mechanisms for **community-based care services**.[61]

Significant efforts to localise care, reintegrate people into their communities and reduce the reliance on institutions saw **the number of psychiatric beds halved** between 2001 and 2014, dropping from 54,000 to just 26,000.[1] The **average length of hospital stay due to mental health conditions fell** from more than 34 days in 2014 to 19 days in 2022.

Out of this shift in focus came the ***Programa De Volta Para Casa (PVC)*** or the ***Back Home Programme*** in 2003. It provides people with the financial help they need to live independently outside of institutions. The programme **grew from just over 200 recipients to more than 4,000** in the space of a decade.



Over the past 30 years, Brazil has made significant progress towards a more community-based mental health system. The funding of community- and evidence-based services must continue in Brazil, and the reform process continue, prioritising approaches that respect dignity and social inclusion.[62]

61 Sampaio, M. L., & Bispo Júnior, J. P. (2021). Towards comprehensive mental health care: experiences and challenges of psychosocial care in Brazil. *BMC Public Health*, *21*, 1-12.
62 https://www.nuppsam.org/wp-content/uploads/2021/05/DESINSTITUCIONALIZACAO-E-ATENCAO-COMUNITARIA-FIOCRUZ-GULBENKIAN.pdf

The recently launched WHO Guidance on Mental Health Policy and Strategic Action Plans outlines concrete policy directives, strategies, and actions that policy makers can take to facilitate deinstitutionalization. These are summarised in Module 5 (see excerpt below), while Module 2 of the WHO Policy Guidance provides a detailed explanation of each directive, strategy, and action.

Policy area 2. Service organization and development

2.4 **Policy directive 2.4** Deinstitutionalization

Strategies

Strategy 2.4.1 Establish the foundation and enabling environment for successful deinstitutionalization

Actions

- **Document** the characteristics and location of institutions and discuss deinstitutionalization with staff to bring them on board.
- **Implement** a communication strategy to support deinstitutionalization.
- **Train** service providers and key stakeholders on the human rights-based approach in mental health and tackling stigma and discrimination.
- **Hold** focused discussions in the new community locations where people leaving institutions will be living, in order to assuage community reservations and prepare for deinstitutionalization.
- **Make** person-centred and rights-based community mental health and physical health services available and accessible to people leaving institutions.
- **Create** or link with a variety of services beyond the health sector to facilitate community inclusion and participation.
- **Budget** sufficient funds, including double funding for the first phase of deinstitutionalization and eliminate financial barriers.

Strategy 2.4.2 Develop and implement a deinstitutionalization plan for each institution that immediately improves rights and quality for all residents

Actions

- **Establish** a deinstitutionalization management committee in each institution to develop and implement the deinstitutionalization process.
- **Develop** and implement a deinstitutionalization plan for each institution.
- **Train** staff working in institutions on rights-based and recovery-oriented approaches in mental health.
- **Train** staff to develop individualized plans for people leaving institutions.
- **Identify** community-based mental health services to which staff can apply for work and be deployed as part of deinstitutionalization transitioning.

Policy area 2. Service organization and development

Policy directive 2.4 Deinstitutionalization *continued*

Strategies

Strategy 2.4.3 Create individualized support plans for each resident transitioning to the community

Actions

- Assess each person's need for support.
- **Provide** individuals with accessible and understandable information on all aspects of the deinstitutionalization process.
- **Develop** an individualized plan for each person based on their active participation, support needs and choices.
- **(Re)establish** and support contact with families and other caregivers and general social networks if residents leaving institutions want this.
- **Assign** everyone leaving institutions a focal point person to assist them through the transition process.
- **Identify**, secure and document each person's living arrangements and personalised support needs.
- **Conduct** formal discussions with each individual and their service providers about their care plan before transitioning to the community.

Strategy 2.4.4 Repurpose suitable infrastructure, buildings and land into centres of excellence and/or community-based services for rights-based integrated care and support

Actions

- **Identify** institutions whose infrastructure, building and land can be repurposed.
- **Develop** a vision and concept paper for repurposing institutions, to ensure that plans align with needs and a human rights-based approach.
- **Appoint** a multidisciplinary management and leadership team with demonstrated expertise, and core values aligned with the centre's goals and a human rights-based approach.
- **Create** close partnerships with academic and research institutions to support research, teaching and training.
- **Collaborate** with innovative services and organizations to develop, provide, and evaluate a person-centred rights-based community service.

The WHO Guidance and technical packages on community mental health services[63] call for a decisive shift away from institutionalisation and towards the development of person-centred, rights-based services in the community, in line with international human rights standards, including the CRPD. Together, the guidance and technical packages serve as a practical roadmap for countries to dismantle institutional systems and build inclusive, rights-affirming community-based mental health services and service networks that respect recovery, dignity, inclusion and legal capacity.

63 Geneva: World Health Organization; 2021 (Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches). Licence: CC BY-NC-SA 3.0 IGO. https://iris.who.int/handle/10665/341648

REPURPOSING EXISTING INSTITUTIONS USING A PERSON-CENTRED APPROACH

Part of the journey of ending institutionalisation is to change the way care is provided in existing institutions. This involves introducing a wider range of evidence-based psychological and psychosocial interventions. It also includes providing specialist support for people facing issues such as substance use, maternal mental health conditions, and comorbidities such as HIV and depression.

It requires greater focus on human rights and freedoms. That means tackling coercion and other human rights abuses. It involves shifting from managing mental health conditions – by treating symptoms, or confining and containing patients, for example – to focusing on a person's recovery and whole-of-life needs, putting them at the centre of their own care.

It also means improving the conditions in institutions, for the benefit of patients and staff, by:

- **repairing and maintaining the physical infrastructure of facilities**
- **creating space to prevent overcrowding**
- **providing areas that encourage social interaction**
- **offering amenities**
- **providing nutritious food**
- **ensuring sanitary conditions.**

But none of this means long-stay institutions should continue to exist any longer than necessary. The position put forward by both the UNCRPD and the WHO in its World Mental Health Report[64] is that long-stay institutions should be shut down, the practice of long stay residents should be ended, and community alternatives put in place. Changing the paradigm of care will in some cases mean ending institutionalisation by working from within.

To support this process, WHO has developed the QualityRights Assessment Toolkit, which enables countries to assess and improve the quality of care and human rights conditions in mental health and social care facilities. In parallel, WHO's Service Transformation Training and Guidance provides practical support for shifting the entrenched mindsets and institutional practices that are often prevalent within long-stay facilities—such as reliance on coercion, paternalism, and containment—towards approaches grounded in dignity, autonomy, and recovery. These tools play a critical role in supporting countries to initiate, guide, and sustain the process of deinstitutionalisation.

To this end, institutions can be repurposed into short-term tertiary care facilities, helping to prevent admissions into long-term institutions. Sri Lanka's efforts towards ending institutions is a positive example of what this journey can look like.

64 World Mental Health Report, Transforming Mental Health For All (WHO 2022)

CASE STUDY: TRANSFORMING THE CARE LANDSCAPE – IMPROVING MENTAL HEALTH SERVICES IN SRI LANKA

In the early 2000s, mental healthcare was largely confined to psychiatric hospitals in Sri Lanka. These facilities were the scene of inadequate staffing, human rights violations, and the mistreatment of patients.[65]

The country's Mental Health Policy (2005–2015) set out a vision for reshaping its mental health landscape, focusing on the creation of a comprehensive, community-based, and decentralised service model. It included plans to move residents from psychiatric hospitals to newly established district facilities or other community-based services.[66]

Using the WHO's pyramid model of care,[67] Sri Lanka worked to:

- **promote self-care**
- **integrate mental health services into primary healthcare**
- **build community mental health services**
- **develop mental health services in general hospitals**
- **limit the number of psychiatric hospitals.**

In 2008, the number of beds at Mulleriyawa Hospital, a major psychiatric facility, was reduced from 900 to 300. The largest psychiatric institution in Sri Lanka, Angoda Mental Hospital, was re-established as the National Institute of Mental Health – an organisation focused on boosting the mental health workforce and integrating mental health care within community health services. Nurses, social workers, doctors and occupational therapists were trained to provide mental health first aid services. Staff were trained to assess how ready patients were to return to their communities, and what support they might need to make the transition. A network of CSOs was encouraged to support people being discharged from hospital by providing services such as psychosocial rehabilitation, independent housing and assisted living.

While stigma persists and its mental health workforce still needs strengthening, the WHO has hailed Sri Lanka for its work to move away from institutions, grow community-based networks and improve its mental health services.[68]

65 Sajeewana Amarasinghe (March 2018). *A Tribute to Dr Jayan Mendis.* Colombo Telegraph. Retrieved from https://www.colombotelegraph.com/index.php/a-tribute-to-dr-jayan-mendis/
66 World Health Organization. (2024). Deinstitutionalization of people with mental health conditions in the WHO South-East Asia Region.
67 Rajasuriya, M., Hewagama, M., Ruwanpriya, S., & Wijesundara, H. (2021). Community-based psychiatric services in Sri Lanka: a model by WHO in the making. *Consortium Psychiatricum*, *2*(4), 40-52.
68 WHO commends Sri Lanka deinstitutionalization approach on mental health (January 2025). Economy Next.

HAVING A STRONG HUMAN-RIGHTS-BASED LEGISLATIVE AND POLICY FRAMEWORK

Mental health legislation and policy can play a crucial role in either ending or perpetuating institutionalisation.

In their guidelines on mental health, human rights and legislation,[69] the WHO and OHCHR recommend adopting clear action plans with concrete timelines, responsibilities, benchmarks and budget lines for ending institutionalisation. They also suggest explicitly prohibiting institutions and repealing provisions – such as those allowing substitute decision making – that facilitate institutionalisation. These can be replaced by laws recognising people's legal capacity and promoting supported decision making, where individuals receive the support they need to make their own choices—and the use of advance plans and directives, which allow people to express their preferences for future care and treatment in anticipation of times when they may have difficulty communicating their wishes.. The design and implementation of such legislation and policies should involve people with lived experience of institutionalisation.

As noted earlier in this document, the WHO Guidance on Mental Health Policies and Strategic Action Plans complements this legal guidance by providing countries with practical direction for developing comprehensive, rights-based national plans to support deinstitutionalisation. It emphasises the importance of coordinated cross-sectoral action, time-bound targets, and adequate resources to enable a sustainable transition from institutional to community-based care

There are examples of national legislation that other countries can learn from. The Basaglia Law of 1978 in Italy,[70] for example, established a ban on building new psychiatric hospitals and admitting new patients to existing ones. It led to the closure of all psychiatric hospitals within the space of 20 years. Similar progressive legislation was introduced in Argentina[71] to the same sort of effect.

THE REFORMS ENDING INSTITUTIONALISATION IN ARGENTINA

Argentina enacted the National Mental Health Law in 2010, legislating for the closure of psychiatric institutions, the establishment of community-based care and the regulation of involuntary admissions. It then enacted the National Mental Health Plan 2023-2027, focused on comprehensive community-based care. A resulting 'Free from Asylums' programme in Buenos Aires has already led to the closure of 18 out of 35 psychiatric wards and a 138% increase in community housing.[72]

69 Mental Health, Human Rights and Legislation (WHO, OHCHR, 2023)
70 Badano V. The Basaglia Law. Returning dignity to psychiatric patients: the historical, political and social factors that led to the closure of psychiatric hospitals in Italy in 1978. History of Psychiatry. 2024;35(2):226-233. doi:10.1177/0957154X231224650
71 Ley Nacional de Salud Mental (2010). Ley nº 26.657 y su decreto reglamentario nº 603/13; Article 27. In: Buenos Aires. Ministerio de Salud; 2010 (https://bancos.salud.gob.ar/recurso/ley-nacional-de-salud-mental-ndeg26657-ydecreto-reglamentario-6032013, accessed 31 May 2023).
72 Advancements in mental health reform in Argentina: towards comprehensive and human rights-respecting care Barcala, Alejandra et al. The Lancet Regional Health – Americas, Volume 26, 100615

Legislation and policy must include obligations to ensure people have access to the community-based services and social support networks they need. Such networks should realise people's right to live independently and be included in the community – by having access to housing, social benefits, employment opportunities and social relationships.

This highlights that deinstitutionalisation is not solely a health sector responsibility, but one that requires strong, coordinated action across multiple sectors, including housing, education, social protection, employment, and justice. WHO's forthcoming Guidance on policy and strategic actions to protect and promote mental health and well-being across government sectors (2025) emphasises the critical roles that these sectors can play in creating enabling environments for rights-based, community-based mental health support.

The UNCRPD's deinstitutionalisation guidelines explicitly highlight people's rights to:

- **legal capacity,**
- **access to justice, liberty and security**
- **equality and non-discrimination.**

These rights, it says, should be explicitly guaranteed through legislation and policy reforms. These can be combined with policies addressing social needs and the social determinants of health, and making the best use of community resources.

In the process of ending institutionalisation, people with the highest risk should be prioritised. Humanitarian, environmental and public health emergencies and conflicts often pose the greatest risks and have been used as excuses to rebuild or repopulate institutions – something legislation and policy reforms can reflect and tackle.

The judiciary can also play a major role in the enforcement of these legislations and policies and the overall process of ending institutionalisation. This includes protection against involuntary confinement and treatment, ensuring dignity and respect of people with mental health conditions, holding carers accountable in case rights are being violated and directing policymakers to execute planned community based and social care services.

CASE STUDY: JUDICIAL INTERVENTIONS SUPPORTING DEINSTITUTIONALISATION IN INDIA

Upon complaints through public interest litigation that mental hospitals were violating human rights and that children with disabilities were being kept in jail for 'safe custody', the Supreme Court of India ordered the keeping of people with mental health conditions in jail as unconstitutional and directed the national human rights committee to monitor specific mental hospitals.[73]

73 Murthy P, Isaac M, Dabholkar H. Mental Hospitals in India in the 21st century: transformation and relevance. Epidemiol Psychiatr Sci. 2017;26(1):10-15. doi:10.1017/S2045796016000755

Existing cross-sectoral policies can be amended to include provisions that address stigma and discrimination against people with lived experience of institutionalisation. Indonesia serves as a case study on the role of legislation and policy to counter stigma and discrimination. The Indonesian government implemented reforms designed to address inhumane practices like '*Pasung*', a form of shackling that has plagued the country for decades.

CASE STUDY: BREAKING THE CHAINS – REFORMING LEGISLATION AND POLICY TO DESTIGMATISE MENTAL HEALTHCARE IN INDONESIA

In Indonesia, the intense stigmatisation of people with mental health issues means most are kept hidden and out of the public eye by their families.[7] Many face isolation, or even being chained or confined in cages – a practice known as '*Pasung*.' Despite the introduction of policies and initiatives aimed at eliminating *Pasung*, including the 'Free Pasung' campaign in 2010, progress in tackling the practice has been slow.[74] As reported by Human Rights Watch in July 2018, 13,000 people with mental conditions in Indonesia were being secluded and restrained. They were forced to sleep, eat, urinate and defecate in the same spot, worsening their mental health.[75]

The Mental Health Act of 2014, along with other health regulations and improvements in mental health services, has helped make mental health issues, and *Pasung* in particular, a focus of the national health agenda. There was a drastic reduction in inpatient admissions between 2014 and 2020 – from over 250 per 100,000 people to less than 100, a decrease of over 60%. There has also been a small increase of around 10% in the number of community-based mental health services.

To reduce stigma and improve community services in Indonesia, Community Mental Health Advisory and Implementation Teams mobilise local communities – including village officials, mental health workers and law enforcement personnel – to support individuals with mental health conditions. These teams work to provide integrated care, including psychoeducation, administrative support, screenings, referrals, and tackling mental health emergencies.[76]

In 2023, Indonesia's Mental Health Act was incorporated into the new Health Omnibus Law (or Health Bill). This merged mental health regulations with broader healthcare regulations – a crucial move towards integrating inclusive mental health care into the country's overall health system and making more resources available for its implementation. This combination of legislation and community based mental health teams, is making efforts to eradicate *Pasung* and improve mental health services.

74 Hidayat, M. T., Oster, C., Muir-Cochrane, E., & Lawn, S. (2023). Indonesia free from Pasung: A policy analysis. *International Journal of Mental Health Systems, 17*(1), 12.
75 Mayestica De Jong (November 2019). *Fiction: Pasung.* Inside Indonesia. Retrieved from https://www.insideindonesia.org/archive/articles/fiction-pasung
76 Kusuma Sari, Osi & Subandi, Subandi & Marchira, Carla. (2021). Cross-sectoral collaboration in mental health services: Identifying the role of mental health care teams in the community. Journal of Community Empowerment for Health. 4. 169. 10.22146/jcoemph.61574.

RECOGNISING THE CRUCIAL ROLE OF THE MENTAL HEALTH WORKFORCE

The mental health workforce, including psychiatrists, psychologists, occupational therapists, social workers and mental health nurses, is essential to ending institutions. It can play a crucial role in the transition towards community-based care and in providing human-rights-based support.[77]

Therefore, the mental health workforce should be trained to deliver culturally appropriate, evidence-based, human-rights centric and community-based care. It should be able to provide recovery-oriented practices[78] as alternatives to coercion. The WHO QualityRights initiative has developed a comprehensive programme—including both face-to-face and online training—that supports countries to transform mindsets, shift away from institutional and coercive practices, and promote rights-based approaches to care. This training is designed not only to build knowledge and skills, but also to challenge stigma, change attitudes, and empower mental health workers to uphold the dignity, autonomy and rights of people using services. Such mindset change is essential for making deinstitutionalisation a reality and ensuring that new models of care, based in the community, are truly person-centred and rights-aligned.[79]

Legislation and policies, and the mechanisms to enforce them, must be put in place to prevent abuse or neglect by mental health workers, and to promptly address any grievances concerning human rights abuses.

The demand for a high-quality mental health workforce will only increase with the process of ending institutionalisation and the destigmatisation of mental health. Systemic reforms that see community-based care complemented by a network of primary and secondary care will require dedicated mental health professionals, as will short-stay inpatient care at general hospitals or other community-based alternatives.

It is vital, therefore, to address the shortage of mental health professionals in community settings. Improvements in the quality of training for mental health professionals must also be made. This could involve measures like the creation of new cadres of mental health workers, task shifting for efficient use of human resources, capacity building of non-mental health workforce[80] through tools like the WHO/UNICEF EQUIP Platform.[81] Lebanon offers an inspiring example of this kind of work:

77 Deinstitutionalisation of people with mental health conditions in the WHO South-East Asia Region (WHO SEARO 2024)
78 Montenegro, C., Irarrázaval, M., González, J., Thomas, F., & Urrutia, J. (2023). Moving psychiatric deinstitutionalization forward: A scoping review of barriers and facilitators. Global Mental Health (Cambridge, England), 10, e29. https://doi.org/10.1017/gmh.2023.18
79 WHO Quality Rights Toolkit (WHO 2012)
80 Innovation in Deinstitutionalisation (WHO 2014)
81 Ensuring Quality in Psychological Support (EQUIP) global scale up training - (WHO/UNICEF 2023)

CASE STUDY: EMPOWERING THE WORKFORCE TO STRENGTHEN COMMUNITY-BASED MENTAL HEALTH SERVICES IN LEBANON

Lebanon has a history of conflict, with a large proportion of the population facing displacement, political turmoil and unemployment. This has led to a prevalence of post-traumatic stress disorder, depression and anxiety among Lebanese young people,[82] and especially refugees. The country's mental healthcare services have struggled to cope – with demand for treatment exceeding provision by 90%.[83]

These challenges prompted the Lebanese government to implement a new mental health strategy in 2015,[84] focusing on scaling up community-based mental health services. Facing a severe lack of mental health professionals, non-specialist health staff were given training ranging from how to identify mental health conditions to making safe referrals to managing mental health emergencies. Lebanon became the first country in the Middle East to have trained all mental health professionals in 'interpersonal psychotherapy' (a timelimited talk therapy that focuses on improving relatioships with others to help relieve mental health symptoms).

The strategy also implemented several other initiatives designed to improve mental health outcomes:

- National guidelines for maternal mental health were put in place for social workers and caregivers.
- Primary health centres were provided with a guaranteed supply of psychotropic medication, supplemented by training for GPs, neurologists and mental health professionals to promote rational prescribing.
- Reporting guidelines and media training was introduced to help reduce stigma and promote services such as government helplines.

These efforts enabled the Lebanese government to roll out the WHO Quality Rights Initiative in 2017, to help shift the country further away from institution-based care. In 2021, the government shut down a mental health institution for violating human rights, relocating all 252 patients to facilities with access to enhanced community-based services. It is now working towards systematically scaling down one of the largest psychiatric institutes in the country.

82 National Mental Health Program Lebanon. (2024). National mental health strategy. Retrieved 11 March 2025, from https://resources.nmhp-lb.com/strategy
83 WHO. WHO-AIMS Report on Mental Health System in Lebanon 2015. Beirut: MoPH & WHO; 2015
84 AlHanna, M., et al. (2023, December). Turning Crises Into Opportunities. World Association for Psychosocial Rehabilitation. Retrieved 11 March 2025, from https://www.wapr.org/wp-content/uploads/2023/12/AlHanna_et_al.pdf

EQUIPPING FAMILIES AND CAREGIVERS TO PROVIDE SUPPORT

Families and caregivers are central to successfully ending institutionalisation. As research underscores, relatives often manage medication, daily routines and crisis signs for people with chronic psychiatric conditions, effectively serving as extensions of the care system. They can therefore help reduce hospital readmissions, allowing people with mental health conditions to live safely in the community.[85] But families cannot shoulder this role alone. They need comprehensive structures of support.

Evidence-based psychoeducational programmes – including illness education, coping strategies and communication training for families – are a key element of this support. Such programmes ease caregiver stress and improve patient outcomes.[86] Interventions that actively involve relatives have been shown to reduce relapse and rehospitalisation rates in the first year after hospital discharge, compared to patient-only interventions.[87]

Caregivers must also be provided with financial and practical support. Studies consistently document the severe economic strain on caregiving families – for example, one review found most caregivers experience "financial constraint, productivity loss and lost employment" while providing care.[88] Policymakers should consider measures such as caregiver allowances, subsidised services or tax credits to offset these costs and prevent caregivers falling into poverty.

In parallel, respite care services play an indispensable role in maintaining caregiver well-being. By offering temporary alternative care (for instance, in-home support or adult day care), family members are able to rest, manage personal needs or even continue working.[89] Because respite can be provided flexibly and continuously, it helps make home-based care a realistic, sustainable alternative to institutionalisation.

Finally, empowering families means formally including them in care planning and linking them to broader support. Where appropriate, caregivers should be invited to participate in treatment and recovery decisions. Service systems must also ensure families have easy access to community based resources so that no family is left navigating complex needs alone.

The stigma surrounding mental illness is a "potent source of distress" for caregivers, so community

85 Akbari M, Alavi M, Irajpour A, Maghsoudi J. Challenges of Family Caregivers of Patients with Mental Disorders in Iran: A Narrative Review. Iran J Nurs Midwifery Res. 2018;23(5):329-337. doi:10.4103/ijnmr.IJNMR_122_17
86 Silaule O, Casteleijn D, Adams F, Nkosi NG. Strategies to Alleviate the Burden Experienced by Informal Caregivers of Persons with Severe Mental Disorders in Low- and Middle-Income Countries: Scoping Review. Interact J Med Res. 2024;13:e48587. Published 2024 Jan 18. doi:10.2196/48587
87 Fulone I, Barreto JOM, Barberato-Filho S, Bergamaschi CC, Silva MT, Lopes LC. Improving Care for Deinstitutionalized People with Mental Disorders: Experiences of the Use of Knowledge Translation Tools. Front Psychiatry. 2021;12:575108. Published 2021 Apr 26. doi:10.3389/fpsyt.2021.575108
88 Addo R, Agyemang SA, Tozan Y, Nonvignon J. Economic burden of caregiving for persons with severe mental illness in sub-Saharan Africa: A systematic review. PLoS One. 2018;13(8):e0199830. Published 2018 Aug 9. doi:10.1371/journal.pone.0199830
89 Zarit SH, Bangerter LR, Liu Y, Rovine MJ. Exploring the benefits of respite services to family caregivers: methodological issues and current findings. Aging Ment Health. 2017;21(3):224-231. doi:10.1080/13607863.2015.1128881

education and anti-stigma initiatives are a critical form of support for them.[90] By reducing stigma and strengthening social networks, policymakers can improve family functioning and resilience.

To sum up, a holistic approach is needed – one that integrates families as partners in care, meets their informational and financial needs, and provides respite and social support. All of which will improve caregiver wellbeing and help end institutionalisation.

PROPER PLANNING AND SUSTAINABILITY

According to the WHO, moving people with mental health conditions and psychosocial disabilities from institutional to community-based care requires planning and preparation. A phased approach, which reorganises and retrains the health workforce while managing their morale, is essential.

Financing is needed to support shifts in policy and legislation. Countries with limited mental health budgets must both work towards incrementally ending institutionalisation using the resources available – with measures such as improving care practices and increasing workforce engagement in rights-based approaches – while pushing for greater external funding. Policymakers also need to rally support from government officials, academics, mental health professionals, families and caregivers among others behind the ending of institutionalisation.

Planning should be culturally sensitive and aim to achieve continuity of care – so people are accounted and cared for after they leave institutions.[91]

As mental health services are implemented, it is vital they are monitored and evaluated, and reliable high-quality data is gathered, to assess the effectiveness of services and inform the allocation of resources. As part of this process, relevant data should be integrated into existing health management information systems or other national data collection tools.

Any community-based services, including housing and social services, need to be run transparently and their work reviewed to assess whether they are providing a high standard of rights-based care. Community and societal attitudes towards people with lived experience of institutionalisation also need to be tracked to gauge the effectiveness of programmes to tackle stigma and discrimination. Crucially, people with lived experience need to be involved in the planning, monitoring and evaluation of deinstitutionalisation, as they are affected more than anyone by this process. This can help avoid the price of failing to properly plan the process of ending institutionalisation – a price tragically illustrated by the well-intentioned example of Gauteng in South Africa.

90 Muralidharan A, Lucksted A, Medoff D, Fang LJ, Dixon L. Stigma: a Unique Source of Distress for Family Members of Individuals with Mental Illness. J Behav Health Serv Res. 2016;43(3):484-493. doi:10.1007/s11414-014-9437-4
91 Lamb, H. Richard, and Leona L. Bachrach. Some Perspectives on Deinstitutionalization. Psychiatric Services, PS, 52, no. 8 (August 2001): 1039–45. doi:10.1176/appi.ps.52.8.1039.

CASE STUDY: SYSTEMIC BREAKDOWN AND HUMAN-RIGHTS VIOLATIONS – INSIGHTS FROM SOUTH AFRICA

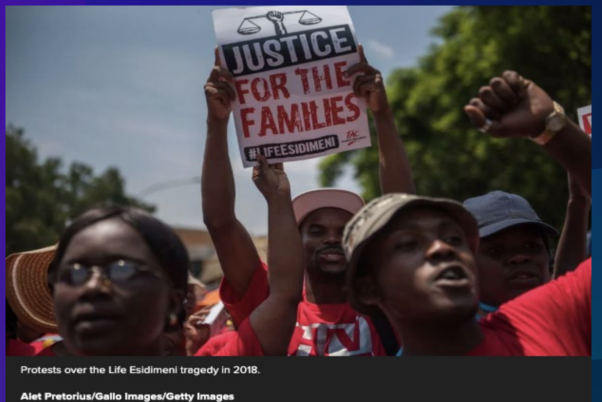
Deinstitutionalisation without systematic long-term investment in community-based healthcare, workforce training and risk appraisal can have devastating consequences.

In South Africa's Gauteng province in 2015, the Department of Health rapidly moved 1,711 mental healthcare users from facilities operated by long-term private provider Life Esidimeni, into the care of NGOs. This deinstitutionalisation measure was taken without adequate oversight mechanisms or safeguards for the rights of vulnerable individuals who were receiving specialised care.[92]

Most of the NGO facilities lacked the expertise and resources to handle the influx of patients effectively. As a result, 144 people died and 44 others are still missing.[93]

Factors such as overcrowding, poor hygiene, inadequate or substandard food, a shortage of qualified staff, and limited access to medicines and other essential supplies caused an entirely preventable tragedy. The government launched an inquest and in July 2024, after an eight-year investigation, found two government officials accountable for the deaths.

The failed attempt to deinstitutionalise in 2015 means the bulk of South Africa's mental health budget is still spent on hospital care. Between 2010 and 2022, the number of standalone psychiatric hospitals increased from 23 to 24, taking the number of beds for mental health patients countrywide to 10,963.[94]
It is still not clear how deinstitutionalisation will be achieved in South Africa. But the country's National Mental Health Policy Framework and Strategic Plan 2023–2030 aims to achieve "comprehensive, high quality, integrated mental health promotion, prevention, care, treatment and rehabilitation for all in South Africa by 2030



Protests in 2018 over the tragedy in South Africa's Guateng province in 2015
Source: Getty Images/Gallo Images

92 Oukouomi Noutchie, S. C. (2024). Systemic failures and human rights violations: lessons from the Life Esidimeni Tragedy. International Journal of Research in Business & Social Science, 13(7).
93 Durojaye E, Agaba DK. Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa. Health Hum Rights. 2018 Dec;20(2):161-168. PMID: 30568410; PMCID: PMC6293341.
94 Sorsdahl, K., Petersen, I., Myers, B., Zingela, Z., Lund, C., & van der Westhuizen, C. (2023). A reflection of the current status of the mental healthcare system in South Africa. SSM-Mental Health, 4, 100247.

RECOMMENDATIONS FROM PEOPLE WITH LIVED EXPERIENCE OF INSTITUTIONALISATION AND FROM CIVIL SOCIETY ORGANISATIONS

The most important voices in the effort to end institutionalisation are the people who have lived or living experience of institutionalisation. Another crucial voice is that of civil society organisations, who advocate for their rights and support them through community-level programmes.

UnitedGMH interviewed people with lived experience and CSO representatives from around the world. We asked them for their recommendations to their governments on what needs to be done to end institutionalisation in their countries. This is what they said:

1. **Prioritise human dignity in all settings:** Respect patient choices about their treatment and focus on improving their overall quality of life through cross-sectoral coordination and the integration of mental health into the health, education, housing, social welfare and justice sectors.
2. **Review and reform laws that allow for involuntary admissions, forced treatment and indefinite institutionalisation:** Implement strict monitoring, accountability and transparency for institutions that remain in operation during the process of ending institutionalisation, including independent oversight by community-led monitoring bodies.
3. **Develop a separate operational plan and budget for ending institutionalisation:** Allocate resources effectively to support the transition to a community-based model, and fund alternative care approaches that prioritise patient choice and recovery.
4. **Increase government budgetary allocation for mental health service reforms:** Allocate adequate resources for diverse patient needs, a wider array of evidence-based care services, the integration of mental health into general healthcare, and community-based mental health and social support services (including crisis intervention teams, peer-support programmes, and employment opportunities for people with mental health conditions, disabilities, or those at risk of institutionalisation).
5. **Implement a system of accountability for human-rights abuses in all care settings:** Safeguard patient wellbeing and maintain high-quality, rights-based standards of care in line with the WHO Quality Rights.
6. **Build capacity and empower people with mental health conditions already living in the community** to support institutionalised individuals and carers to help end institutionalisation.

7. **Focus on families and caregivers, and empower them to allow for the provision of care at home:** Offer education, training and support services to families and caregivers so they are willing and able to provide care at home with support from the broader mental health care system.
8. **Use evidence-based methods to reduce stigma and discrimination** which include the direct participation of people who have lived experience, and make policy changes that foster inclusion and empower individuals to seek care.
9. **Strengthen the collection of data on institutions and community-based alternatives** to support evidence-based policy making and practices, and ensure mental health indicators are included in national development plans.

Ending institutionalisation will take time and financial resources, and the path to achieving it is not linear. But every country can adopt the necessary legislative and policy reforms to lay the foundation for the health system deinstitutionalisation requires. They can also choose implementation options that align with available finances, while exploring additional financing options – something the next brief in this series will explore further.

If policymakers, civil society organisations, people with mental health conditions and mental health professionals work together, every country in the world can find their own path to end institutionalisation.

ANNEX 1: METHODOLOGY

This annex is designed to explain the methodological approach to investigating the data on deinstitutionalisation contained in this brief, as well as to gathering the quotes, stories and recommendations from people with lived experience of institutionalisation and civil society organisations.

For the figures on people in psychiatric institutions and other forms of long-stay facility, we looked mostly at WHO Mental Health Atlas 2020 data. To estimate total admissions into mental hospitals, values for countries with missing data were imputed as the median for their income grouping. Global aggregates were considered as the means for measuring the total numbers in mental hospitals, rather than admissions. We did not use these figures, however, because they have low coverage (just 87 countries) and were not presented in detail in the WHO Mental Health Atlas 2020, suggesting low confidence in them. There is brief discussion of child and adolescent numbers, and due to the lack of detail, desk research was conducted to provide further information in certain settings.

There is little to no quantitative data on people held in institutions for reasons not relating to severe mental health conditions. Naturally, there is little incentive for governments to report this data. However, there are reports and case studies on specific examples, which are the subject of a literature review we conducted. We also interviewed civil society organisations working with people in institutions to try to make up for the lack of quantitative data.

To capture data on lengths of stay in institutions, we looked mostly at WHO Mental Health Atlas 2020 data as it contains strong information on duration of stays. As a result, the vast majority of the analysis in this section of the brief is taken from the WHO Mental Health Atlas 2020 directly or is manipulations of the original data, which backs up the WHO Mental Health Atlas 2020. Again, it is important to note that countries are always anonymised here deliberately, due to the conditions under which the WHO Mental Health Atlas 2020 supplied the data. One issue with the data from the WHO Mental Health Atlas 2020 is that it only has ‘More than 5 years’ as an upper bound category. Therefore, we looked into case study reports of the longest duration of stays in mental hospitals in a variety of countries.

There is limited quantitative data on human rights violations and how often they occur. So to ascertain the most commonly occurring human rights violations in all forms of institutional care, we had to limit our approach to:

- **case study literature research**
- **interviews with people with lived experience and civil society organisations working with people in institutions**

For the quotes, case studies and recommendations on ending institutionalisation from people with lived experience and civil society organisations, we selected individuals to interview from 21 countries covering Asia, Africa, North and South America, Europe and the Pacific: Trinidad & Tobago, St Lucia, Grenada, Brazil, Nigeria, South Africa, Sierra Leone, Malawi, Ghana, Kenya, Liberia, India, Pakistan, Malaysia, Bangladesh, Sri Lanka, Nepal, Indonesia, Ukraine, the Philippines and Lebanon. We gathered a total of 25 combined responses to surveys and in-person interviews. Questions were provided in advance and interviewees were invited to answer only those they were comfortable speaking about. Their consent was taken prior to the inclusion of their answers in the policy brief.

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NO ONE SHOULD BE MADE TO FEEL LIKE A PRISONER ON ACCOUNT OF THEIR MENTAL HEALTH