

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

Practical guide to the **deinstitutionalization** of psychiatric hospitals



#MentalHealthForAll

DI and the right to community life

A planned transition and a value-driven movement.

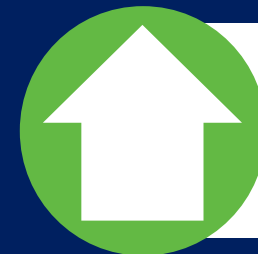
Institutions globally absorb about **half of governments' resources for mental health**

Institutions are associated with **isolation, loss of autonomy, and human rights violations.**

DI is the planned transition from institutional to **community-based care.**



DI is about enabling people to live with **dignity, freedom, choice** and the **support** they need in their communities.



Well-planned DI improves recovery, health and inclusion.

What DI is, and is not

Avoiding common misconceptions.

DI can mean:

- downsizing and shifting resources
- building links with community services
- changing care practices for recovery
- expanding the role of general hospitals
- working with families

DI is not:

- rapid bed closure without alternatives
- unsupported discharge
- a cost-cutting exercise
- shifting responsibilities to families
- smaller but still restrictive settings



The point is not that people do not need support. Many people need significant support. The question is **where**, **how** and **with whom** support is provided.

A transformation that is possible

Across the world, we have seen progress.

Many countries have:

- Closed or reformed psychiatric hospitals.
- Expanded community-based services.
- Strengthened human rights frameworks.
- Increased role of people with lived experience.



9% Countries have fully transitioned to community-based care

18% Countries are in late stages of transition



Leading to improved **access**, **quality** of care and social **inclusion**.

Global frameworks support DI:

- WHO Comprehensive Mental Health Action Plan
- UN CRPD

Yet institutionalization persists

Progress is real, but uneven and fragile



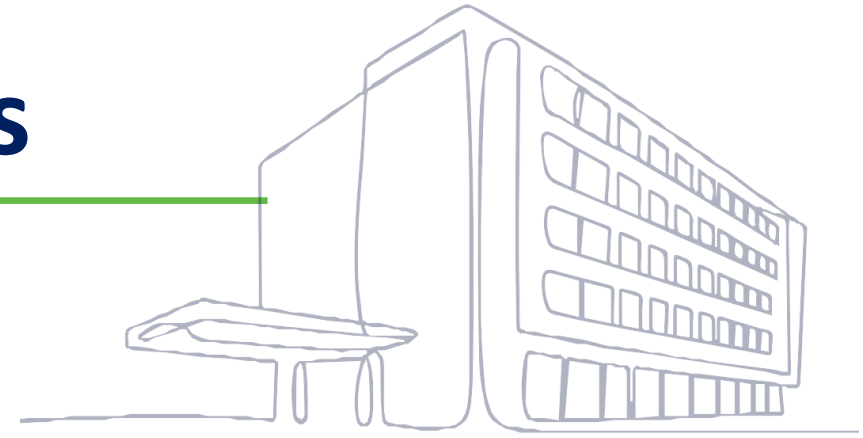
- Nearly half the world remains in **early stages** of transition away from institutional care.



- Psychiatric hospitals get nearly **half** of government mental health budgets.



- Around **one in four** people admitted to them stay longer than six months.



Transformation cannot be assumed. It must be **planned, funded, led** and **sustained**.

About the DI guide

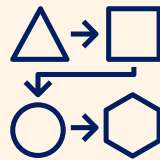
A tool for turning commitment into practical, context-sensitive action.

Practical action



The guide outlines **key activities and considerations** for driving DI at the local level.

Flexible framework

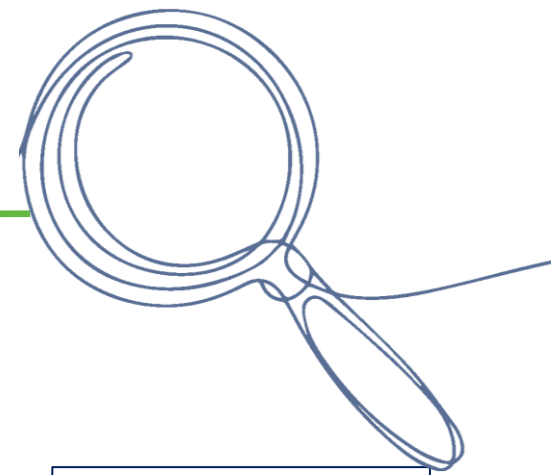


The guide can be **tailored to meet the specific needs** and constraints of different contexts.

Global examples

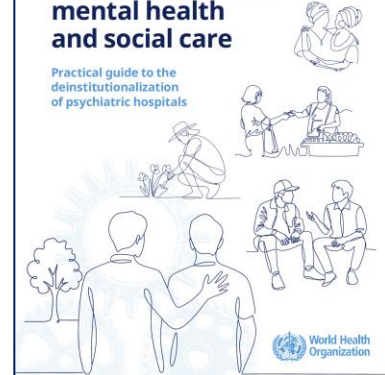


The guide features case studies and examples of DI **from every WHO region**.



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Audience

Hospital leaders and senior policy-makers

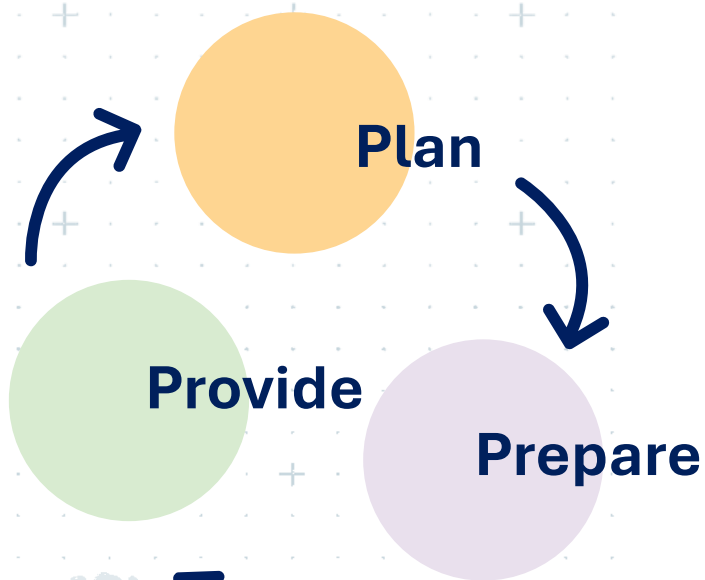
Focus

Long-stay residents (> 6 months)

Developed through extensive **literature** review and **global expert** consultation, including PWLE.

Practical pathways

A focus on activities within the influence of psychiatric hospitals.



Reduce admissions

The entrance

Prevent admissions and shorten stays



Transform practices

Experience of care

Improve quality of care and uphold human rights



Increase discharges

The exit

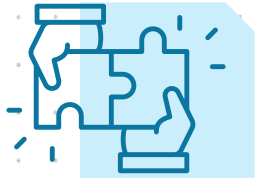
Discharge with continuity of care and supports for social inclusion

Stakeholder engagement

Monitoring & evaluation

Three principles

Principles that matter throughout.



Lead with people with lived experience.



Do **not recreate** institutional care in the community.



Reduce beds and **expand** community services and supports **together**.



Reinvest bed closure savings in community services and supports

Resources follow people

Take action now!

Start where change is possible

- + No setting starts from a perfect position but every setting can **take the next step**.

Explore the guide, **reflect** on what is possible, identify **one action** to advance DI.

- + Together we can help make community life a **real possibility for everyone**.

Real mental health reform is not only about changing services – it is about changing whose **knowledge** counts, who makes **decisions**, and what kind of **lives** our systems make possible



Changing the Culture of Mental Health Care: The Nursing Contribution

ESPEN GADE ROLLAND · NORWAY

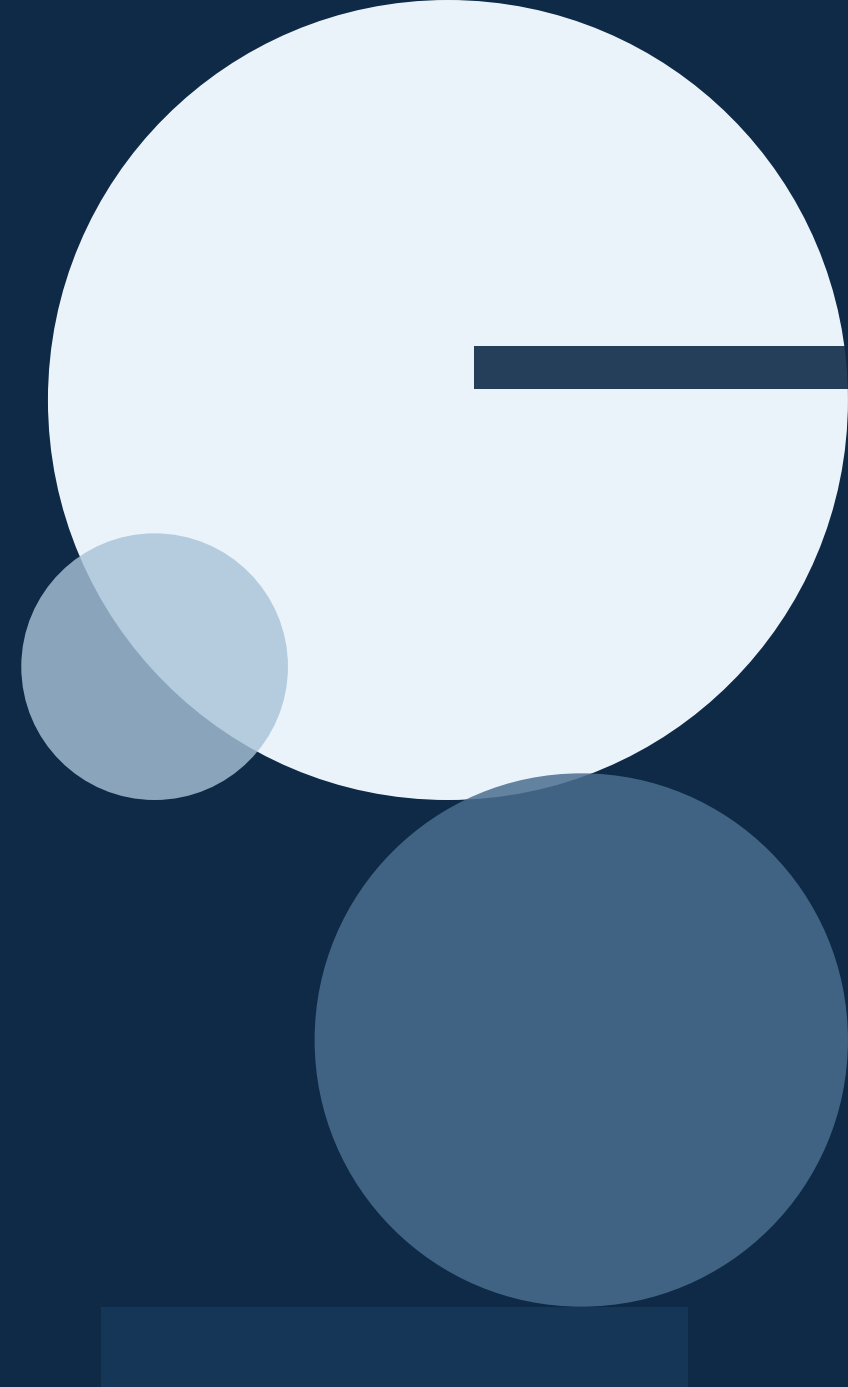
RN, MNSc, CGNC, FAAN

President Norwegian Nurses Organization's professional group in mental health and addiction

Associate Professor, Lovisenberg Diaconal University College, Oslo, Norway



NORWEGIAN NURSES
ORGANISATION



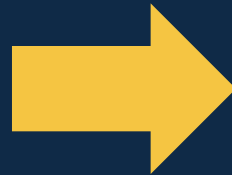
Culture change means moving from control to partnership

FROM

Control

- Professional dominance
- Risk-focused care
- Dependency
- Institutional thinking

“What is wrong with you?”



TO

Partnership

- Strengths and recovery
- Autonomy
- Community participation

“What matters to you?”

EVERYDAY PRACTICE

Nurses shape everyday culture

Largest workforce

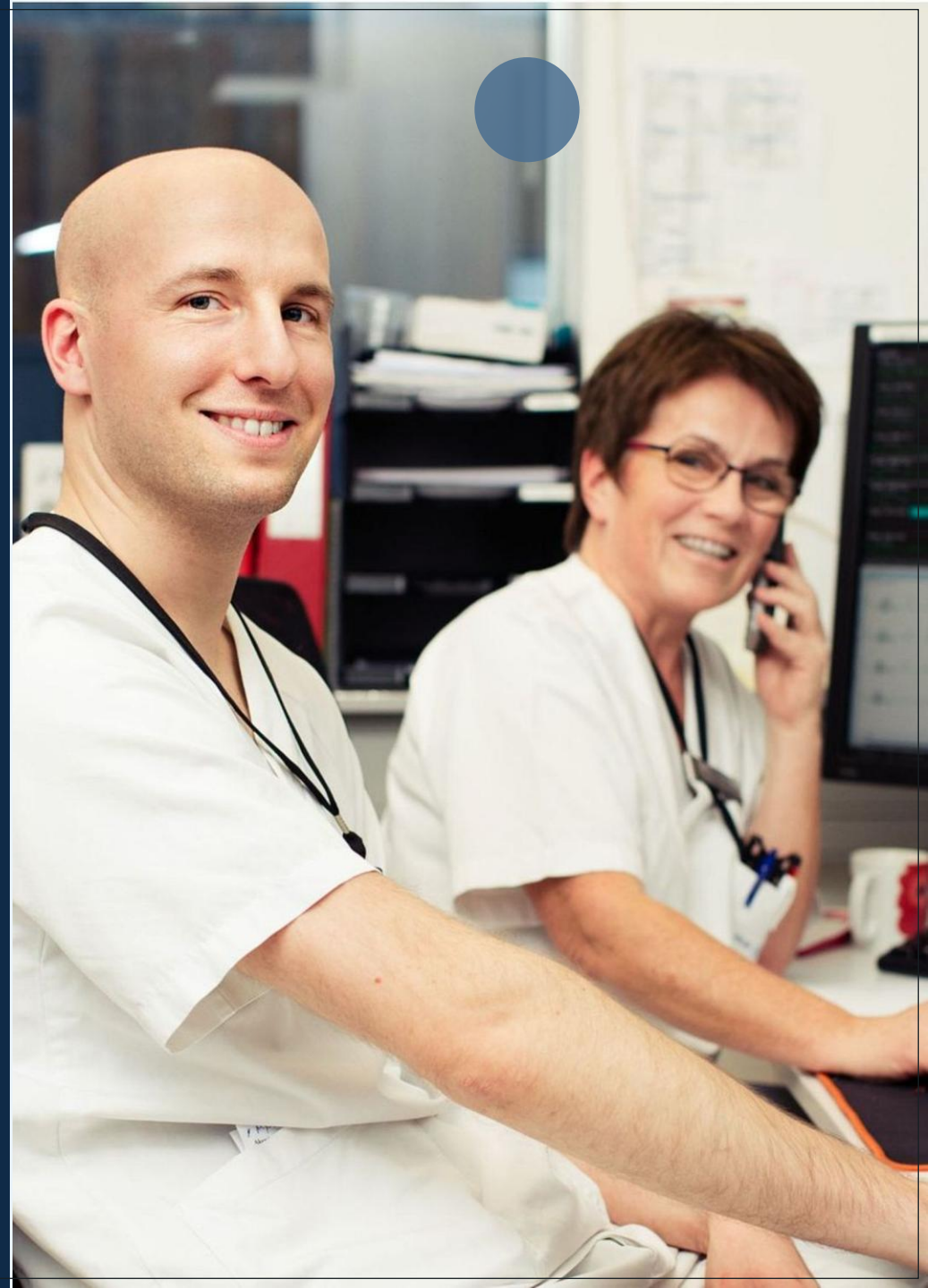
Whole care journey

Therapeutic relationships

Hope and recovery

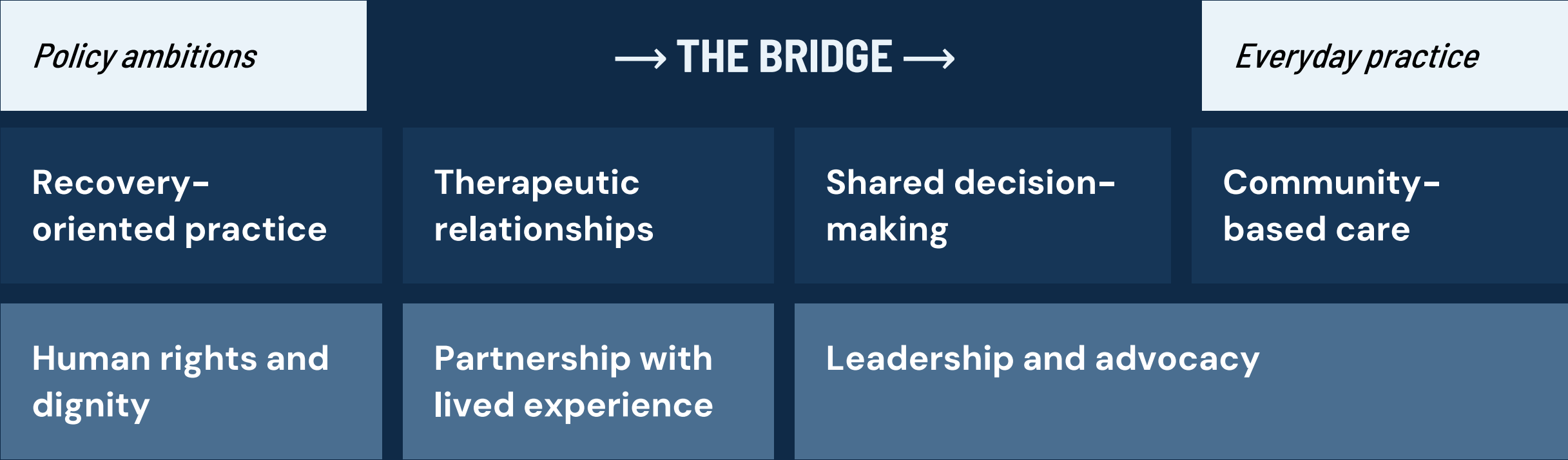
Trust and participation

Culture changes through everyday interactions.



FROM AMBITION TO PRACTICE

Culture follows competence



Competencies are the bridge between policy ambitions and everyday practice.



NORWAY · LEARNING TOGETHER

Lived experience is expertise: learning with people, not about them

Listening to people



Working with people

Lived experience in nursing education

Co-authored books

Joint conferences

Shared presentations and knowledge development

Co-design · co-production · co-teaching

**Professional
expertise**

+

**Lived
experience**

=

**Better
services**

Education shapes future practice

Partnership

Recovery orientation

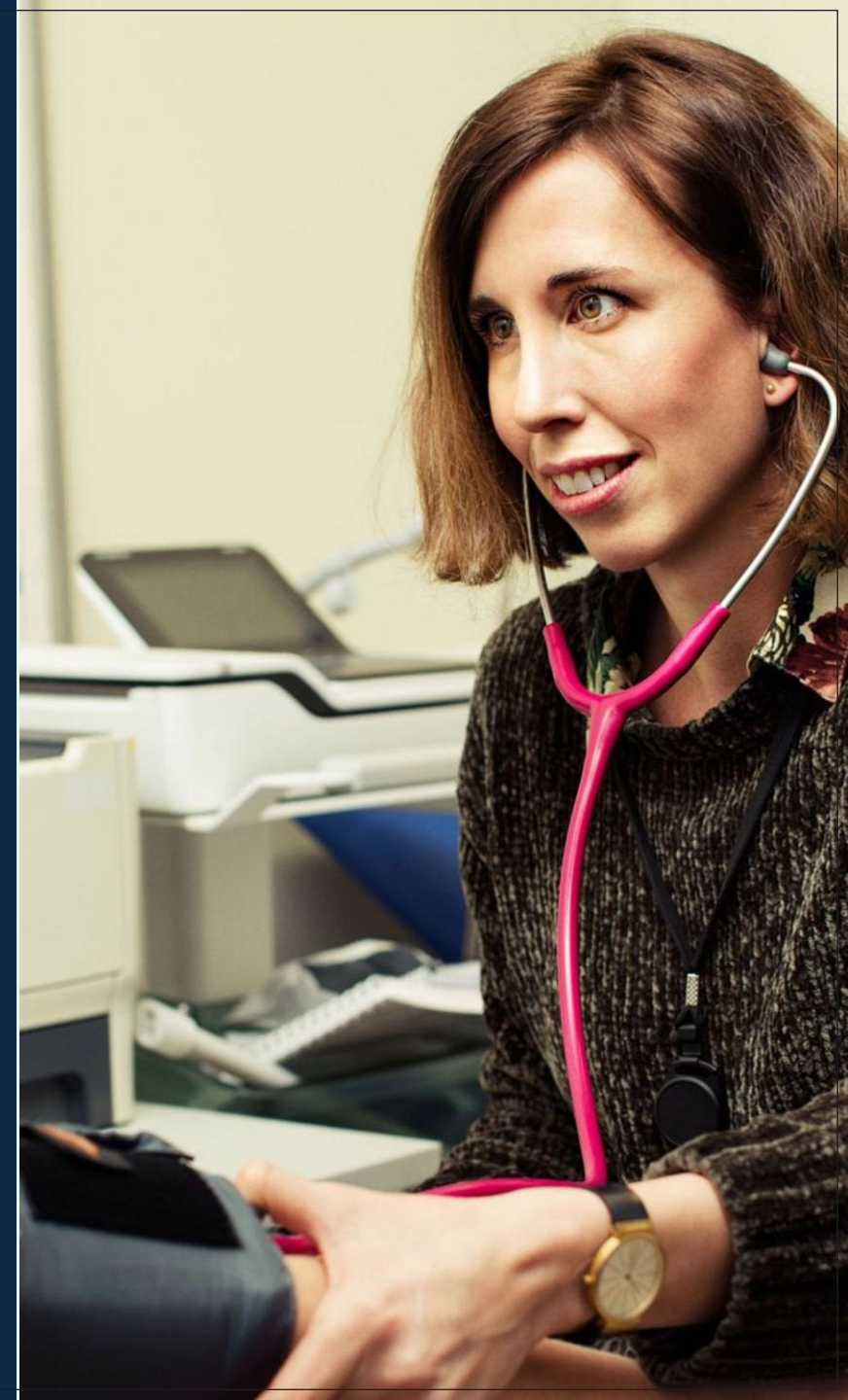
Shared power

Respect for lived experience

Community-based approaches

Human rights perspectives

Today's learning creates tomorrow's culture.



RELATIONSHIPS · COMPETENCE · PARTNERSHIP

Trust is preparedness

Culture change begins with relationships. Mental health nurses build trust through competence, partnership and recovery-oriented practice.

One conversation.

One relationship.

One act of trust at a time.



Take-home messages and one action

1 · Dignity, not dependency

2 · Autonomy, not paternalism

3 · Community living, not institutional thinking

4 · Partnership, not consultation

5 · Competencies that support recovery

6 · Lived experience recognised as expertise

ACTION

**Move from asking “What is wrong with you?”
to asking “What matters to you?”**



Thank you – please stay in contact

Espen Gade Rolland

RN, MNSc, CGNC, FAAN

President Norwegian Nurses Organization's professional group in mental health and addiction

Associate Professor, Lovisenberg Diaconal University College, Oslo, Norway

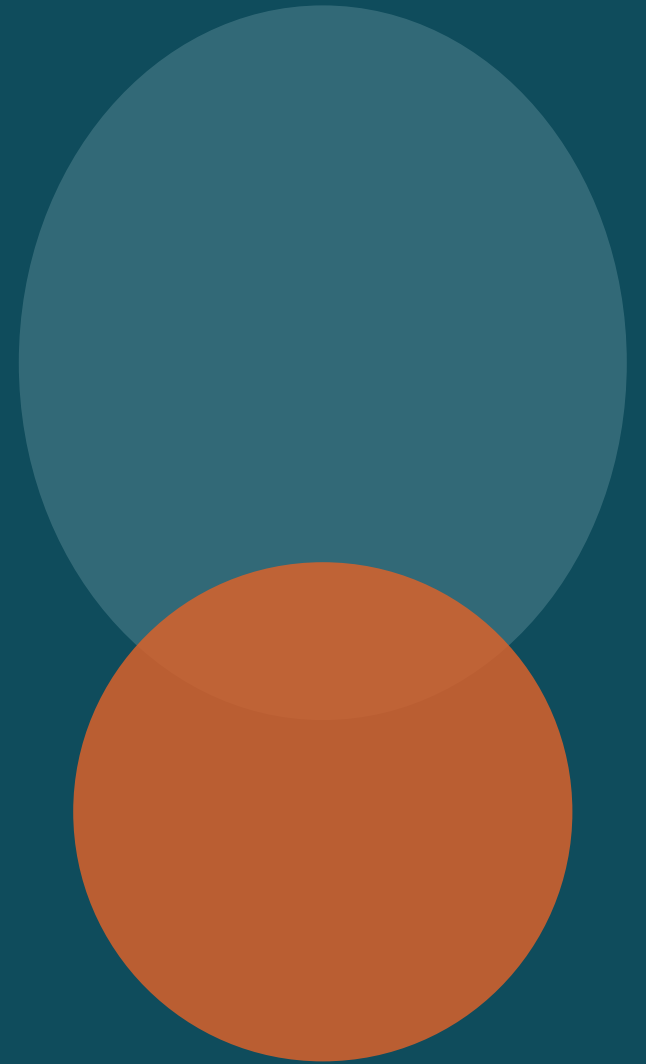
Phone: +47 408 42 941

E-mail: espen.gade.rolland@nsfverv.no



Lived Experience in Mental Health Nursing: The Future

Nurses' capacities to understand persons' relevant lived experiences, builds trust, supports a working relationship (Peplau) in which provider and person reach shared decisions. It can support engagement with treatment and involvement with community resources. Basic and specialist mental health nurses build trusting bonds and alliances.



Same diagnosis, different lived experience

A form of expertise

WHO asks that lived experience be valued alongside professional knowledge.

The key word is relevant

The experiences, meanings, beliefs, fears and strengths shape how a person understands accepts, mental health disorders and treatment.

“Nothing about us without us”



Fears medication

Severe side effects in the past



Distrusts services

Coercive treatment, betrayal of trust



Values congruence: family approval, culture, religion



Spiritual framework

A spiritual view of symptoms

Why it matters

Decisions and treatment done *to* a person, group, organization



Relationship, treatment, actions developed/planned *with* persons, groups, advocates



Builds trust

and reduces fear and anxiety, affirms value of participants



Exposes barriers

that no symptom checklist will find



Shows strengths

and the persons' resources and strengths



Fits demands of reality

housing, money, family and belief, work

The nurse direct provider, leader, teacher

1 Asks about meaning

“What has this been like for you?” “How would you tell your story?”

2 Explores earlier treatment, actions

What helped, what did not, what damaged trust

3 Observes, asks, affirms

Hesitation, avoidance, family dynamics, coping, interest in collaboration

4 Understands the context

Economic, organizational, political, performance..where the power lies

5 Build the relationship

Peplau: trust, to partner (shared authority in decision making), collaboration

6 Shared decisions

“Collaborative review of options that fit best”

Teaching: the lived experience in the curriculum

89%

of attitude measures moved in a more favourable direction after teaching led by Experts by Experience

Happell et al., 2019. Mental health nursing students in Australia, Ireland and Finland.

FOUR LEVELS OF INVOLVEMENT

1

**Guest
storytelling**

One class, one
story

2

Co-teaching

Alongside faculty,
with feedback in
simulation

3

Co-production

Designing,
selecting and
assessing

4

Academic posts

Paid academics
leading units

Recognizing specificity



Individual specificity

Lived experience belongs to one person. It cannot be read off a diagnosis, a culture or an age group.

One story does not represent everyone.



Contextual specificity

What is relevant depends on the setting, the moment and the decision at hand.

“Which part of this person's experience matters for this decision, here and now?”

Why implementation is complex



Time

System demands squeeze out the conversations that build enable insight and bonding



Power

Inclusion without influence is tokenism



Burden

Retelling a painful story has a cost: preparation, fair pay and support; let the person set the guidelines



Readiness

Participants need preparation and debriefing



Nurses' own experience

Disclose? When and how calls for judgement



Evaluation

Attitudes are easier to measure than practice or outcomes, influence

Systems, organizations, politics: Doors open



Interdisciplinary teams include person(s) with experience of mental health disorders

Organized advocacy by persons and groups with lived experience i.e. Nurses in recovery, family representation in treatment planning with persons with mental health disorder

Persons with lived experience appointed to Boards of Directors/Trustees at agencies, hospitals, local and national government bodies. Community facilities include representatives with experience.

Education and continuing education include course planning and co-teaching with persons with lived experience

Lived experience is expertise

Seek the part that is relevant, for this person, group, or organization, in this context, and let it change what we do.

Thank you!



Lived Experiences Heard: From Real Voices to Real Change

Making person-centred mental health care a reality across different contexts

Sheryl Garriques-Lloyd, MSc, RN
Lecturer (UWI, Mona), Mental Health Professional



Mental health: high concern, unequal attention

Ipsos Health Service Report 2025

45%

**name mental health
among the biggest
health problems in
their country**



**Highest-ranked health concern
in the 30-country average**

The gap between values and perceived care

76%

say mental and
physical health are
equally important



76%

38%

think their
healthcare system
treats them equally



38%



Lived experience is expertise

A diagnosis cannot tell us everything about a person's life.

We are moving away from labels. Someone is living with a mental disorder. That disorder does not define them.

Ask about priorities, strengths and barriers.

Give the person a real role in care decisions.



Illustrative AI-generated scene

Meaningful engagement values lived experience and shares decision-making power (WHO, 2023b).



The nursing encounter: listening that changes care

01

Listen

Ask: “What matters to you in your care?”

02

Agree

Discuss options and record one shared goal.

03

Support

Explain care clearly.
Check understanding.

04

Follow through

Confirm the next contact and referral plan.

Throughout: pay attention to privacy, consent, cultural respect and physical health



Jamaica: building on community mental health care



Illustrative AI-generated scene

An established community model

PAHO in 1963 recommended mental health care being integrated into primary care, with clinic visits, home visits and outreach.

Community mental health services began in Jamaica in 1964 (PAHO, 2025)

Nursing priority

Provision of deinstitutionalised care and mental health care advocacy.

Community expansion was announced in 2025. Announcement does not establish full implementation (MoHW, 2025).



Caribbean care needs local adaptation

Regional direction

PAHO continues to call for mental health reform grounded in human rights and equity.

(PAHO, 2023)

Countries and communities need to continue working collaboratively and independently on their own delivery plans.

Questions for a local nursing team

Access

Can people access care and protect their privacy?

Culture

Does the current mental health service respect language and preferred support?

Continuity

How will care continue during disruption or relocation?



Global guidance gives nurses a shared foundation

Person-centred services

WHO guidance (mhGAP) connects recovery and rights with community support.

Care should be linked to everyday life, including housing, education and work.
(WHO, 2021)

Supported clinical practice

mhGAP supports non-specialist health workers with evidence-based guidance.

Training needs supervision and clear referral pathways.
(WHO, 2023a)

Local protocols and professional scope still govern nursing practice.



Jamaica: patient voices identified reform priorities

57

participants across six stakeholder groups

Including people with serious mental illness and chronic physical illness, caregivers and mental health nurses.

What participants called for

Less stigma and discrimination

Action on policy and practice gaps

Better staffing and service operations

Attention to social needs

Evidence boundary

The study reports recommendations, that can guide implementation and measure patient outcomes.



Nepal: lived experience changed staff training

Real implementation example: PhotoVoice

Whose voice?

People with lived experience developed photographic recovery stories and shared them with primary healthcare workers.

What changed?

Training included service-user narratives and direct contact. People receiving care became contributors to professional learning.

For nursing education: support and prepare lived-experience co-educators, share lived-experiences as a part of the curricula.

(Rai et al., 2023).



Victoria: lived experience helped shape reform

01 People shared their experiences

Thousands contributed to the Royal Commission. Their stories informed its reform recommendations.

02 Government changed the legal framework

The Mental Health and Wellbeing Act 2022 commenced on 1 September 2023.

03 Participation gained an oversight role

The Commission supports lived-experience leadership, handles complaints and monitors the system.

Evidence of policy and governance change. Better clinical outcomes still require evaluation.

Department of Health, Victoria (n.d.-a, n.d.-b); Mental Health and Wellbeing Commission (2026).



An illustrative case: a plan the person can use

Teaching scenario, not a real person or testimony

An adult living with depression misses a follow-up appointment.

Listen: work hours conflict with clinic times, and treatment concerns remain unanswered.

Agree: on a feasible review, potential options, discussion of concerns and one personally meaningful goal.

Review together: Next visit, did the revised plan help?

Illustrative application of WHO (2021, 2023a).



Illustrative AI-generated scene



Nursing leaders make participation possible

Protected learning

Provide supervision and skills practice.
Include lived-experience educators with
consent and support.

Shared service decisions

Give service users influence over
improvement priorities. Report back on
changes and barriers.



Illustrative AI-generated scene

WHO (2023b). Jamaica's EQUIP training illustrates attention to competence and supervision (PAHO, 2024).



Improvement should include the person’s experience

A proposed small-scale review for a ward, clinic or community team

What to review	A practical measure
Voice in the plan	Care plans with a goal stated in the person’s own words
Continuity	Agreed follow-up contacts completed
Experience of care	People reporting respect and involvement
Recovery that matters	Progress towards each person’s treatment and chosen goals

Proposed improvement measures informed by WHO (2021, 2023b).



Call to action: a 90-day nursing commitment

Nurses and students

At the next encounter, ask what matters and record one shared goal.

Students: practise with supervision.

Nursing leaders and services

Within 30 days, choose one care pathway to improve with service users. Small wins count.

Review experience and follow-up at 90 days.

Policymakers

Resource funding, community nursing, supervision and meaningful participation.

Require public reporting on access and experience.

Whose voice will change a decision you make this week?

Proposed commitments, informed by WHO (2021, 2023b) and PAHO (2023).



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Preparing Nurses to Lead the Change: From Passive Listening to Co- Created Practice

Dan Wesemann, DNP, PMHNP-BC, APRN, FISP, FAANP, FAAN |
PMHNP-DNP Program Director, University of Iowa |
Past President, International Society of Psychiatric Nurses (ISPN)



Paradigm Shift: Moving Beyond Bio-Medical Centered Models

- **The Structural Barrier:** Academic curricula historically train nurses to focus heavily on symptom management and task-oriented interventions, often isolating care from lived experience.
- **The Relational Reality:** True recovery happens within interpersonal relationships (Peplau's Interpersonal Relations Theory).
- **De-stigmatizing Systems:** Nurses must be trained in high-acuity, vulnerable environments (e.g., community-based care, carceral settings, and youth programs) to dismantle implicit bias before entering practice.



3 Pillars for Modern Mental Health Nursing Education



1. Co-Designed Curricula: Integrate individuals with lived experience directly into the classroom as co-educators and evaluators, not just guest speakers.



2. Experiential Immersion: Embed nursing students in non-traditional community and forensic settings where non-pharmacological modalities and group psychotherapy build true rapport and empathy.



3. Relational Practice & Advocacy: Teach psychodynamic principles alongside psychopharmacology—empowering nurses to advocate against forced treatments and medication discontinuity.

Building Human-Centered Care Partnerships

Shift Power Dynamics: Transition from clinician-driven treatment plans to shared decision-making models.

Evidence of Impact: Student clinical immersions in community/carceral group therapies show dramatic drops in student anxiety, shifts in negative biases, and improved therapeutic alliance.

Policy Integration: Aligning academic leadership with national and WHO QualityRights frameworks to embed human rights into daily clinical workflows.

One Clear Mandate for Healthcare Leaders, Educators, and Policymakers

For Educators: Do not design a single course or clinical rotation without real patient/consumer voice steering the learning objectives.

For Health Services & Policymakers: Allocate funding and policy mandates that compensate individuals with lived experience for their expertise in training the healthcare workforce.

The Result: We build a resilient nursing workforce capable of transforming institutional cultures into human-centered environments.