International Trends in Community Mental Health Services

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Introduction

This chapter will provide summaries of the state of community mental health in some countries around the world, allowing readers to compare and contrast the nature of services and to further understand the successes and challenges of innovative programing. We cannot hope to provide an exhaustive international survey of the rest of the world in such a short space, but the table (see Table 1 at the end of the chapter) and the section on global psychiatry redress this to some extent. We will describe examples from countries of which we have the most firsthand knowledge and focus on some leading-edge innovations and systems reforms. Although the countries discussed are different on many levels, it is intriguing to note that there are consistent themes across these nations: (1) movement away from institutional hospital-centricity; (2) greater provision of mental health services in the community; (3) providing supported housing and purposeful and productive activity (e.g., work); (4) emphasis on human rights and facilitating individual choice and control, voluntary or least restrictive care; (5) family education and consultations wherever possible; (6) committed leadership enabling lived experience empowerment, stigma reduction and

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Table 1 Brief survey of notable examples of community mental health services

Nigeria, Ghana, and Zimbabwe	The origin of contemporary community mental health services owes a huge debt to Dr. Tom Lambo in Nigeria. Lambo initiated a system of village care of individuals identified as acutely or severely mentally ill. It relied on occupants of several villages taking these individuals into their homes as lodgers for a very small fee, while a combination of nurses, doctors, and local traditional healers jointly provided care in the villages with a 24-h on-call service providing emergency cover from the main village. Unfortunately, this system was dismantled after rebuilding of the Aro psychiatric hospital was completed (Asuni 1967; Adewunmi 2002). In recent years, WHO has initiated very promising human rights-based interventions in countries like Ghana, while NGOs with international support are trying to support recovery and work opportunities in Togo, Sierra Leone and other countries to abolish the archaic use of chaining people to trees. The "Friendship Bench" is a CBT-related problem-solving and communal support group program for depression, training grandmothers as local lay health workers (LHW's) originating in Zimbabwe, with growing RCT evidence of effectiveness (Chibanda et al. 2016; Riley 2018; WHO 2021) and dissemination to other countries, especially in Africa.
Palestinian territories	Since 2004, the WHO and various European Union donors have supported an ambitious program of development of mental health services in the West Bank and Gaza (Bassam 2005). The main thrust of the plan entailed developing local community mental health centers located close to primary care centers, in each of the regions of the West Bank and Gaza, and extensive retraining of the practitioner workforce. It established family and service-user associations including public awareness campaigns to help overcome stigma, discrimination and misunderstanding. It also developed a new mental health legislation to protect human rights (WHO 2006; Palestinian National Authority 2004). Sustaining these improvements and reform of the old psychiatric hospitals in Bethlehem in the West Bank and in Gaza City, which continue consuming most of the relatively small mental health budget, remain as continuing challenges (WHO-AIMS 2006).
Israel	Comprehensive community mental health service reform had been delayed except for some crisis intervention and trauma-related developments and community rehabilitation initiated by family organizations. A mental health insurance reform was launched in July 2015, transferring responsibility for treating patients with mental illness from the government to four nationally mandated health maintenance organizations. Prior to this reform, separation between physical and mental health care exacerbated disparities in psychiatric service funding and availability. The mental health reform was intended to closely link physical health and mental health and by doing so to reduce (hopefully) the visibility and subsequent impact of stigma (Cohen et al. 2020).
Sri Lanka and Indonesia	Both have undertaken a widespread process of deinstitutionalization following the disaster caused by Tsunami in 2006 and have developed community services based on primary care which include mental health (and also mobile) components (WHO 2016).
Malaysia	In Malaysia, the Permai Hospital in Johor Bahru has developed a grassroots program to stop the use of restraints, alongside work-integration schemes and good quality pilot community-based services.

India	Parts of rural India have excelled at low-cost community village-based rehabilitation (Thara et al. 2008). "The Banyan" recovers homeless women with severe mental illness from the streets and supports them in a process of housing, social integration, and community engagement. Another program implemented the WHO "Quality Rights" Initiative on a large scale with the creation of peer support groups.
China & Hong Kong	China has begun to devolve from institutionally based mental health services to community health centers. In some places, outpost centers have been established in large residential blocks or complexes. Community-based individual and group family sessions focus on psychoeducational, traditional herbal remedies, and improving marriage prospects (Xiong et al. 1996) as well as more orthodox psychopharmacology (Rathbone et al. 2007). Some Chinese Psychiatrists have been dually trained in Western and traditional Chinese medicine. In Hong Kong, despite the persistence of western-style psychiatric hospitals, and recent political upheaval, community-based programs are being developed including Work Employment Social Enterprises (WISEs) (Po-Ying and Chan 2010) and Early Intervention in Psychosis for young people (Chen et al. 2019) as well as often NGO-based individual, family, and group rehabilitation and support programs.
Japan	Japan is still stuck in one of the most immobile hospital-based systems worldwide, despite regional efforts to embed reforms. The number of beds is huge (about 340.000), and the ownership of private hospitals is usually in the hands of psychiatrist directors. Only initial steps have been taken toward reducing the average length of stay and creating community care facilities (Hiroto et al. 2013; Cohen et al. 2020), although international dialogue to assist change is ongoing.
Brazil and Argentina	In the 1970's–1980's Brazil and Argentina, the influence of Italian reforms was greater than elsewhere in the world (Delgado 1991). Basaglia's impact in Brazil was enormous (Basaglia 2000; Venturini et al. 2020) in tune with the political movements of that time. The first federal reform law was applied in the 1980s with the creation of Community Mental Health Services, with all states phasing out of mental hospitals (Nicacio 1990). In the 1990s, a very innovative program of community services formed using resources of a former private hospital. Their National Health Law (Larrobla and Botega 2001) guaranteed full citizenship to people with mental health problems and fostered the growth of community-based services (CAPS), a clear shift from psychiatric hospitals to community-based services (Tykanori 2011). While about 19,000 beds were closed in hospitals, 3000 long-stay beds were created in group-homes and in short-stay beds in CMHCs with linkage of public mental health to housing, work, and income generation in a national program of poverty eradication (Tykanori 2011). The government of Lula Da Silva (2003–2010) was committed to the creation of a national health service with equal access for all citizens (Caldas de Almeida and Cohen 2008). Unfortunately, more recent ultraconservative policies have undermined this fundamental transformation and curtailed community mental health development. Training in Integrative Community Therapy, a large group dialogic intervention offered within communities, has been widely networked in Brazil (purportedly with 40,000 facilitators) and now elsewhere to facilitate communal discussions of mental health and drug and alcohol problems, as well as common concerns, fears and anxieties to build interpersonal recovery, emotional resilience and solidarity, as a loose informal social movement co-led by Brazilian psychiatrist Adalberto Barreto (https://www.visiblehandscollaborative.org/). Argentina developed some pilot models of public community service in Cordoba in the late 1980s and the 1990s. In Rio Negro, a regional law developed a network of effective community services and work cooperatives (Cohen and Natella 1995). This was one of the first reforms to successfully implement an integrated mental health system with no psychiatric hospital with extensive psychosocial rehabilitation and patient participation. In 2008, more than 25,000 inpatients were still in Argentinian mental hospitals (CELS 2009). In 2010, with a new mental health law, the closure of mental hospitals became a goal, and a network of community-based services was envisioned (Mauri and Barcala 2020). Unfortunately, the implementation of this vision has been very slow.

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Chile and Peru	Chile (Minoletti et al. 2012; Minoletti 2016) with its system of primary care centers and teams and Peru (Peru Ministerio de la Salud 2021) are undertaking a rapid transition from outmoded psychiatric institutions to modern Community Mental Health Centers, inspired by the Italian model. In general, WHO/PAHO data show that the reduction in psychiatric hospitals has recently occurred in this part of the world faster than elsewhere.
Czech Republic and Belgium	Both these countries have chosen to develop community teams to provide some alternatives to hospitalization. The Czech reforms, supported by structural European funds, combines a welfare component in these teams that promotes social integration. The Belgian reform (Jacob et al. 2016; Borgermans et al. 2018) promotes wide ranging mobile teams which are only loosely linked with private hospitals with no clearly defined catchment areas.
Germany	Despite having well-resourced welfare and health organizations, most mental health services are still heavily hospital based, usually poorly integrated with separate community mental health services. Hospital-centric systems, occasionally with community outreach components, often take a lead role in coordinating different care providers for individuals with long-lasting conditions, often with high levels of inpatient occupancy (Brunn et al. 2021; Cruz-Arez 2021).
France	Lille has developed mental health service reforms with a particular emphasis on supporting social inclusion through foster families for persons in crisis, a wide variety of residential solutions and promoting products of artists with lived experience of mental illness (Roelandt 2010, 2016) France has otherwise failed to substantially reduce the role of psychiatric hospitals (Brunn et al. 2021). However, it has issued a new law for reinforcing the decentralization of welfare and health services, and the government began evaluating the WHO good practice examples of Trieste and Lille in 2019
Spain	Spain began to close their asylums and developing community services (Aparicio Basauri 2010; Salvador-Carulla et al. 2010) around the same time as Italy. There were 120 psychiatric hospitals in 1975, with 91 still functioning in 2003, coexisting with a mix of community services. There was a national heath law in 1986, but regional models varied as they were autonomous (Aparicio Basauri and Sanchez Gutierrez 2002). Job orientation and supported employment in the open market have commonly been provided, as are day hospitals, rehabilitation communities, and community mental health teams, with small general hospital psychiatric units (Lopez 2004). The successful implementation process of ACT (TAC) teams throughout Spain has resulted in a national network of teams with an annual TAC conference (Martinez-Jambrina J, 2009, & personal communications, 21 June, 2021)
The Netherlands	Ari Querido pioneered a citywide mobile crisis team with follow-up management in the 1930s, with a focus on social factors precipitating mental disorders (Querido 1935). Nonetheless, the Netherlands' mental health care remains dependent on hospital-based care, although there are policies aimed at its reduction, being hindered by (mostly insurance-based) financial systems that favor remuneration of hospitalization over outpatient care. The Netherlands have implemented hybrid FACT teams (flexible assertive community treatment and general community teams) (Keet et al. 2019). However rigorous controlled evidence of effectiveness has not yet been established, and FACT fidelity to model appears to depend on a detailed external inspection system, wherever it exists. Yet, FACT could provide practical solutions for rural teamwork and smoother transitions to less intensive care (Rosen et al. 2015; Killaspy and Rosen 2022; Bond and Drake 2015). Netherlands clinicians initiated the European Community Mental Health Services Provider EUCOMS Network (Keet et al. 2019) to combine evidence-based service delivery systems with recovery orientation, peer workers, and other community mental health reforms.

Sweden and Denmark	Sweden closed most of its asylums and pioneered a 24-h "social psychiatry" service in Stockholm. The general trend is toward evidence-based and clinically orientated community mental health services. A strong service user movement with involvement in care actively advocates for human rights. A 1994 law separating health care from social welfare programs still lets vulnerable individuals "slip between the cracks" (Topor 2020) Similar reforms in Denmark have been at an impasse, split between an institutional highly biological-orientated hospital psychiatry and fairly advanced services run by local municipalities.
Finland	The world-renowned program of Open Dialogue originated here, centered in rural Western Lapland, but a hospital-based psychiatric system remains dominant in Finland (Wahlbeck K & Salvador-Carulla, personal communications, 3–4 July 2015). Research of Open Dialogue has been hampered possibly by problematic methodology, theoretical ambiguity of its "fidelity criteria," and tacit encouragement of outpatient or private practice more than its outreach components (Mueser 2019; Bergstrom et al. 2018; Rosen et al. 2020a; Waters et al. 2021). Whether it is an effective alternative to good practice guidelines, acute care of psychosis has not yet been established. Many of the principles on which it is based have parallels in crisis intervention (e.g., rapid response, home visiting, family and resource network involvement, nonjudgmental dialogue, and negotiation) with more emphasis in Open Dialogue on tolerating uncertainty, ensuring all voices are heard ("polyphony"), sharing of responsibility, and avoiding clinical dominance.

advocacy; (7) expansion of the mental health professional and peer workforce, supporting interdisciplinary integrated teamwork; (8) holistic and comprehensive assessment addressing social determinants; (9) providing trauma-informed, recovery-oriented treatment across the life span; (10) optimal balance between in-person or home delivery care and telehealth or digitally augmented care; (11) culturally respectful global mental health approaches integrated in general health services. Structural reform of mental health services is easier to achieve than improvements in service quality. Success comes when leadership is shared and inspired, trustworthy, and transparent, and when political exigencies and funding are stable and predictable. Accomplishing all or most of these objectives is rarely seen in countries around the world. In these national profiles, we will be describing the attempts of several countries to achieve them.

Oceania

The histories of Australian and New Zealand psychiatry are entwined with the impact of European (British) invasion and settlement, initially in Australia, in 1788, to form penal colonies to alleviate the overcrowding of English jails; this generated a masculine-dominated, individualistic culture. As European settlement in Australia and New Zealand expanded, the colonists began to struggle over land and resources with the original inhabitants, some of whom had been there over 60,000 years. Culturally congenial methods of working with indigenous peoples are being integrated into mental health services of both countries, i.e., increasingly training and employing indigenous clinical professionals, support workers, and traditional healers. With accelerating immigration from many parts of the developed and developing world since the 1950s, both countries have become increasingly multicultural in their approaches.

Australia

Australia serves as an example of a country whose mental health provision structure has been evolving from institutional to community-based care. We will trace its trajectory over the last 50 years.

Reform Implementation By the mid-1950s, occupation of psychiatric institutions reached its peak in Australia, much like the USA. A random controlled trial (Hoult et al. 1984) replicating the research of Stein and Test (1980) and Polak and Kirby (1976) demonstrated that acute mental health care for people with severe and complex disorders could be shifted safely and effectively from institutions to mobile community teams that are available around the clock. This became the core of the community mental health reforms proposed in the Richmond Report (1983) in the most populous state, New South Wales (NSW). Crisis and assertive community treatment teams, residential programs, and community support services were developed to meet complex needs.

The First Australian National Mental Health Policy was endorsed in 1992. It provided initial transitional (bridging) funding as part of the National Mental Health Strategy. Communities of practice networks (teams of similar functions from different regions swapping experiences and solutions) emerged in NSW, and then nationally, ultimately through the support of The Mental Health Services (TheMHS) Conference of Australia and New Zealand. There have been five distinct phases of the National Mental Health Strategy over 27 years (1993–2020) (Department of Health and Family Services 2002; Australian Health Ministers' Advisory Committee 2003;

Department of Health and Aging 2005; Rosen 2006a, b; Rosen et al. 2012a). The first phase effectively accelerated deinstitutionalization in the first 5 years, but these strategies have since lost much of their momentum (O'Halloran and O'Connor 2015). National Mental Health Service Standards based on the world's first fully integrated community and hospital (Rosen et al. 1995) became the national basis for integration and accreditation of all mental health facilities. However, subsequent regressive revisions of the national mental health service standards (Miller et al. 2009; Rosenberg 2010) diminished full consultation with stakeholders and diluted the national strategy (Miller et al. 2009; Rosen and Sweet 2016).

Recovery Support Services Following intensive advocacy, individuals with severe and complex mental health disorders were included in the National Disability Insurance Scheme (NDIS), with personal budget packages allowing individuals and their families to exercise choice of rehabilitation supports from the NGO or private sector. Pilot sites were developed starting in 2013, but only with substantial national implementation since 2020. Too many people with moderate rehabilitation needs (80% of Australians with psychiatric disability) are still excluded, but hopefully, this may now be addressed by a new federal government from mid-2022 which demonstrates a greater commitment to the NDIS.

Workforce Australian governments are beginning to focus belatedly on a nationally consistent workforce training system, which should include interdisciplinary team-based upskilling, supervision, pastoral support, and mentoring system for professionals and support workers, including peer workers operating in interdisciplinary teams. For example, a proposed national mental health workforce institute has been endorsed by a prominent government committee with a high priority for implementation (Teesson et al. 2021). As a result, people with lived experience and family peer workers with "Recovery College" or technical college certificate qualifications are being employed increasingly (Byrne et al. 2021). Aboriginal Mental Health Workers (Brideson and Rosen 2013) are being trained and integrated as well, especially by Aboriginal community-controlled primary health services, NGOs, and the public sector. Active Australian participation is growing in internationally connected networks of people with lived experience and family educators, researchers, peer practitioners, and thought leaders (Byrne et al. 2021; Rosen et al. 2020c).

Advocacy Mental Health Australia coproduced reports that reinforced the need for reform (Groom et al. 2003; Human Rights and Equal Opportunity Commission 2005). The Mental Health Services (TheMHS) Conference (www.themhs.org) (Andrews 2005) has provided a melting pot for deliberation between all stakeholder interests. It provides binational (Australia and New Zealand) forums involving members of all mental health professions, peer workers, service users, family, indigenous, and transcultural stakeholders. It promotes an inclusive, human rights approach (Rosen et al. 2012a). It also convenes the annual Australasian mental health service achievement awards for interdisciplinary team innovations and implementation research.

Global pioneers and champions of early intervention (EI) programs for young people with mental illnesses in Australia include Professors Patrick McGorry, Eoin Killacky (jobs and careers), Andrew Chanen (personality disorders), Ian Hickie (online applications and modeling), and Dr. Jackie Curtis (physical health algorithms for EI) (McGorry and Jackson 1999; Byrne and Rosen 2014; Rosen et al. 2016). Australia has increased public awareness of mental health and illness through media campaigns, schools, and workplaces, expanding mental health literacy and ability to access resources (e.g., Rosen et al. 2000). Mental Health First Aid, a mental health equivalent of a physical first aid course originated by Betty Kitchener in Australia (Jorm et al.

2019), has been widely disseminated to develop mental health lay resource people in many walks of life, in the UK, Canada, the USA, Ireland, and many other countries and translations.

Politics Following the examples of New Zealand, and then Canada, several independent statutory reform-oriented standing mental health commissions have formed, state and federal, to revive movement toward evidence-based, consumer and family congenial, recovery-oriented mental health care, and suicide prevention (Rosen et al. 2004, 2010b; Rosen 2012; Rosenberg and Rosen 2012a, b). Despite some advances, they have not yet overcome fragmentary, poorly integrated, and underfunded mental health services. They lack affordable services for the "missing middle" (not severe enough for public psychiatric services, but too complex for primary care) (National Mental Health Commission 2014; National Productivity Commission 2020; Royal Commission into Victoria's Mental Health System 2021). Of these, the reforms in the State of Victoria have the most momentum with committed state funding. In other areas, federal funding streams and management structures have become even more separated into silos with poor coordination between them: public sector specialist clinical services funded by the states, primary mental health care, private professional, and nongovernment support services partly funded directly by federal government, some via the NDIS.

Implications These trends reflect the uneven but incremental evidence-based shift of the center of gravity of mental health services and resources from hospital-centric with occasional outreach when convenient for staff, to community-based services where people in need live, with in-reach to hospital only as necessary (Rosen et al. 2020a, b).

Mental health services are being eroded or have never developed sufficient breadth (Rosen et al. 2010a). Even after sporadic spending spurts, Australia has still lagged far behind similar Western countries (e.g., the UK and USA) in terms of the proportion of national health budget (e.g., 7.6% from 2016 to 2020, slightly more than Canada) spent on mental health services (Rosen et al. 2010a, b; AIHW 2022). Support of consumers, carers, and workforce is a critical factor in the success of mental health reforms (Whiteford & Buckingham 2005). Mental health commissions should be effective conduits to governments of all stakeholder voices and needs. As the only nation where both federal and most state and territory governments have implemented reform-oriented commissions, Australia is in a unique position to determine what coordinated efforts between them could achieve – almost like an opportunistic natural experiment. Eventually if stronger, more independent, focused, and combined voices of Australian mental health commissions are heard and heeded, governments could still restore momentum and coherence to Australian mental health reforms (Rosen et al. 2010b; Rosen 2012; Rosenberg and Rosen 2012a, b; Van Spijker et al. 2019).

New Zealand

New Zealand has had the benefit of being a close observer of the high-level decision-making of Australian reforms, and learning from their mistakes, they were able to improve that process. In the absence of private sector services, New Zealand created health services using public sources and nongovernmental organizations (NGOs).

Innovations New Zealand's Mental Health Commission, operating since 1996, was the *first* worldwide to adopt a system-wide reform agenda as its priority (New Zealand Mental Health Commission 1998, 2001). It closely monitored the quality of all mental health services. Recovery-oriented competencies, workforce development (O'Hagan 2001), and grassroots strategies for challenging stigma ("Like Minds, Like Mine" (2022) http://www.likeminds.org.nz/page/5-Home) were evaluated.

One of the most important initial achievements of the New Zealand Commission was to produce the Blueprint (New Zealand Mental Health Commission 1998), a detailed plan to offer mental health services with a recovery agenda to be developed in regular consultations with all stakeholders, including indigenous peoples. Financial commitment to the Blueprint from an incoming government enhanced the caliber and consistency of mental health services remarkably (New Zealand Mental Health Commission, 2010). As a result, by 2012, more than 80% of mental health services were provided in the community with 30% of mental health budgets spent on strict contracts with the NGO sector to enhance community services (Rosen et al. 2010b). New Zealand's per capita expenditure on mental health far exceeded Australia's, by more than 100% of public and NGO funding. However, the impact of the 2008 global financial crisis was much more severe in New Zealand than in Australia, and the budgets of both public and NGO services were cut back. Consequently, the pioneering, reform-focused, world-renowned New Zealand Mental Health Commission was "disestablished" in 2012 except for its Chair Commissioner, left in a Health and Disability Complaints Commission.

In 2014, the Ministry contracted with three organizations: (1) Te Rau Matatini, (2) the National Centre for Māori Health and Māori Workforce Development and Excellence, and (3) Le Va a Pasifika (Pacific Islander) Mental Health Support Organization, to establish a national Māori and Pasifika Community Suicide Prevention Program. Addressing unacceptable rates of compulsory orders for Māori became a priority (Director-General's report 2016), as noted in the following examples:

Te Pou o te Whakaaro Nui The long-standing New Zealand national government-funded center of evidence-based workforce development for the mental health, addiction, and disability sectors (https://www.tepou.co.nz/training-development).

Equally Well A Te Pou initiative that is a collaborative group of organizations and individuals with a common goal of reducing physical health disparities of those living with mental disorders and/or addictions.

He Ara Oranga (Pathways to Wellness) The Mental Health & Addictions Inquiry (New Zealand Government 2018, (https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/) was commissioned by a new Labor Government to recommendations that were reported in 2018. Its mission is (1) to take a whole-of-government approach to well-being, tackling social determinants, and supporting prevention activities that impact on multiple outcomes; (2) to markedly improve access, wait times, and quality of care to a broader proportion of the population; (3) to provide more systematic attention to Māori and Pacific Islander mental and physical health and well-being, strengthening ties to family, tribal identity, language, spirituality, and addressing social determinants; (4) to undertake a mental health human rights focused reframing of mental health laws to honor their international treaty obligations; (5) to reduce involuntary care and eliminating restraints; and (6) to establish a new reform-oriented standing Commission to act as a watchdog at an arm's length from government, providing leadership and oversight of mental health and well-being (Howie A, pers.comm. 13 May 2021).

New Zealand's current government has been highly responsive to mental health needs, promptly implementing the recommendations of the Mental Health Inquiry, particularly by enhancing well-being programs across all departments, based on both Māori and health economic approaches (e.g., Dalziel et al. 2018), and reestablishing a Mental Health and Well-Being Commission (https://www.mhwc.govt.nz).

Efforts to achieve the goals of expanding access and choice have included being able to access specialist services, and the provision of a

broader menu and flexible choice of and self-referral to therapeutic roles by primary health organizations and general practices. This entails training counselor/behavioral health consultants, peer/cultural health coaches, and peer and community support workers to address practical needs. The public embrace of these approaches has been most encouraging, far exceeding IAPT (Improving Access to Psychological Therapies) (D. Codyre, personal communication, 20 April 2020; Appleton-Dyer and Andrews 2018).

Britain and Ireland

The UK

In 1998, the UK Secretary of State for Health Frank Dobson noted that, "Care in the community has failed" (Burns and Priebe 1999), referring to the process in the UK of deinstitutionalization, the closure of the old mental asylum system, and transfer of patients to the community. While movement into the community for some patients had been beneficial (Leff et al. 2000), for others it had led to homelessness and dislocation from care and their familiar community (Craig 1998). Dobson recognized that simply discharging many long-stay hospital residents (155,000 in 1954 to less than 20,000 in 1998) into the "nonsystem" of community living without consistent care had been a mistake (Keown et al. 2008).

In 1999, the National Service Framework (NSF) for Mental Health was published, (Department of Health 1999) outlining a quality framework for services. This was accompanied by NSF's detailed strategic approach to implementation of community care, known as the NHS (National Health Service) Plan (Department of Health 2000). The NSF clearly spelled out for the first time a blueprint for community-based mental health services. The NSF's NHS Plan for Mental Health set out, again for the first time in the UK, a clear and progressive national mental health policy. Importantly, it included a prescriptive, centrally driven, performance-managed, and relatively well-funded 10-year plan of implementation.

The performance management dimension involved clear targets, centralized monitoring, and primary care-based entities called Primary Care Trusts (PCTs). The latter involved payment by results and development of more competitive quasi-market forces. NHS Trusts (the main entity of public mental health) were redeveloped as more locally responsive "business" entities, which shifted planning away from a top-down direction and toward integration of health and social care functions.

In addition, priority was given to expanding and reforming the existing workforce through the introduction of new roles and tackling traditional problems. Collaboration with professional and accrediting bodies and higher education institutions along with the introduction of progressive workforce training and educational methodologies were part of the plan. These efforts were enhanced by funding of over $ two billion (US) annually under the leadership of the National Institute for Mental Health in England (National Institute for Mental Health in England 2004). This was a partial redirection of savings from the closure of over 130 psychiatric institutions in England. Workforce reform led to an expansion of new roles in the practitioner workforce, including 1000 new primary care mental health workers, 500 additional "gateway" workers to work with primary care providers, 3000 support workers, many with lived experience, and 14,000 additional clinical roles, including consultant psychiatrists, clinical psychologists, and 10,000 mental health nurses. These reforms pushed for 24-h per day/7 days per week community treatment with on-demand accessibility, early detection and prevention, consumer-centered care, evidenced-based practices, and care coordination (Department of Health 2007).

A multidisciplinary approach with greater promotion of self-management and peer support was planned. In 2008, the IAPT (Improving Access to Psychological Therapies) program was launched with teams of graduate psychologists offering team-supervised cognitive behavioral

therapy (CBT) based on primary healthcare practices (https://www.england.nhs.uk/mental-health/adults/iapt/). Colocated in general practices, these teams mainly of graduate psychologists maintain strict fidelity criteria. However, waiting times for admission to these services can vary between 6 and 124 days, its reach to most needy populations is limited, and the uptake penetration for them is still too low (D. Codyre, personal communication, 20 April, 2021).

New Horizons, the UK's 2010 national mental health policy, was built on these NSF achievements with a greater focus on self-management, emphasizing social outcomes of work, housing, and inclusion (Department of Health 2009). It aimed at driving up quality and increasing choice, through encouraging a "plurality of providers." The use of direct payments and individual service-user budgets were to open the market to alternative providers, increasing choice, with a greater emphasis on outcomes. General practitioners' willingness and capacity to be gatekeepers and determine need was a limitation. With many providers involved, coherent pathways to care, integration, and whole system functioning would be challenging. Other challenges that lie ahead included how a national health service with a tradition of providing clinical treatment could deliver much more on outcomes, such as employment and housing, requiring greater integration and closer work with public welfare. Collaboration with the voluntary sector and other stakeholders would be required. However, by 2015, only 14 percent of adults surveyed felt they were provided with the right response when in crisis, and only around half of community teams were able to offer an adequate 24/7 crisis service (Care Quality Commission, 2019, 2021). By 2019, low fidelity to evidence guidelines was found in over a third of crisis teams (Lamb et al. 2019).

The Health and Social Care Act 2012 created a new legal responsibility for the NHS to deliver "parity of esteem" between mental and physical health by 2020. Parity of esteem was meant to ensure as much focus on mental as physical health and that people with mental health problems receive equal standard of care. However, this benchmark was not met in the designated time frame (Care Quality Commission, 2021).

Assertive Community Treatment

The more recent demise of "Assertive Outreach" (Assertive Community Treatment) teams in England, based on a dubious reading of the evidence, proved costly, and was arguably politically motivated and discriminatory. The influential UK Schizophrenia Commission Report (2012) called for investment in high-quality services to deliver evidence-based treatments for people with long-term psychosis. Ironically, this report did not include anything about the need to invest in Assertive Community Treatment (ACT) teams. It specifically recommended extension of principles of early intervention to support people experiencing ongoing psychosis but ignored fidelity guidelines specifying an ACT pathway for these individuals (Rosen et al. 2013). Financial constraints and some flawed evaluations in the UK led to the remodeling of English ACT teams and their integration into standard care) (Killaspy and Rosen 2013, 2022; Rosen et al. 2013). However most UK purported studies of or proxies for ACT did not meet the ACT fidelity standards established in the USA, Australia, and Canada. Subsequently, many affected individuals were sent from major city hospitals to distant inpatient facilities, dislocated from their families and familiar environments. This was using up the resources that could have been used for community-based rehabilitation services. This disinvestment in ACT in England has deprived many individuals and their families of the intensive support they needed and discouraged research to inform the intelligent evolution of the ACT model within different contexts (Rosen et al. 2013).

A review of UK mental psychiatric rehabilitation services (Rethink Mental Illness & Royal College of Psychiatrists 2020) demonstrated that fewer than one in four mental health trusts employed a dedicated community mental health rehabilitation team to help these patients in their local area. Some UK community rehabilitation teams have endeavored to retain many features of

mobile ACT teams, but overall disinvestment in services for this complex needs group has been detrimental, prompting some moves toward rebuilding of community rehabilitation services for them (H. Killaspy, personal communication, 18 February 2021).

Rehabilitation Research

Research and practice promoting the recovery movements led by professors Mike Slade (Nottingham University) and Geoff Shepherd (Sainsbury Trust) now routinely include experts with lived experience, often trained in peer-run Recovery Colleges (Whitley et al. 2019). Of individuals living with severe mental illnesses, 90% were supported by the community mental health services. However, within these services, there is lack of access to, or very long waits for, most of the key interventions recommended by NICE (the National Institute of Clinical Excellence), such as psychological therapies. A review of UK mental psychiatric rehabilitation services in 2020 (Rethink Mental Illness & Royal College of Psychiatrists 2020) demonstrated that nearly half of regional services which had decommissioned beds revealed that they also had placed patients out of area, 75% had no plans to reduce the number of patients with enduring mental health problems being sent often hundreds of miles from home, as such placements were "now routine, despite their negative impacts," and fewer than 25% of mental health trusts employ a dedicated community mental health rehabilitation team to help these patients in their local area. Disappointingly, 25% of people using secondary mental health services do not know who is responsible for coordinating their care or participated in treatment planning. Almost 20% had not had a formal meeting to review their care plan in the previous 12 months.

The Early Intervention in Psychosis (EIP) Program

This program in England was co-led by Drs. David Shiers and Jo Smith, developing EIP NICE guidelines. Meaningful Lives (supporting young people with psychosis in education training employment and career development) and Healthy Active Lives (HeAL) led to physical health monitoring protocols for GPs, EIPs, and community mental health teams. They convened initially in the UK, together with Australians Jackie Curtis and Eoin Killackey, utilizing widespread international translations, declarations, and adoption of the "Bondi Algorithm" and the "Lester Resource," which are concise graphic physical monitoring protocols for GPs and EIP mental health team (Shiers and Smith 2014; Byrne and Rosen 2014; Curtis et al. 2012).

Multiple leaders facilitated deployment of social movements as powerful dissemination tools in evidence-based knowledge translation (e.g., via the related IRIS initiative), which also disseminated understanding of the uses of "woodshedding" in recovery (Shiers et al. 2009; Iris Initiative 2018).

Crisis Intervention

The evidence-based practice guidance for Crisis Intervention teams in the UK is well developed via the Cochrane Collaboration and NICE guidelines. The Crisis Care Concordat, launched by the Department of Health in February, 2014, has triggered joint agreements at the local level between the police, social care, mental health, and ambulance services to improve how professionals work together. Achievements so far include a significant drop in the number of people being detained in police cells during mental health crises. In October, 2014, the government announced access and waiting time standards for some mental health services, the first time such targets had been set for mental health, psychological therapies, and early intervention (EIP). The majority of people with first episode psychosis were to access EIPs within 2 weeks of first presentation for comprehensive EIP care.

A report of an independent taskforce to NHS England (2016) and the NHS Long Term Plan (2019) developed a 10-year strategy to improve and widen access to care for children and adults. It promised to transform mental health care so more people could access treatment by increasing funding for a range of mental health services

matched to their age- and gender-related needs. It would also make it easier and quicker for people of all ages to receive mental health crisis care around the clock (Sashidharan S.P., pers. comm. 6 March 21).

Ireland

The Republic of Ireland is a high-income European country. The population has been growing in recent years and has passed 4.83 million. In the middle of the twentieth century, the country had an extremely high rate of institutionalization. In 1961, there were 7.3 psychiatric beds per 1000 population. This was possibly the highest provision in the world (Kelly 2016). A national mental health policy called *A Vision for Change* (AVFC) was launched in 2006. This was a progressive document that envisioned a wide range of community-based inputs and a shift to a recovery philosophy within services. While a good deal of progress has been made and many of the initiatives proposed in AVFC have been implemented, it is widely accepted that there is much left to do (Cullen and McDaid 2017). In 1963, there were 19,801 people in psychiatric hospitals in the country. By 2017, this figure had dropped to 2324, a fall of 88% (Daly and Craig 2018). Ireland now has one of the lowest beds to population ratios in Europe. However, the economic crash of 2007/2008 hit Ireland hard, and community mental health service development suffered. With poor community services in place, some people are now calling for more beds.

An updated national policy called *Sharing the Vision* was launched (Department of Health, Ireland 2020) providing an overview of recent developments in the country. National Clinical Programmes (NCPs) for mental health in various stages of implementation include (i) assessment and management of service users presenting to emergency departments following self-harm; (ii) the national clinical program for eating disorders; and (iii) an early intervention in psychosis model of care. As in other countries, the voluntary sector now plays an important role in service provision in Ireland. Nongovernmental organizations (NGOs) and recovery colleges provide workshops and training on healthy living, mental health awareness, resilience, Mental Health First Aid and trauma-informed care, peer support, and service user involvement at national and regional level are being incorporated (Bracken P. pers. comm. 20 February 2021).

Italy

A Short History of Law 180

Learning from the experience of the historical and decisive anti-institutional movement in Italy is fundamental. This movement began with the pioneering experiences of Franco Basaglia and others in the 1960s and 1970s. Initially improving care conditions of inpatients of asylums, then promoting their freedom, and finally closing these institutions, Basaglia's influence led to Italy's renowned psychiatric reform Law 180 in 1978 and ultimately had a considerable impact on community mental health system reforms in other countries (Sashidharan et al. 2019a, b).

Italy was the first in the world to mandate halting all admissions to mental hospitals (where more than 100,000 inpatients were confined in 1970) and to severely limit involuntary care. Inpatient units were limited to 15 beds and attached to general hospitals, while most clientele were cared for by community mental health centers and/or relocated to community dwellings, serviced initially by institutional staff and later by social cooperatives providing human services to "hosted" residents. It led to the healthcare goal plans of the 1990s and generated the political clout necessary to finally close all psychiatric hospitals and bring the Asylum Era to an end in the country by 2000. A well-staffed local CMHC, open up to 24/7, can be the core of an effective one-stop shop for all psychiatric requirements of its catchment areas (Mezzina 2018).

The existence of six forensic ("judiciary") psychiatric hospitals in Italy was extended until they could be replaced by small units (no more than 20 beds each (Barbui and Saraceno 2015)). Forensic inpatient beds fell from 1400 in 2008 to 652 in the range of residential facilities (Corleone

2018). The closure of all forensic hospitals occurred a year later. Social acceptance of the reform law and a general decrease of stigma attached to psychiatry mark a series of fundamental changes in public attitudes. After some initial strong resistance, families began to advocate strongly for improved community services as it was demonstrated that family burden was much lower relative to European countries (Basaglia 2000; Magliano et al. 2002).

Compulsory treatments dropped dramatically after 1978 as an immediate effect of Law 180, and Italy attained the lowest annual rate of these events in Europe (15 per 100,000) (Ministero della Salute 2018). Many general hospital units are still inadequate and continue the use of mechanical restraints, even though there is a wide campaign to abolish them. Some regions also use short- and medium-term admissions to private hospitals (De Girolamo et al. 2007). Sheltered community-based residences expanded to more than 17,000 places by the end of the 1990s (De Girolamo et al. 2002) and to about 30,000 by 2018 (Starace and Baccari 2018). In Italy, rehabilitation and reintegration of former long-term patients in transitional community residential settings is more extensive than in any other Western country, although the quality of care varies by region regarding the range of staff coverage (up to 24 h) and community inclusion. The development of personal recovery-oriented planning with associated healthcare individual budgets has been shown to speed up the move toward independent living, with provision of daily life supports in some regions (Ridente and Mezzina 2016).

For people with mental health problems, recovery includes citizenship and social reintegration. Social cooperatives have been developed that provide work activities, such as gardening, building, cleaning, hotel, restaurant, radio station and tailoring businesses, as a vehicle to enhance such reintegration. These are social enterprises which try to be competitive in the market. All workers are voting members of these cooperative businesses. More than 8500 such cooperatives are now operating in Italy. These enterprises must include at least 30% disabled service users to qualify for tax benefits that sustain a viable business (Leff and Warner 2006).

Trieste: An Exemplary Model Fully Implemented

Trieste is one practical example of how the Italian movement achieved deinstitutionalization. In other countries, the situation is conceptualized as a bed-reduction process, limiting institutional resources (as a mere de-hospitalization; De Leonardis et al. 1986). In Trieste, there was a gradual relocation of the economic and human resources to create 24-h CMHCs and community living for former inpatients. The institutional hierarchy was dismantled and replaced by a more flexible organization, with a critical paradigm shift, from a narrow focus on mental illness to the whole person's needs (Rotelli 1988; Bennett 1985; Mezzina 2014, 2016).

According to the WHO (World Health Organization) (WHO 2001), Trieste's 50 years of experience in the field of mental health is a proven success. After a 9-year process, there was the creation of a system of open door, open access community services which completely replaced the old asylum (Dell'Acqua and Cogliati Dezza 1986; Dell'Acqua 2010; Mezzina 2014; Muusse and Van Rojien 2015). CMHCs were made fully responsible for small catchment areas of 60,000 on average, working 24 h/7 days per week with a small number (6–8) of "hospitality" (crisis respite) beds for an effective crisis care (Mezzina and Johnson 2008; Mezzina 2014, 2016). The organization and philosophy of these CMHCs were based on the principles of (1) non-selection of demand (i.e., not based on particular diagnoses, severity thresholds, or other exclusion criteria); (2) non-hospitalization; (3) service flexibility and mobility; and (4) the involvement of multiple comprehensive resources, such as a wide range of welfare provisions, in the therapeutic and support programs (Mezzina and Vidoni 1995).

The budget of the Trieste Mental Health Department was 37% of the former psychiatric hospital. In Trieste, 94% of the mental health budget is spent in the community with only 6% of the budget going to a six-bed general hospital-based service which acts as an emergency first

aid station at night (Mezzina 2020). The wide range of responses include (1) supported community accommodation for individual and small groups; (2) job training and placement for about 300 service users annually; and (3) a range of day center activities, including sport and cultural events. About 150 people are supported by personal budgets in the areas of housing, work, and social inclusion each year (Mezzina et al. 2019).

This experimental WHO pilot area of deinstitutionalization in 1974 (Bennett 1985) demonstrated that a city like Trieste can manage and provide a safe environment and provide maximum safeguards for individual freedom. The system became a regional model in Friuli Venezia Giulia and was implemented in other parts of Italy. Over the past 50 years, all forms of intrusive practices have been abolished, including physical restraint and ECT, using compulsory treatments only when absolutely unavoidable (from 7 to 9 per 100,000 inhabitants annually). There are continuous efforts to avoid incarceration of people with mental illness. The rate of suicide rate halved, from 25 per 100,000 in the mid-1990s, to 12 per 100,000 in 2003 (Dell'Acqua et al. 2003). With a dedicated prevention program, Trieste's suicide rate is on a par with other Mediterranean countries, with much less compulsion and hospital admissions (Mezzina 2010, 2014).

The comparative impact of the Trieste model of care has been limited by uncoordinated regional policies and by the fact that Italian mental health care is still severely underfunded with only 3.6% of the overall health budget allocated for mental health (Starace and Baccari 2018). It has inspired and sometimes shaped service reforms in other countries. It is an exemplary model for the recovery and human rights movements (WHO 2021).

Current regional government policies are posing a major threat to Trieste and the Friuli-Venezia Giulia Region. Cuts in 24 hrs community mental health services and staff, with the possible retreat to more inpatient care, may open the potential for privatization. This happens at a time when the COVID-19 has demonstrated the dire need for more community health systems (Mezzina et al. 2020; Sashidharan 2022; Frances 2021). This could hamper any possibility of developing a comprehensive mental health service network across the whole country, and internationally, that has been long awaited by stakeholder organizations (Mezzina 2018; United Nations 2020; International Mental Health Collaborating Network 2021).

North America and the Caribbean

Cuba

It is difficult to penetrate the mental health service provision in Cuba because of a paucity of written descriptions or published research. It has been reported (Gorry 2013) that 25% of the Cuban population is depressed, that suicide is in the top ten causes of death, and that the rate of alcoholism is increasing. In 1995, in recognition of the importance of mental health, and in the face of limited access and few coordinated services, the Havana Charter was developed: psychiatric care was integrated with primary care and focused on the development of neighborhood clinics that offered prevention, treatment, and rehabilitation.

People would seek health care at neighborhood clinics and be referred to specialty mental health clinics if need be. While the move to integrated care has improved access, particularly in urban areas (101 community mental health offices exist), Cuba continues to struggle with access in rural clinics. There are 17 specialized psychiatric hospitals, but access to outpatient care is always a concern. However, the creation of local day hospitals has helped those transitioning back to the community and allows for more intense community-based care. There is growing understanding of the importance of including family members in community care and stabilization of patients. As with other medical specialties in Cuba, access to and quality of care is much more assured at the primary healthcare level than at the specialty psychiatry level.

Access to a variety of pharmaceutical products has been limited by the level of poverty and

the US embargo. Workforce issues are reflected in less than adequate numbers of mental health professionals (in 2012, there were 1051 psychiatrists = <10/100,000 psychiatrists for 11.26 million population). While access to medication is free in the hospital, outpatient medications must be paid for, and there is limited access to medications for those living with psychoactive substances use disorders. Concern has also been expressed about declining services for the expanding elderly population. There are some positive results regarding a significant subset of the population utilizing and responding to natural/traditional approaches to treatment (ACN 2022). More contentious as potential contributors to well-being are widespread locally inclusive communal projects, like urban communal vegetable gardens and cooperative house-building initiatives by "micro-brigades," possibly motivated more by political ideology, the prospect of food insecurity, shortages of affordable housing, and tradespeople (Marsh 2020; Minoff 2015).

Caribbean

Multiple island nations as well as land-locked countries are included in this survey (e.g., Bahamas, Turks & Caicos, Belize, Guyana, Surinam, Trinidad, Tobago). Schizophrenia and depression top the list in terms of clinical presentations. It is noted that the prevalence of mental illness seems high and that services are absent or inaccessible in most places. Sixty percent of those with symptoms of mental illness are unable to access services. An average of only 3% of their health budget is expended on mental health across the region. Care is typically centralized; some nations offer mainly hospital care for mental illness (where rates of seclusion and restraint appear high), while others offer only outpatient care.

Poverty and economic instability combined with overwhelming stigma and discrimination contribute to development of depression and disincentives to seek care. The increasing population, anxiety, and stress related to the consequences of climate change, trauma, disasters, social decline, and the lack of political leadership all negatively impact attempts at improvement in the development of plans and policies. Some innovations are moving systems of care forward: consideration of day hospitals, increased nonprofessional workforce development, and integrative care (primary care and psychiatry) have been instituted in some locations (enhancing access). The mental health workforce is limited, though numbers of psychiatric nurses are climbing significantly. Surprisingly, access to psychotropic medication is relatively good, and medication seems affordable for most (WHO 2011b).

Exceptionally, the Dominican Republic is now a WHO model for LMIC's mental health services. Its asylum was closed in the 1990s with ongoing support from Trieste. It was repurposed as an open rehabilitation center, with other functions completely replaced by a comprehensive range of services, from primary care to community care, encompassing general hospitals acute units, crisis services with respite beds, day centers, supported living, and outpatient psychiatric and psychological care (Plan Nacional de Salud Mental: República Dominicana 2019).

Mexico

It is reported that at least 17% of the Mexican population is living with at least one psychiatric diagnosis. Workforce development and access to mental health services are challenges faced across the nation, particularly in rural areas. One study reflects in the Jalisco region found that there are limited numbers of outpatient clinics, and those that do exist are often long distances from those patients who need them, creating barriers to access.

MD staffing (psychiatrists) is inadequate (3.71/100,000). In the face of limited outpatient mental health services, it is difficult to address the challenge of mental illness. The need for an expanded array of services has been identified (Carmona-Huerta et al. 2021). A nonprofit group of organizations has formed the Red Voz Pro Salud/Borgan Project to increase access to men-

tal health services by combatting stigma with psychoeducation. They report that Mexico ranks second in the world in level of stigma associated with mental health services, 40% of the population lacks insurance, and that Mexican youth have twice the numbers of mental disorders when compared to the USA and Canada. Red Voz Pro Salud is working to provide education (via NAMI family-to-family lessons, social media, advocacy with political leadership) to tackle stigma (Daniels 2022).

Canada

Canada has an impressive record of community mental health innovation and of being early replicators and adopters of evidence-based initiatives (Fenton et al. 1979; Wasylenki et al. 1985, 1993). Earlier programmatic examples include collaboration of greater Vancouver's "Car 87" joint mental health and police crisis intervention team with Venture House, a community sited 24-h low-key respite facility (Torrey et al. 1993). Other key initiatives include crisis intervention and integrated care delivered in naturalistic settings (Mercier 1990; Fenton et al. 1979), system-wide implementation of ACT in Ontario (George et al. 2009), and Quebec (Latimer and Nadeau 1998), as well as early psychosis intervention teams (Malla et al. 2005). A national Mental Health Commission (MHCC) was launched in 2007, developing a national mental health strategy to support movement toward community-based care, recovery orientation, a knowledge exchange center, community awareness, and anti-stigma campaign (Mental Health Commission of Canada 2015; Goldbloom and Bradley 2012). Programs focusing on developing and adapting evidence-based practice of providing homes and support services for those living with mental illness who were homeless ("Chez Soi" housing) were launched by MHCC in 2009 with considerable success, supported by a sizeable federal research and implementation grant to MHCC enabling large-scale research supporting its effectiveness (Latimer et al. 2020). "Housing First"-type programs are being widely disseminated, partly based on these studies.

In 2015, 15.8 billion dollars were spent on mental health (private and public funding) which is only 7% of the total healthcare budget (much less that England or France). Barriers to care included stigma, membership in some demographic groups (child/adolescent, rural, Indigenous), and lack of public funding (especially psychotherapy services). In 2017, $950 million dollars were paid for private practice therapists, while 30% of those needing these services had to pay out of pocket. At the same time, it was reported that the unmet needs of those with mental health problems were responsible for $51 billion dollars in additional healthcare spending, lost productivity, and decreased quality of life. It was reported that there was a 75% increase in emergency room mental health services since 2007. Extended wait times for mental health services peaked, especially for children; the average wait time for intensive services was 92 days.

In 2017, the government (federal and provincial) responded by drafting and accepting the Common Statement of Principles in Shared Health Priorities, which seeks to increase mental health priorities by (1) increasing mental health spending to 9% of health costs; (2) maximizing the use of technology (e.g., the use of telehealth mental health, which has proven especially helpful during the COVID pandemic); (3) increasing the mental health workforce; (4) improving stable housing opportunities; (5) developing and using "stepped care" (utilization of primary care resources first and establishing policies and procedures for integrated care); (6) promulgating early intervention; and (7) increasing access to therapy (Moroz et al. 2020).

Global Community Mental Health Practices of the Future

The Global Mental Health movement (Patel and Prince 2010; WHO (mh-GAP) 2019a) is still largely dominated by Western models of care. Low- and medium-income countries often have national mental health systems severely limited

by a paucity of resources. Many of these countries have systems that still retain asylums and other forms of long-term institutionalization (WHO 2011a). Task-shifting approach from psychiatric clinicians to primary care disciplines (Patel and Prince 2010) appears to be an effective strategy when combined with a development approach addressing the social determinants of poor health and the environmental contexts (Sashidharan et al. 2016). Global mental health is still in a process of growth and development. This has much to do with operationalizing the premises of deinstitutionalization overcoming colonial legacy in many LMIC (low- and middle-income countries). This transition must be combined with retention of human and economic resources to be converted into community supports and services. Cultural sensitivity must be respected through a "two-ways" or "two worlds" approach to implementation, combining least restrictive Western evidence-based interventions with expert traditional healing, extended kinship support and guided progression through rites of passage (Rosen 2006b, Gayaa Dhuwi (Proud Spirit) Declaration (https//:www.gayaadhuwi.org.au/resources/the-gayaa-dhuwi-proud-spirit--declaration/, Durie M, Foreword, in NiaNia W, Bush A, Epston D, Collaborative and Indigenous Mental Health Therapy: Tataihono, Routledge, New York, 2017, (https://www.routledge.com/Collaborative-and-Indigenous-Mental-Health-Therapy-Tataihono-Stories/NiaNia-Bush-Epston/p/book/9781138230309).

Any effective community mental health care can only be realized with a sincere process for phasing out psychiatric hospitals. The WHO reports that 80% of resources are still spent in psychiatric hospitals worldwide (WHO Atlas 2021; Saxena et al. 2011), while a clear gap still exists between the need for care and the available services. Even in Europe, only few countries are considered by WHO to have a full range of services for people with mental illness living in the community. Up to 50.3% of those with severe illness did not receive any treatment within the prior year in developed countries, while in developing countries, these data were much higher – 76–85% (WHO 2004a, b; Economist Intelligence Unit (2014).

The "balanced care model" (Thornicroft and Tansella 2013) was proposed, and although unintended by these authors, it can be misconstrued to suggest that the evidence base for psychiatric hospitalization is as strong as intensive community care and to support the persistence of standalone hospital-based services (Rosen et al. 2018, 2020b). The Lancet Psychiatry-WPA Future of Psychiatry Commission's uncritical endorsement of the balanced care model (Lancet Mental Health Group 2007; Bhugra et al. 2017) implies such scientific justification for hospital care, which is unwarranted. Virtually all rigorous studies have demonstrated the superiority of high-fidelity mobile outreach community mental health systems over hospital-based care (Rosen et al. 2018, 2020a). The evidence supports an integrated mental healthcare ecosystem model, shifting of the center of gravity of services toward a greater proportion of community care (Rosen et al. 2020a).

One important aspect of newly implemented mental health policies in several countries was the integration of mental health into primary care. Cuba was the first to include mental health in primary care as the basis of the new mental health system and to implement this strategy at the national level. The existence of a network of primary care covering the entire population was certainly a factor that greatly facilitated this strategy, but arguably (Caldas de Almeida and Cohen 2008), it would never have been implemented without a detailed mental health plan, making it possible to train professionals, create specific programs, and develop new facilities in the community.

Beyond the relevant issue of expanding coverage, the concept of comprehensive services organized in several steps, from self-care to specialist services (WHO 2003, 2011a), doesn't seem to "get" or convey the real issue of the need to transform cultures and practices. The Global Mental Health Action Plan (WHO 2020) points out four objectives, two of which deserve extra emphasis:

1. To strengthen effective leadership and governance for mental health with a highly consultative interdisciplinary leadership team.
2. To provide comprehensive, integrated, and responsive mental health and social care services in community-based settings and the empowerment of persons with mental disorders and psychosocial disabilities.

Regarding these objectives, the World Health Organization states:

> Community-based service delivery for mental health needs to encompass a recovery-based approach that puts the emphasis on supporting individuals with mental disorders and psychosocial disabilities to achieve their own aspirations and goals," while "more active involvement and support of service users in the reorganization, delivery and evaluation and monitoring of services is required so that care and treatment become more responsive to their needs. Greater collaboration with 'informal' mental health care providers, including families, as well as religious leaders, faith healers, traditional healers, school teachers, police officers, and local nongovernmental organizations, is also needed (WHO 2020).

and sometimes also welfare workers, pharmacists, hairdressers, real estate agents, and helpline workers.

Conclusion

Are we destined to fight the same battles to save community mental health over and over again? For example, although a celebrated global and WHO beacon of mental health reform, the fate of Trieste mental health services and many years of humane Italian reforms again hang in the balance (Frances 2021; Sashidharan 2022), and too many Australian community mental health services have suffered funding diversion and retraction to hospital sites (Rosen et al. 2012b). A shift of the center of gravity of mental health services to community-based care is squarely supported by worldwide evidence and is long overdue in many countries. However, community teams and facilities do not have a high public profile, so they are vulnerable to variable and chronic underfunding and recurrent attempts to dismantle them on the basis of faux economy of scale (Rosen et al. 2010a). Some dismiss community mental health reforms as having a marked ideological component and being extremely dependent on and vulnerable to political shifts (Caldas de Almeida and Cohen 2008). However, inpatient bed-preoccupied institutionally centered services have been defended on the basis of habit, ideology, and political expediency for several centuries (Rosen et al. 2020b).

The WHO has embraced for many years now a clear direction toward a comprehensive mental health service system, where hospital beds should be better located in general hospitals or community residential respite facilities. Long-term institutions were even officially (WHO 2009) considered as the relics of the past. The Global MH Action Plan encompasses some of the principles of the community mental health movement: facilitating an integrated multisectoral and interdisciplinary approach, where those with lived experience and family members become empowered and engaged in co-leadership. Services should actively facilitate both recovery and human rights agendas (Rosen et al. 2012a; Rosen and O'Halloran 2014; Mezzina et al. 2019; Rosen et al. 2020a; WHO Quality Rights 2019b).

Community mental health services have been strengthened and enriched by empowering of individuals with lived experience and their families as advocates and mutual support networks, and the accelerating valuing and inclusion of peer workers in interdisciplinary teams. These networks have now engaged the mental health services sector in the quest to include lived experience leadership and research at every level of the system: teams, services, organizations, and governments (Byrne and Wykes 2020; Jones et al. 2021).

Too many lower- and middle-income countries' mental health systems are still concentrated in postcolonial asylums and other forms of total institutions (Raja et al. 2021). The data in the WHO Mental Health Atlas (WHO 2021) and DESDE Atlas (Salvador-Carulla et al. 2013; Romero-López-Alberca et al. 2019; Rosen et al. 2020a, b) demonstrate that the availability of

much evidence-based community components of service for moderate to severe and complex mental illness is still limited to higher-income countries. To complete deinstitutionalization of mental health care (WHO 2021a), we must converge human rights, person-centered, and recovery approaches with comprehensive, strong, accountable, and responsive community-centric services. The centrality of innovative and cost-effective service arrays based in local communities, with in-reach to acute care transitional admissions only as needed, should replace the hospital-centric approaches of the past.

There is a true paradigm shift from a reductionist biological-medical approach to treating mental illness to a model that helps people with mental health problems in their journey of recovery and social inclusion (Mezzina 2005). This entails a mental health care ecosystems approach at both micro and macro levels (Rosen et al. 2020a) facilitating human rights, ensuring freedom, choices, opportunities (Mezzina et al. 2019, Rosen et al. 2012); transcultural awareness, respect, safety and responsiveness; and community alternatives, from entering to leaving the service network (Rosen 2006a, b); while addressing the mental health impacts of warfare, climate change, environmental and economic disasters in small communities to large populations.

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