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# STAGES, STRATEGIES, AND POLICIES OF DEINSTITUTIONALIZATION FOR PEOPLE WITH MENTAL DISORDERS: A SCOPING REVIEW

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**ABSTRACT**
Deinstitutionalization represents a major global reform in mental health care, shifting from long-term psychiatric hospitalization toward community-based services. While widely promoted by the World Health Organization (WHO), the processes, strategies, and policies underpinning this transition vary substantially across contexts. This scoping review aimed to map the stages, strategies, and policy frameworks of psychiatric deinstitutionalization worldwide, with particular attention to Indonesia's evolving experience. Guided by Arksey and O'Malley's scoping review framework, we searched PubMed, Scopus, ProQuest, Science Direct, Google scholar and WHO grey literature for studies published between 2005-2025. Keywords included deinstitutionalization, community mental health, rehabilitation, mental disorders, policy. Eligible studies examined deinstitutionalization in relation to people with mental disorders, focusing on stages, strategies, or policies. Data were charted by country/region and synthesized thematically. Seventeen studies were selected for inclusion from 983 articles screened. Globally, deinstitutionalization follows a continuum: (1) reducing psychiatric bed, (2) transition to community care, (3) strengthening of community-based services, (4) consolidation of integrated systems, and (5) implementing advanced model (e.g., Trieste, Italy). Strategies include community integration, therapeutic residential services, civic engagement, and multisectoral collaboration. Policy range from limited reforms to comprehensive laws institutionalizing community mental health.: Deinstitutionalization is a complex. In Indonesia remains in a transitional stage, with community engagement compensating for policy gaps. Strengthening legal enforcement, expanding community services, and promoting multisectoral integration are key to achieving a rights-based mental health system.

Keywords: community-based mental health; deinstitutionalization; mental disorders; policy; scoping review

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## INTRODUCTION

Over the past five decades, mental health systems worldwide have experienced significant transformation, shifting from a reliance on large psychiatric institutions to community-based models of care. This process, known as deinstitutionalization, is recognized as one of the most critical reforms in mental health policy (Fakhoury & Priebe, 2007) While deinstitutionalization has been widely endorsed by the World Health Organization (WHO) and integrated into global frameworks such as the Mental Health Action Plan, its implementation has varied considerably across regions and countries (Montenegro et al., 2023; WHO SEARO, 2024).

International experiences reveal diverse trajectories. Italy's Trieste model exemplifies the successful replacement of psychiatric hospitals with community mental health centers under a rights-based approach (Mezzina, 2014, 2018; Mezzina et al., 2019). In Brazil, progress in deinstitutionalization has been facilitated by psychiatric reform laws and the establishment of therapeutic residential services (Fulone et al., 2021; Silva et al., 2022). Taiwan's community-based rehabilitation (CBR) programs have proven effective in reducing stigma and preventing relapse (Lin

et al., 2022). Conversely, countries such as Ghana and Slovenia are still navigating transitional phases, presenting both opportunities and challenges in adapting deinstitutionalization to their sociopolitical contexts (Adu & Oudshoorn, 2020; Horvat Golob et al., 2025).

In Indonesia, the deinstitutionalization process is closely linked to the decentralization of the health system and the enactment of the Mental Health Law (No. 18/2014), which was subsequently revoked and replaced by Health Law No. 17 of 2023. The mental health provisions in Health Law No. 17 of 2023 are outlined in Articles 74 to 85 of Chapter V of Health Efforts, Part 11, pages 39-43. Earlier efforts indicated a gradual transition from institutional care to community-oriented approaches (Idaiani, 2010). More recent initiatives encompass community care for schizophrenia (Kurniawan et al., 2023), civic engagement strategies that mobilize families and community networks (Irmansyah et al., 2020), and localized adaptations of mental health policy in Yogyakarta (Arisanti et al., 2018). Despite these advancements, the national trajectory remains inconsistent, characterized by significant regional disparities in service provision and ongoing challenges related to stigma, resources, and policy enforcement.

Given the diversity of approaches, a scoping review is warranted to systematically map the stages, strategies, and policies of deinstitutionalization across global, regional, and national contexts. This review aims to (1) identify the stages of deinstitutionalization documented in the literature, (2) examine the supporting strategies employed in various settings, and (3) analyze the policy frameworks that have facilitated or impeded deinstitutionalization, with a particular emphasis on Indonesia's evolving experience.

## METHOD

This review adhered to the scoping review methodological framework established by Arksey and O'Malley (2005) and Westphaln et al.(2021) The process comprised five stages: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarizing, and reporting the results.

### Research Questions

The guiding questions were as follows: 1) What stages of deinstitutionalization are identified in the global literature? 2)What strategies support the implementation of deinstitutionalization? 3)What policies enable or constrain the deinstitutionalization process? 4). How is Indonesia positioned within the global landscape of deinstitutionalization?

### Search Strategy

A comprehensive literature search was conducted using multiple databases, including PubMed, Scopus, ProQuest, Science Direct, Google scholar and WHO grey literature. Keywords included deinstitutionalization, community mental health, rehabilitation, mental disorders, policy. The search was restricted to articles published between 2000 and 2025 to capture contemporary policy and practice.

### Eligibility Criteria

Studies were included if they: Examined deinstitutionalization in relation to individuals with mental disorders; Addressed the stages, strategies, or policies of deinstitutionalization; Were original research articles, reviews, or policy analyses published in peer-reviewed journals; They were written in English or Indonesian. Exclusion criteria included studies that focused exclusively on substance use disorders, non-peer-reviewed reports, or articles lacking relevance to mental health service reform.

### Study Selection and Data Charting

After duplicates were removed, titles and abstracts were screened independently by reviewers. Full texts were then evaluated against the inclusion criteria. The flow of information npresented with a

PRISMA flowchart Figure 1 below. Data were extracted and charted using a standardized template that captured: (1) country or region, (2) stage of deinstitutionalization, (3) supporting strategies, and (4) policy frameworks.

**Analysis**

Data were synthesized thematically into three domains: stages, strategies, and policies. The findings were summarized in comparative tables (Tables 1–2), and the results were analyzed to identify cross-country patterns, barriers, facilitators, and implications for Indonesia

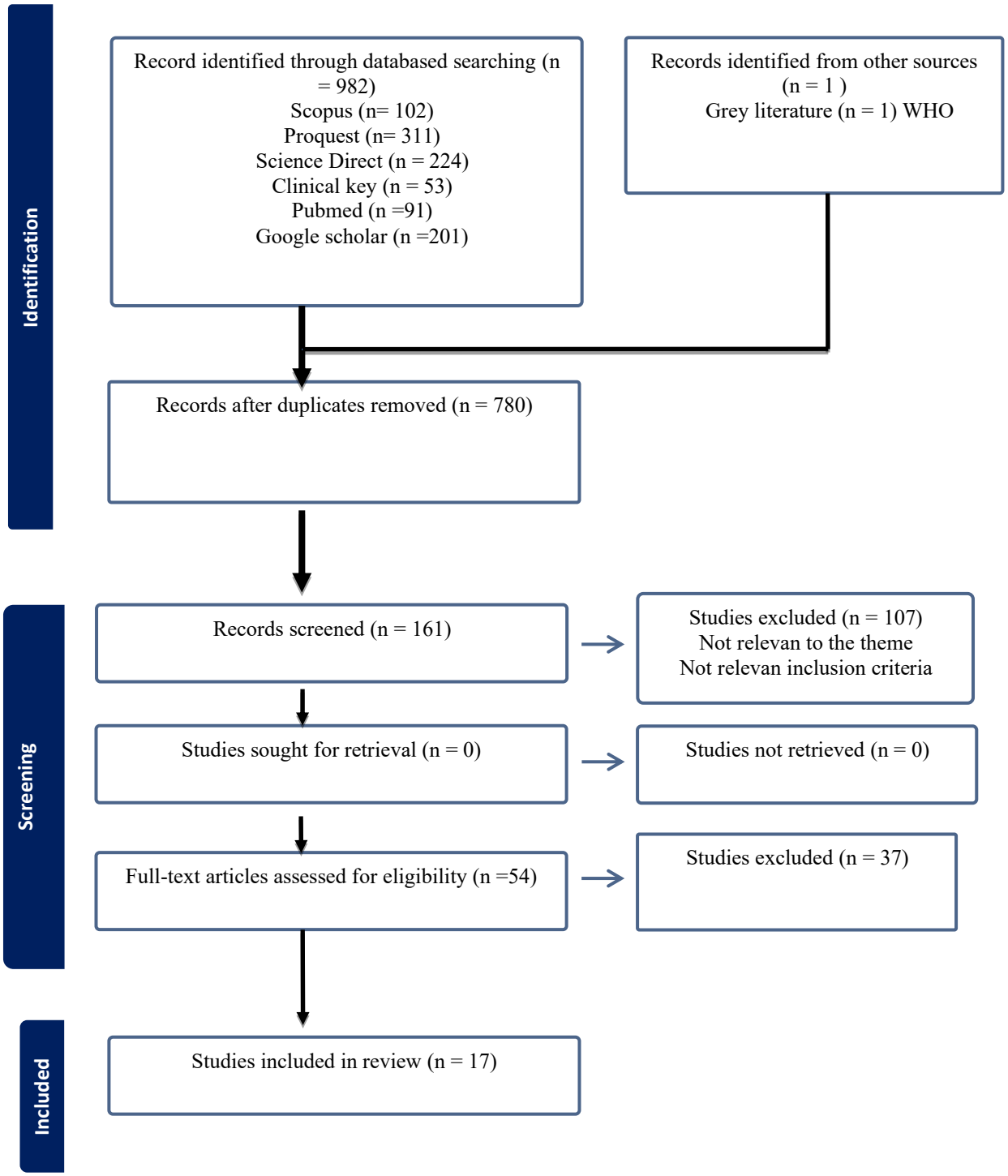


Figure 1. PRISMA flowchart of this syreview

## RESULT

Of the total 983 article screened, seventeen studies were selected. A total of seventeen studies were included in this scoping review, encompassing global frameworks, international experiences, regional perspectives, and national evidence from Indonesia.

Table 1.
Characteristics of Included Studies

| No | Country / Source | Stage of Deinstitutionalization | Supporting Strategies | Related Policies | Reference |
|---|---|---|---|---|---|
| 1 | Global – Fakhoury & Priebe (2007) | Initial stage: reduction of large psychiatric hospitals | Integration of community services | Global psychiatric reform | Fakhoury & Priebe (2007). Current Opinion in Psychiatry, 15(2), 187–192. |
| 2 | Indonesia – Idaiani (2010) | Early stage: deinstitutionalization → decentralization | Role of mental hospitals and social care institutions | Law No. 22/1999 & National Policy | Idaiani (2010). |
| 3 | Ghana – Adu & Oudshoorn (2020) | Early stage | Bronfenbrenner's social-ecological model | Mental Health Act Ghana 2012 | Adu & Oudshoorn (2020). |
| 4 | Indonesia – Irmansyah et al. (2020) | Transitional stage: community shift | Civic engagement, cadres, advocacy, family participation | Mental Health Law, community advocacy | Irmansyah et al. (2020). |
| 5 | Europe – Horvat Golob et al. (2025) | Transition from institutions to community | Risk–benefit analysis | EU community care policies | Horvat Golob et al. (2025). IJERPH, 22(7), 1066. |
| 6 | Italy – Trieste (Mezzina, 2014, 2018; Mezzina et al., 2019)) | Optimal model: complete closure of psychiatric hospitals | Open-door, no-restraint system, 24/7 CMHCs | Law 180/1978 (Basaglia Reform) | Mezzina (2014, 2018). |
| 7 | Brazil – Silva et al. (2022) | Advanced stage: patient autonomy | Therapeutic residential services | Brazilian Psychiatric Reform | Silva et al. (2022). Ciência & Saúde Coletiva, 27(1), 101–110. |
| 8 | Taiwan – Lin et al. (2022) | Advanced stage | CBR more effective than IBR in reducing stigma | Taiwan community rehabilitation policy | Lin et al. (2022). |
| 9 | UK – Killaspy et al. (2005) | Consolidation post-deinstitutionalization | Rehabilitation, housing, social support | NHS Mental Health Policy | Killaspy et al. (2005). |
| 10 | Canada – Piat & Polvere (2014) | Consolidation and integration | Continuity of care, service integration | Canadian integrated care policy | Piat & Polvere (2014). |
| 11 | Brazil – Fulone et al. (2020, 2021) | Post-deinstitutionalization | Knowledge translation tools | Brazilian reform policy | Fulone et al. (2020, 2021). |
| 12 | Taiwan – Lin et al. (2022) | Post-deinstitutionalization | Family support, risk of rehospitalization | Taiwan Mental Health Act | Lin et al. (2022). |

| No | Country / Source | Stage of Deinstitutionalization | Supporting Strategies | Related Policies | Reference |
|---|---|---|---|---|---|
| 13 | Indonesia – Kurniawan et al. (2023) | Post-deinstitutionalization | Community care, family and community support | Yogyakarta community practice | Kurniawan et al. (2023). |
| 14 | Global – Ribeiro et al. (2021) | Innovations in deinstitutionalization | Task-shifting, multisectoral collaboration | WHO Mental Health Action Plan | Ribeiro et al. (2021). Epidemiology and Psychiatric Sciences, 30, e64. |
| 15 | Global – Montenegro et al. (2023) | Barriers and facilitators | Social, political, and structural factors | Global reform processes | Montenegro et al. (2023). Global Mental Health, 10, e29. |
| 16 | Indonesia – Arisanti et al. (2023) | Policy implementation | Local adaptation of Mental Health Law in DIY | Law No. 18/2014 on Mental Health | Arisanti et al. (2023). |
| 17 | South-East Asia – WHO SEARO (2024) | Regional status | Paro Declaration 2022, primary–community integration | WHO SEARO Mental Health Strategy 2023–2030 | WHO SEARO (2024). |

Table 2.
Thematic Framework: Stages, Strategies, and Policies of Deinstitutionalization

| Stage | Supporting Strategies | Related Policies | References |
|---|---|---|---|
| Initial Stage: Reduction of psychiatric hospitals | Identifying patient needs, phased hospital closures | Global psychiatric reform (1980s–1990s); Indonesia pre-2000 | Fakhoury & Priebe (2002); Idaiani (2010) |
| Transitional Stage: From institution to community | Community integration, intermediate care, family/community support, civic engagement | Slovenia, Taiwan, Ghana, Indonesia | Horvat Golob et al. (2025); Lin et al. (2008); Adu & Oudshoorn (2020); Irmansyah et al. (2020) |
| Advanced Stage: Strengthening community services | Knowledge translation, therapeutic residential care, promoting autonomy | Brazil, Taiwan | Fulone et al. (2020, 2021); Silva et al. (2022); Lin et al. (2022) |
| Consolidation Stage: Integration and innovation | Rehabilitation, multisectoral integration, local advocacy | UK, Canada, WHO SEARO, Indonesia | Killaspy et al. (2005); Piat & Polvere (2014); Ribeiro et al. (2021); WHO SEARO (2024); Kurniawan et al. (2023); Arisanti et al. (2023) |
| Optimal Model: Full deinstitutionalization | *Open-door, no-restraint*, 24/7 CMHCs, community participation | Italy's Law 180/1978 | Mezzina (2014, 2020) |

The findings were organized into three thematic domains: stages of deinstitutionalization, supporting strategies, and policy frameworks.

1. Stages of Deinstitutionalization

The literature outlines a continuum of deinstitutionalization, starting with the initial stage, which involves reducing large psychiatric hospitals (Fakhoury & Priebe, 2007). This stage established the foundation for structural reform, particularly in high-income countries during the 1980s and 1990s.The transitional stage signifies a move toward community-based services, integrating intermediate care models and social supports. Notable examples include Slovenia, which assessed both the benefits and challenges of deinstitutionalization (Horvat Golob et al., 2025), Ghana, where a socio-ecological model was applied (Adu & Oudshoorn, 2020b) and Taiwan, which compared community rehabilitation to institutional care (Lin et al., 2008). In Indonesia, this stage has been

significantly influenced by civic engagement, with families, health cadres, and civil society organizations actively participating in service delivery (Irmansyah et al., 2020). The advanced stage emphasizes the enhancement of community services through rehabilitation, autonomy, and knowledge translation. Brazil serves as a pivotal example, showcasing therapeutic residential services and innovations in psychiatric reform (Fulone et al., 2021a; Silva et al., 2022).

Taiwan has also reported that community-based rehabilitation (CBR) is more effective than institutional-based rehabilitation (IBR) in reducing stigma (Lin et al., 2022). The consolidation stage demonstrates integration and innovation, particularly in high-income countries like the UK and Canada, where rehabilitation services, service integration, and continuity of care have been institutionalized (Killaspy et al., 2005; Piat & Polvere, 2011). At the regional level, WHO SEARO (2024) underscores the importance of integrating mental health into primary and community care, supported by the Paro Declaration 2022. In Indonesia, this phase is exemplified by ongoing initiatives in Yogyakarta (Kurniawan et al., 2023) and local policy implementations in the DIY Province (Arisanti et al., 2018). Finally, the optimal model is represented by the Trieste experience in Italy, where the complete closure of psychiatric hospitals was achieved under Law 180/1978, replaced by community mental health centers operating 24/7 under an *open-door, no-restraint* principle (Mezzina, 2014, 2018; Mezzina et al., 2019).

2. Supporting Strategies
Several strategies have been consistently applied across various contexts:Community integration through family involvement, health cadres, and social networks (Irmansyah et al., 2020; Lin et al., 2008). Knowledge translation and innovation to ensure that evidence aligns with practice (Fulone et al., 2021b). Rehabilitation and empowerment through therapeutic residential care and autonomy-based services (Silva et al., 2022). Civic engagement and advocacy, particularly in Indonesia, where grassroots participation has been crucial in enhancing community services (Irmansyah et al., 2020). Multisectoral collaboration linking health, social, and policy sectors in both global and national reforms (Ribeiro et al., 2021; (WHO SEARO, 2024).

3. Policy Frameworks
The policies supporting deinstitutionalization vary significantly. Global reforms in the 1980s and 1990s initiated the closure of psychiatric hospitals (Fakhoury & Priebe, 2007) with Italy's Law 180/1978 being the most frequently cited landmark (Mezzina, 2014, 2018; Mezzina et al., 2019). Brazil's psychiatric reform laws institutionalized community care and residential therapeutic services (Silva et al., 2022). Ghana and Taiwan developed national mental health laws that promote community rehabilitation (Adu & Oudshoorn, 2020b); Lin et al., 2022). In Indonesia, policy has evolved from early decentralization reforms (Idaiani, 2010a) to the enactment of the Mental Health Law (No. 18/2014), which establishes a legal framework for community-based services. However, implementation remains inconsistent, influenced by civic engagement (Irmansyah et al., 2020), community care initiatives (Kurniawan et al., 2023), and local policy adaptations (Arisanti et al., 2018).

## DISCUSSION

### Deinstitutionalization as a Global Reform Trajectory

This scoping review demonstrates that deinstitutionalization is a complex, multi-stage process influenced by historical context, sociopolitical dynamics, and policy frameworks. The international trajectory typically follows four stages: (1) initial reduction of psychiatric hospital beds, (2) a transitional shift toward community-based services, (3) strengthening community structures through innovation and rehabilitation, and (4) consolidation of integrated systems(Fakhoury & Priebe, 2007; Montenegro, Dominguez, et al., 2023). The Italian experience in Trieste serves as an optimal model, where the closure of psychiatric hospitals was accompanied by the establishment of 24/7 community mental health centers, embedding citizenship and human rights at the heart of mental health care (Mezzina, 2014, 2018; Mezzina et al., 2019).

While Trieste is often regarded as a global benchmark, the review reveals that many countries remain in transitional or advanced stages, grappling with challenges related to community infrastructure, financing, and intersectoral collaboration. Brazil and Taiwan exemplify middle-path approaches, combining legislative reforms with innovative service models such as therapeutic residential facilities and community-based rehabilitation (Fulone et al., 2021b; Silva et al., 2022); Lin et al., 2022). In contrast, Ghana and Slovenia illustrate contexts where deinstitutionalization is only partially realized, hindered by limited resources, social stigma, and systemic inertia (Adu & Oudshoorn, 2020; Horvat Golob et al., 2025).

**Strategies: From Structural Reform to Civic Engagement**

The findings emphasize that deinstitutionalization strategies extend beyond structural reform of psychiatric services. Effective transitions necessitate community integration, including family support, health cadres, and user-led advocacy movements. This aligns with Bronfenbrenner's ecological systems theory, which suggests that individual outcomes are shaped by multilayered social environments (Adu & Oudshoorn, 2020b).

In high-income settings, strategies often focus on knowledge translation, rehabilitation, and multisectoral integration, ensuring that service delivery aligns with both evidence and policy (Fulone et al., 2021b; Killaspy et al., 2020; Piat et al., 2019). Conversely, in low- and middle-income countries (LMICs), civic engagement emerges as a vital strategy, addressing gaps in formal infrastructure. The Indonesian experience, as documented by Irmansyah et al. (2020), illustrates how families, cadres, and civil society organizations collaborate to create community-based mental health initiatives. This participatory approach is not merely supplementary but essential for sustaining deinstitutionalization in resource-constrained settings.

**Policy Frameworks and Implementation Gaps**

Policy plays a crucial role in determining the success or failure of deinstitutionalization. Italy's Law 180 (Basaglia Reform) exemplifies how legislation can institutionalize community-based care and mandate the closure of psychiatric hospitals (Mezzina, 2014, 2018; Mezzina et al., 2019). Similarly, Brazil's psychiatric reform laws established a legal and financial framework for therapeutic residential services (Silva et al., 2022).

In contrast, Indonesia illustrates a persistent policy-practice gap. The Mental Health Law (No. 18/2014) provides a robust legal foundation for community mental health, yet its implementation remains fragmented. Studies indicate uneven progress: initial decentralization efforts led to jurisdictional ambiguities (Idaiani, 2010b), while more recent initiatives—such as community care for schizophrenia (Kurniawan et al., 2023) (Kurniawan et al., 2023) and local policy adaptation in Yogyakarta (Arisanti et al., 2018)—are highly localized. Findings from Irmansyah et al. (2020) suggest that policy success in Indonesia relies heavily on civic engagement rather than consistent top-down enforcement.

**Implications for Indonesia in the Global Context**

The trajectory of deinstitutionalization in Indonesia can be characterized as transitional, fragmented, and community-dependent. In comparison to global benchmarks, Indonesia is positioned between the transitional and consolidation stages, exhibiting isolated instances of innovation without comprehensive nationwide integration. The reliance on civic engagement presents both strengths and limitations: while it empowers communities, it also poses risks of uneven coverage and sustainability.

This situation contrasts with the institutionalized models observed in Italy and Brazil, where reforms are bolstered by legal mandates, stable financing, and political will. For Indonesia, the challenge lies in translating legislative intent into systemic implementation, ensuring equitable

access across regions. Without sufficient state investment and intersectoral collaboration, deinstitutionalization risks remaining a rhetorical endeavor rather than a transformative one.

**Theoretical and Practical Contributions**

From a theoretical standpoint, this review enhances Arksey and O'Malley's (2005) scoping framework by illustrating that deinstitutionalization occurs not only through policy reform but also via community-level participation. The Indonesian case exemplifies how bottom-up strategies (civic engagement) intersect with top-down frameworks (Mental Health Law), providing valuable insights for other low- and middle-income countries (LMICs) facing resource constraints that impede full institutional reform.

Practically, the findings indicate that deinstitutionalization in LMICs may necessitate hybrid models that integrate legal mandates with grassroots mobilization. International examples underscore the importance of securing political commitment, financing, and rights-based frameworks. However, Indonesia's experience illustrates that community networks can sustain reform even in the absence of comprehensive infrastructure.

## CONCLUSION

This scoping review illustrates that deinstitutionalization is a dynamic, multi-stage process influenced by contextual, strategic, and policy factors. Internationally, trajectories range from early reductions in psychiatric hospital reliance (e.g., Slovenia, Ghana) to advanced integration and innovation (e.g., UK, Canada, Brazil), with Italy's Trieste model serving as the global benchmark. Across various settings, strategies such as knowledge translation, therapeutic residential care, and multisectoral collaboration have facilitated reform. In Indonesia, deinstitutionalization reflects a transitional path marked by decentralization, civic engagement, and localized innovation. While the Health Law No. 17/2023 provides a legal framework, implementation remains inconsistent, with community networks addressing systemic gaps. The Indonesian case underscores both the potential and limitations of community-driven deinstitutionalization in resource-constrained environments.

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