World mental health report

Transforming mental health for all

7
Restructuring and scaling up care for impact

COMMUNITY-BASED CARE
INTEGRATED SERVICES
COMMUNITY MENTAL HEALTH SERVICES
SERVICES BEYOND THE HEALTH SECTOR

Chapter summary

In this chapter we explore the major restructuring and scaling up required to transform mental health care services so that they meet the needs of all. We emphasize the need for a community-based mental health system. And we show the importance of providing person-centred, human rights-based and recovery-oriented care.

Key messages from this chapter are:

→ Community-based mental health care is more accessible and acceptable than institutional care, helps prevent human rights violations, and delivers better recovery outcomes for people with mental health conditions.

→ The vast care gap for common mental health conditions such as depression and anxiety means countries must diversify and scale up care, for example through non-specialist psychological counselling or digital self-help.

→ Community-based mental health care comprises a network of intercon-nected services that include: mental health services integrated in general health care; community mental health services; and services that deliver mental health care in non-health settings and support access to key social services.

→ Social and informal supports delivered by community providers (such as peers, community volunteers and women's groups) complement formal services and are vital to ensure enabling environments for people with mental health conditions.

→ Integrating mental health into health services typically involves task-sharing with non-specialist health care providers; or adding dedicated mental health staff and resources to primary and secondary health care.

→ General hospitals and community mental health centres or teams often provide the cornerstone of community-based mental health care and help blend clinical services and support with psychosocial rehabilitation.

→ Where feasible, supported living services are key to deinstitutionalization; they include a mix of facilities with varying levels of support for different levels of dependency.

→ Complementing health interventions with key social services, including child protection and access to education, employment and social benefits, is essential to enable people with mental health conditions to achieve their recovery goals and live a more satisfying and meaningful life.

At the heart of mental health reform for most countries, lies a major reorganization of mental health services. The task is to simultaneously shift the locus of care for severe mental health conditions away from any institutions and towards communities, while scaling up the availability of care for common conditions such as depression and anxiety. Both strategies are critical to advance human rights and improve the coverage and quality of mental health care.

Every district, province, prefecture, region, major city or other sizeable administrative division (here called "district") should have a network of accessible community-based mental health services to provide an inter-connected platform for supporting people with a broad range of mental health conditions. This network must also be able to help meet the broader social and economic needs of people living with mental health conditions, which means that the network must be developed and delivered in close collaboration with multiple sectors and stakeholders *(423)*.

This chapter explores what comprehensive community-based mental health care means in theory and what it might look like in practice. We outline some of the principles behind the idea, consider each of its main component parts, and showcase examples of practice from around the globe. Not all examples necessarily represent the best solution for all contexts. Rather, each country will need to consider what is feasible and adequate depending on their own realities, capacities and needs.

7.1 Understanding community-based mental health care

Discussions on services reform are often confused by a lack of common language. WHO uses the term "community-based mental health care" for any mental health care that is provided outside of a psychiatric hospital. This includes services available through primary health care, specific health programmes (for example HIV clinics), district or regional general hospitals as well as relevant social services. It also includes a range of community mental health services, including community mental health centres and teams, psychosocial rehabilitation programmes and small-scale residential facilities, among others.

7.1.1 Putting people first

WHO has long strongly advocated community-based mental health care as an alternative to institutional care *(1, 23)*. Through the *Comprehensive mental health action plan 2013–2030*, countries are committed to doubling the number of community-based mental health facilities by 2030.

Compared with institutional care, community-based mental health care is broadly acknowledged to:

- **Increase accessibility.** Community-based care means people can access services closer to home, which eliminates potentially prohibitive costs of seeking care in distant locations and makes services more accessible. It also allows for treatment in a familiar environment, in which people can maintain support networks, relationships, friendships and employment, educational and other activities while receiving care, which facilitates recovery *(424)*.

- **Reduce stigma.** Community-based care can help shift attitudes around mental health conditions to lessen social exclusion for those affected and make them more likely to seek help *(425)*.
- **Better protect human rights.** Community-based care reduces the likelihood of seclusion, restraint, overmedication neglect and abuse, which are especially common in institutional settings. Community-based care is also important to reduce discrimination and meet people's rights to liberty, and participation and inclusion in their community *(23)*.
- **Improve outcomes.** Community-based care is more effective than institution-based care in addressing people's preferences, supporting community reintegration and improving quality of life *(426)*.

When it comes to implementing community-based care in practice, WHO emphasizes the need for a person-centred, recovery-based approach that ensures all people have access to a range of services and supports, from promotion and prevention to treatment and rehabilitation. So care should be coordinated across different levels and sites within and beyond the health sector, according to people's needs throughout the life-course *(427)*.

A life-course approach is especially important to target critical stages, transitions and settings where different interventions may be particularly relevant (see section 2.1.3 Mental health is experienced over the life-course). Mental health services often focus on adults rather than children, adolescents and older people even though these are critical life stages for mental health.

Person-centred care
In all cases, good and supportive community-based health care is organized around the health needs and expectations of people, not diseases. Such person-centred care engages individuals, families and communities as active participants in, rather than passive recipients of, care. It consciously adopts people's own perspectives and priorities and responds to these in humane and holistic ways *(427)*. Thus it seeks to understand and respect people's cultural understandings of mental health, and to ensure that mental health care providers engage in meaningful conversations about people's needs and concerns *(428)*.

Importantly, person-centred care encourages a more holistic approach to identifying and managing an individual's overall health needs rather than focusing on a particular pathology or disease. This is especially valuable for people with multiple needs or conditions.

> *Good and supportive community-based health care is organized around the health needs and expectations of people, not diseases.*

In practice, person-centred care means many things, including:

- fully respecting people's human rights and personal values;
- accounting for and respecting people's treatment preferences and expressed needs;
- coordinating and integrating care across services and sites;
- involving individuals in planning and delivering their care;
- making sure people are physically comfortable and safe; and
- providing intervention and support as and where needed.

For children and adolescents, person-centred care is typically family-oriented, engaging caregivers in decisions and care as required while respecting older adolescents' evolving autonomy. Across all ages, implementing person-centred care relies on people having

NARRATIVE

Access to good quality care put me on my road to recovery

Claudia's experience

In my experience, good quality mental health care is about reciprocal understanding: uncovering the underlying problems and finding solutions by focusing on the individual's unique needs.

My journey in a snapshot is: two voluntary admissions, a clear multi-disciplinary approach to treatment, inpatient and outpatient treatment and continuous therapy. Both hospitalizations were frightening. The first time I was afraid of having knowingly decided to undergo treatment that I did not know much about. The second time I was more versed in mental health but I was still unsure of what to expect. White walls, long queues, constant monitoring, strict visiting hours: it was all new and intimidating.

During my second hospitalization, I had daily sessions with trained practitioners as well as group work that taught me about my diagnosis, what it means to live with a mental health condition and what I could do

to help myself get better. There were other optional classes on meditation, breathing exercises, and arts and craft therapy. It was this mental health care that secured me on my road to recovery.

After my discharge I wanted to help people in the same way my health care practitioners and their person-centred treatment had helped me. I pursued a career in psychology and today I am a certified wellness counsellor and deputy chief executive officer at an international mental health lived experience organization.

Living with a mental health condition does not make you less of a person, nor does it need to take away your ability to function optimally. With the right health care systems in place, I believe that many more people like me can be helped worldwide. With the right skills and tools we can all thrive in life and reach our full potential.

Claudia Sartor, South Africa

the information and support they need to make decisions and participate in their own care *(427)*.

Person-centred care can have lasting benefits for individuals, communities, health workers and even whole health systems *(429)*. It can enhance the trust, experience and outcomes people have from care (read Claudia's experience). Person-centred

care can also improve access to care and strengthen the health literacy and decision-making skills that promote independence. It can increase confidence and job satisfaction for health professionals. And it can improve the quality and efficiency of health systems.

Recovery-oriented care

Recovery is widely accepted as an important aspect of person-centred care in community-based mental health services, including in those designed for people living with severe mental health conditions such as schizophrenia *(430)*.

The term recovery used to be largely defined in clinical terms to mean a remission of symptoms alongside improved cognitive, social and occupational functioning. But people with lived experience have long challenged the assumption that having a mental health condition means you cannot live a productive and satisfying life, arguing that recovery can occur even as symptoms persist. In this context, the idea of personal recovery emerged to mean a way of living a satisfying, hopeful and contributing life despite the limitations that experiencing mental health problems can impose *(431)*.

From a human rights perspective, recovery focuses on the right to participate in all facets of life on an equal basis with all other people *(432)*.

> *Recovery-oriented care is not about treatment of symptoms but about empowering people to have control of their own lives.*

In practice, recovery-oriented care includes elements of both personal and social recovery. It can mean different things to different people. Importantly recovery-oriented care is not about treatment of symptoms but about empowering people to have control of their own lives *(430)*. It involves supporting people to find hope, develop self-esteem and resilience, build healthy relationships, regain independence and to live a life that has meaning for them, whether that be through school, vocational training, work, friendships, community engagement, spirituality, or something else *(23)*.

Effective recovery-oriented care is often characterized by:

- **Recovery planning**. Individuals are guided to articulate what their expectations and goals are and to describe how they want to live their life, for example by writing a recovery plan, taking into account all aspects of their lives, such as relationships, work, and education *(321)*. For adolescents, recovery planning includes recognizing and respecting their evolving capacities in making recovery plans for themselves *(432)*.

- **Supported self-management.** Individuals are supported to build the skills and confidence they need to recognize and manage the physical, social and emotional impacts of a mental health condition. Supported self-management includes, for example, psychoeducation about the condition and its treatment, recognizing early warning signs of relapse and developing a relapse prevention plan; and strengthening coping skills for dealing with persistent symptoms *(433)*. Evidence suggests that supported self-management can improve outcomes for people with severe mental health conditions *(434)*. It is also relatively straightforward compared with other therapeutic interventions and can be delivered across settings and in various ways.

- **Multisectoral coordination.** Services are coordinated between health, social and other care sectors including child protection. The aim is to simultaneously address the multiple needs of people with mental health conditions.

Human rights-based care

The CRPD requires that governments provide people with disabilities access to quality mental health services that respect their rights and dignity. This means that mental health services should not only be affordable, available, person-centred, recovery-oriented and evidence-based, among other attributes, but also that they should promote

autonomy, legal capacity (equal recognition before the law), non-coercion, confidentiality, participation, and community inclusion.

Respecting people's autonomy can be challenging but good practice case examples show that is it possible (see section 4.2.3. Autonomy in health decision-making) *(23)*. For example, services are increasingly introducing advance plans or directives that enable people to indicate what they want to happen in case of a crisis *(203)*. Advance plans can cover many topics, including when and how to activate them, who to contact for supported decision-making, and what treatment is acceptable or not acceptable, among other things *(205)*.

Similarly, services should and can make much progress on care that fully involves the person in their care plan. People subjected to care without

their agreement report feeling dehumanized and long-term effects on their mental well-being (read Sandra 's experience and Alexandra's experience in Chapter 4). Coercive practices undermine people's confidence and trust in mental health service staff, leading people to avoid mental health care *(23)*. All services can and should promote non-coercive practices (see Box 7.1 Promoting non-coercive practices).

Throughout this chapter, we use case studies from around the world to illustrate what community-based care looks like in practice and how it can be achieved through mental health care reform. Not all the examples presented here fully live up to all aspects of person-centred, recovery-oriented, human rights-based care in their entirety, but all of them represent advances in care.

TOOL

BOX 7.1
Promoting non-coercive practices

In addition to changing laws and policies, WHO identifies several actions as key to advancing non-coercive practices.

1. Educate service staff about power differentials, hierarchies and how these can lead to intimidation, fear and loss of trust.

2. Help staff to understand what are considered coercive practices and the consequences of using them.

3. Provide systematic training for all staff on non-coercive responses to crisis situations, including de-escalation strategies and good communication.

4. Support individualized planning, including crisis plans and advance directives.

5. Modify physical and social environments to create a welcoming atmosphere, including by using comfort rooms and response teams to avoid or address and overcome conflict or otherwise challenging situations.

6. Establish effective grievance mechanisms for receiving, responding to and learning from complaints, including having a technical debriefing after any use of coercion.

7. Reflect on, and where appropriate change, the role of all stakeholders in coercion, including the justice system, the police, general health care workers and the community at large.

Sources: WHO, 2021 *(23)*; WHO, 2019 *(435)*.

7.1.2 A mix of services and supports

People's needs for mental health care vary enormously. Some people may be able to manage their mental health conditions themselves, especially with support from community providers such as family members, peer support groups, faith-based organizations, or community workers *(318)*. Many others will need formal interventions to support their recovery, which are typically offered through a range of daytime services. Some people will experience acute symptoms that require short-term overnight care with follow-up care in the community. Only rarely do people experience conditions that require highly specialized or longer-term round-the-clock care, which should be in the community, for example within general hospitals or in community residential facilities. Children, adolescents, adults or older adults may need different or adapted services.

Many people experiencing mental health conditions also require help accessing key social services such as housing, employment, education and welfare. And anyone with mental health conditions may need different types of services and supports at different points in their lives *(436)*.

All countries will need to organize access to specialized care at the district level or equivalent.

Effective community-based mental health care includes a careful mix of services and supports that can cater to all these needs *(437)*. It also ensures continuity of care between different services and supports, especially for those people who have complex needs or require ongoing care, as is common in schizophrenia. For each person, the aim is to avoid breaks or gaps in the support provided.
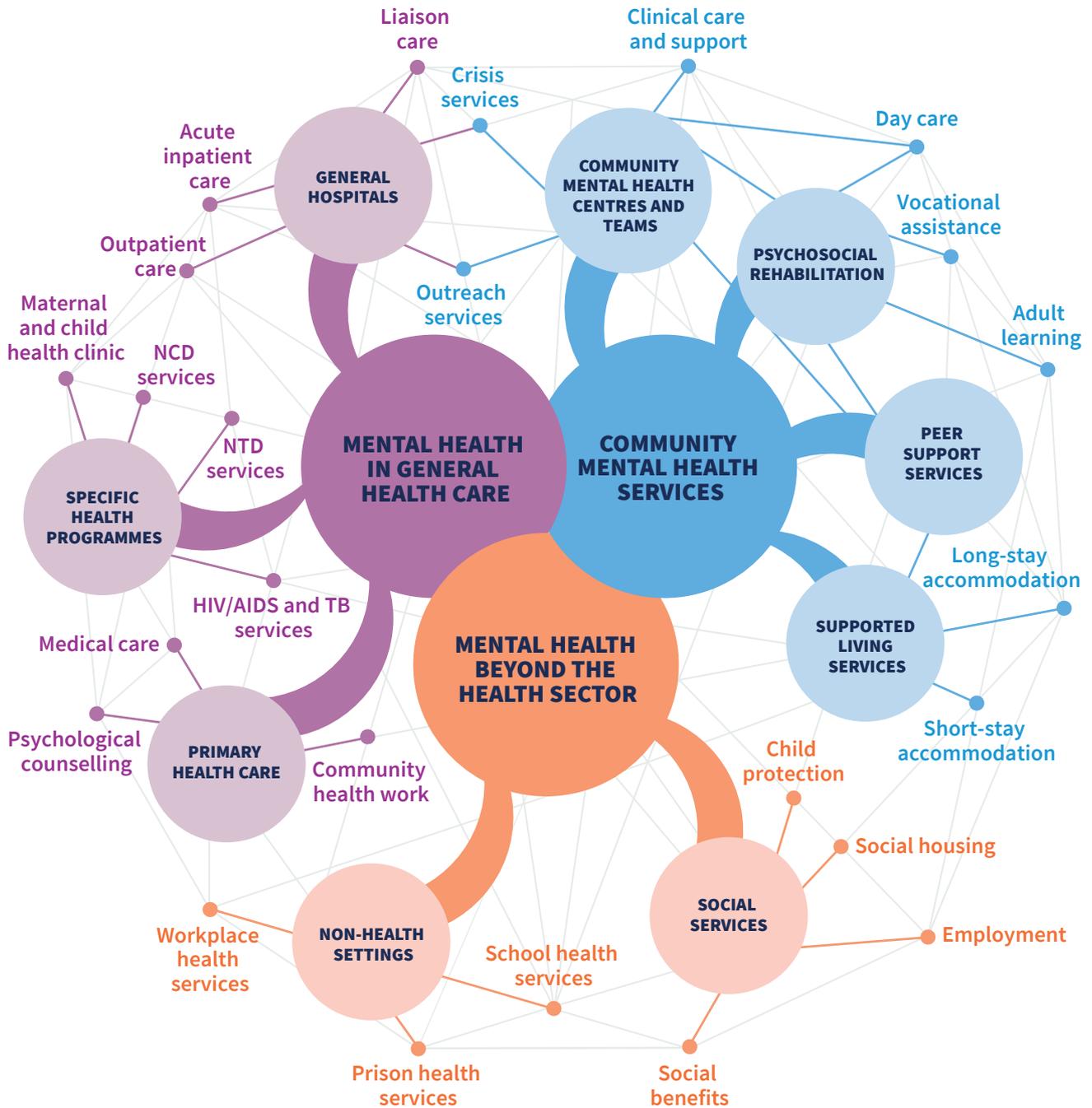
In practice, a community-based mental health system can broadly be described as a network of interconnected services that typically includes a mix of (see Fig. 7.1):

- **Mental health services that are integrated in general health care**, at primary care facilities and general hospitals, including within existing specific health programmes (for example for HIV).
- **Community mental health services** that focus on meeting the needs of people living with mental health conditions and of their families, and that potentially include community mental health centres or teams, as well as peer support services, psychosocial rehabilitation programmes and, where feasible, supported living through small-scale residential facilities. These services are still very rare in low-income countries.
- **Services beyond the health sector** that deliver mental health care in non-health settings such as schools, workplaces and prisons; and that support access to key social services such as housing, education, employment, social benefits and livelihood support.

Fig. 7.1 shows a vision of a comprehensive network of interconnected formal services. This cannot be achieved without sufficient resources, and low-income countries are unlikely to be in a position to have such comprehensive network of services in the near future. In general, most countries need to decide which services to develop or strengthen first. So how service networks for mental health are developed and organized in practice will vary. Almost all countries rightly give primary health care a key role in supporting people with mental health conditions. Yet all countries – including low-income ones – will also need to organize access to some form of specialized mental health care at the district level or equivalent.

FIG. 7.1

Model network of community-based mental health services

Liaison care

Crisis services

Clinical care and support

Acute inpatient care

GENERAL HOSPITALS

COMMUNITY MENTAL HEALTH CENTRES AND TEAMS

Day care

Outpatient care

PSYCHOSOCIAL REHABILITATION

Vocational assistance

Outreach services

Maternal and child health clinic

NCD services

NTD services

MENTAL HEALTH IN GENERAL HEALTH CARE

COMMUNITY MENTAL HEALTH SERVICES

Adult learning

SPECIFIC HEALTH PROGRAMMES

PEER SUPPORT SERVICES

HIV/AIDS and TB services

Long-stay accommodation

Medical care

MENTAL HEALTH BEYOND THE HEALTH SECTOR

SUPPORTED LIVING SERVICES

Psychological counselling

PRIMARY HEALTH CARE

Community health work

Short-stay accommodation

Child protection

Social housing

Workplace health services

NON-HEALTH SETTINGS

School health services

SOCIAL SERVICES

Employment

Prison health services

Social benefits

Some countries offer specialized care by developing community mental health centres or teams, or by adding community mental health nurses to primary health care. Many others offer these services within district-level general hospitals. And higher-resourced countries tend to combine multiple types of specialized services. As described in Chapter 5 Foundations for change, when lower-resourced countries do not have sufficient specialists to provide these services at the district level, they should consider strategies to address this gap. This may be, for example,

by introducing and training up new cadres of professionals who can, for the time being, substitute for psychiatrists, clinical psychologists or psychiatric nurses (see Box 5.11 Innovations in human resources to develop specialist expertise).

Overall, there is no single model for organizing community-based mental health services that will apply to all country contexts. Yet every country, no matter its resource constraints, can take steps to restructure and scale up mental health care. Differences in health system structures, human resources and the legacies of pre-existing mental health services will influence the exact configuration of service networks; and local differences in geography, means of accessing services, literacy and social and informal support systems need to be considered.

Beyond formal services

Beyond the formal services described in Fig. 7.1, community support systems in particular are an important consideration in developing community-based mental health care networks. These systems include the psychosocial supports delivered by a diverse range of community providers, including family members, friends, peers, community and faith-based leaders, community volunteers, teachers, hairdressers, women's groups, youth clubs and traditional and complementary practitioners.

Social and informal supports complement formal services and are vital to ensuring supportive environments for people with mental health conditions (read Eleni's experience). According to a 2020 global survey, talking to natural carers (i.e. friends and family) is the most common approach people take to alleviate depression or anxiety *(150)*.

As shown elsewhere in this report, people with lived experience can have a big role in supporting others experiencing mental health conditions,

advocating for their rights and perspectives, promoting their social inclusion, and delivering services (see Chapter 4, In focus: Engaging and empowering people with lived experience and section 7.3.2 Peer support services) *(438)*.

In most countries, faith-based leaders and traditional and complementary practitioners are widely consulted. Their beliefs and practices vary widely across settings, as does their effectiveness *(439)*. Traditional healers sometimes apply highly harmful practices *(440)*. But they are often the first point of contact for people with mental health conditions, who see their input as meaningful and likely to be helpful *(441)*. And there are likely many occasions where fruitful collaboration between health services and local healers is possible. Indeed, a large randomized controlled trial in Ghana and Nigeria showed the effectiveness and cost–effectiveness of a shared care model for psychosis delivered by local healers and primary health care providers *(442)*.

In parallel to developing a network of formal services, all countries should establish an enabling environment for community providers. To that end, governments should make resources (for example, funds and spaces) available to community-based initiatives that can activate and strengthen helpful community supports for people with mental health conditions.

Planning at the national and local level

Comprehensive and cohesive service networks need careful planning and management at multiple levels *(443)*. National mental health authorities, directorates or departments – which oversee and coordinate country-wide policies and legislation – have a crucial role *(444)*. These authorities advise the central government and can help prioritize mental health matters at the national level. They also develop quality and service provision norms and compile national data on all mental health services.

They conduct monitoring and evaluation and can facilitate exchanges of good practices across regions. They keep up to date with international developments in mental health and engage in international forums, bringing lessons learned back to the country. A mental health authority can be held accountable for achieving (or not achieving) mental health improvements and development in the country.

Local mental health authorities plan services for a particular geographical area such as a district, taking into consideration local differences in context and availability of human and other resources. Local planning makes it easier to involve local stakeholders, including people with lived experience. And it allows service users to hold local planners to account *(445)*.

Whether national or local, mental health service planning and implementation must identify and budget for an appropriate range of mental health services, based on assessed needs, priorities and available resources in the population, including trained personnel (see Fig. 7.2).

NARRATIVE

My family are my community care workers

Eleni's experience

I live with bipolar disorder in Ethiopia, where until recently no treatment options beyond medication were available. A decade ago, mental health care was given by a few psychiatrists who had to ration their services across a long queue of people. Other therapies were non-existent; they were not even acknowledged by the country's health system.

For me, my family members are my community care workers. I have the privilege of having parents with a medical background, and a sister and husband who are social workers. Their belief in me has been a major support in my recovery journey. Investing in my mental health care has never been considered a wasted effort or resource in my family. Their empathy, emotional and financial support helped me overcome my own limitations and self-stigma.
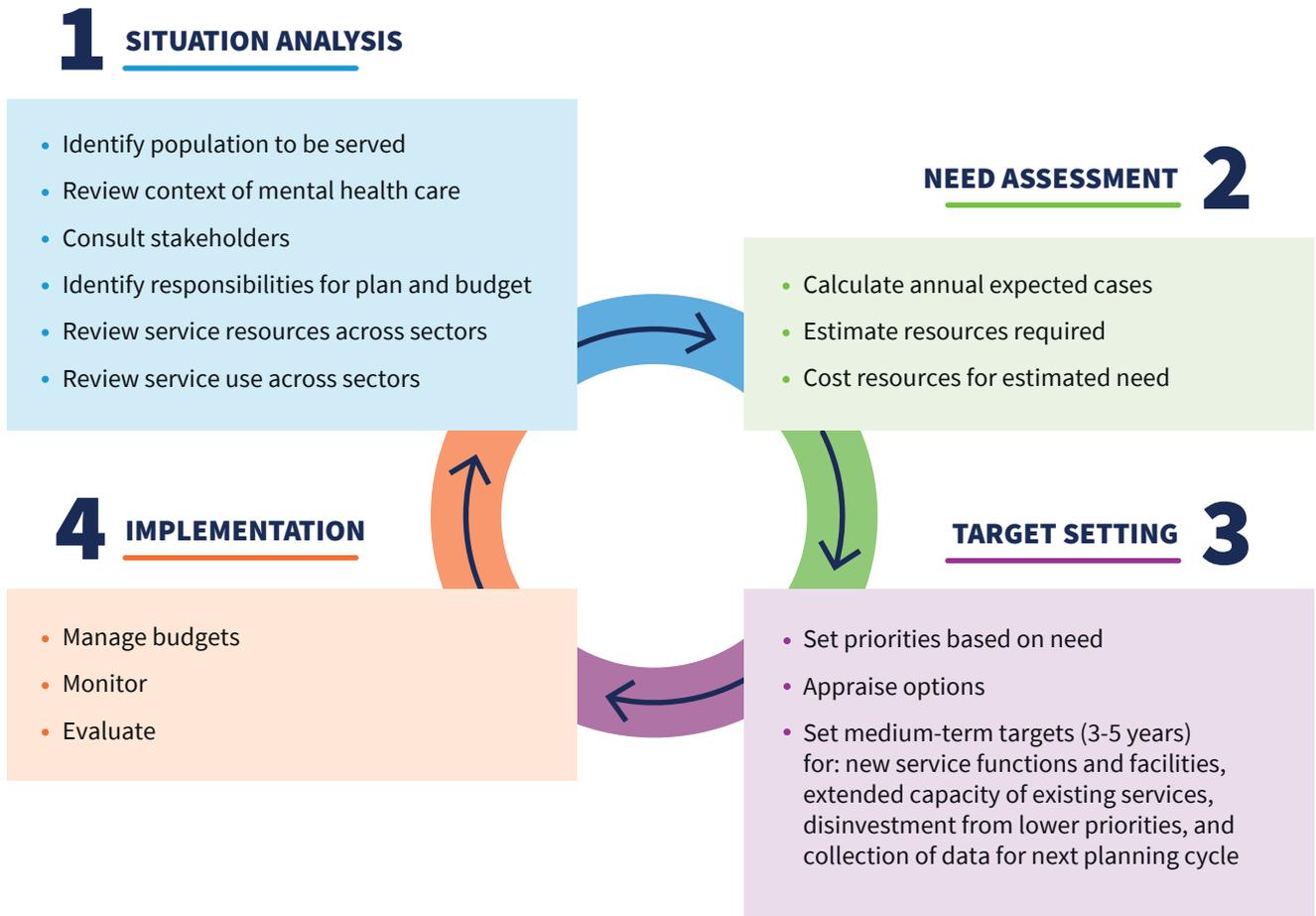
During the times when there were no counselling services for mental health in town, my family filled the gap graciously; they continue to do so today. I would never have got this far on my recovery journey if my family had not supported me along the road.

Eleni Misganaw, Ethiopia

FIG. 7.2

Steps in planning and budgeting mental health services

1 SITUATION ANALYSIS

- Identify population to be served
- Review context of mental health care
- Consult stakeholders
- Identify responsibilities for plan and budget
- Review service resources across sectors
- Review service use across sectors

NEED ASSESSMENT 2

- Calculate annual expected cases
- Estimate resources required
- Cost resources for estimated need

4 IMPLEMENTATION

- Manage budgets
- Monitor
- Evaluate

TARGET SETTING 3

- Set priorities based on need
- Appraise options
- Set medium-term targets (3-5 years) for: new service functions and facilities, extended capacity of existing services, disinvestment from lower priorities, and collection of data for next planning cycle

Source: adapted from WHO, 2003 *(443)*.

Integrated and dedicated mental health services

Service networks for mental health will always include some services that combine physical and mental health care at the point of delivery (integrated services), and some services that are unique to mental health (dedicated services).

Integrated services include mental health interventions that are provided as part of general health care, mainly at primary care and general hospital facilities. Integration ensures that wherever physical health services are provided, mental health care is also available.

Dedicated services encompass any service specifically designed to support mental health. They include, for example, psychiatric inpatient and outpatient units in general hospitals, community mental health centres or teams, mental health outreach services, day care centres, mental health crisis services and many other services at the secondary care level of the health system.

Dedicated services are often described as referral or specialized care in UHC packages *(446)*. But, in reality, they can be broader than that because some dedicated services (such as crisis mental health services) should be

accessible without referral. And others (such as lay psychological counselling) may be provided by community workers who have been trained and supervised but who cannot be considered specialists as they lack advanced training.

In all cases, when planning mental health care and developing UHC packages, the overall question should never be whether services should be integrated or dedicated but rather how to provide both. Investing to integrate mental health into primary care is unlikely to be sustainable unless there are dedicated mental health services that can support, mentor and supervise primary care staff and accept referrals for complex cases. Conversely, investments in dedicated mental health services alone are unlikely to enable or improve care for the vast majority of people who need it because of the high prevalence of mental health conditions.

Multisectoral responsibilities

The responsibility for delivering community-based mental health care, whether through integrated or dedicated services, straddles multiple sectors.

The ministry or department of health is responsible for providing mental health services in general health care and for most community mental health services. But other responsibilities are not so clearly defined.

For example, in countries that offer supported living services and economic support to people living with severe mental health conditions, these services and supports may, or may not be, included in the health ministry's remit. Similarly, providing mental health services within schools may fall to either the health or education ministry. And many other community-based mental health and psychosocial services – such as those specifically for victims of gender-based violence, homeless people and children in care – are usually run by the ministry of social welfare.

Moreover, in several countries, other ministries are responsible for large, long-term institutions that are de facto asylums for people with mental health conditions, substance use disorders and cognitive, intellectual and psychosocial disabilities.

Deciding which sector takes responsibility for which service is important. But what matters even more is ensuring that a full spectrum of accessible, affordable and quality community-based services exists, that there is strong multisectoral collaboration and coordination mechanisms in place to achieve that, and that long-term institutional care is strategically phased out across sectors.

Including relevant stakeholders is also important. In many countries, local nongovernmental organization are major providers of community-based mental health and social services. These services can be commissioned by the government or established independently. Independent services led by nongovernmental organizations often find it easier to adapt to changing needs and to innovate than government services. But, like government services, they still require regulatory oversight.

7.1.3 Deinstitutionalizing mental health care

In most countries, developing effective service networks for mental health relies on successfully deinstitutionalizing mental health care away from custodial care in psychiatric hospitals or asylums towards care in the community – for all ages. Deinstitutionalization is equally relevant to traditional institutions such as prayer camps *(440)*. And it also applies to any other custodial care institution run by charity or government that operates as an asylum for people with severe mental health conditions.

Deinstitutionalization is a technically and organizationally challenging and complex process that is often gradual and rarely linear.

It is more than just a process that needs to be well-managed. It requires transforming the lives and mindsets of all involved. Responsible deinstitutionalization puts into operation a shared vision to humanize mental health care, based on understanding the importance of community, liberty and autonomy to all people.

Deinstitutionalization is not the same as discharging people from institutions.

Progressively reducing caseloads to close or repurpose long-stay psychiatric institutions is important. Deinstitutionalization is not the same as discharging people from institutions as it must be accompanied by sufficient financial, structural and strategic investment in community-based services. This is essential to meet the health and social needs of former institutional residents, and their families or carers, and also to prevent new- or re-admissions (see Fig. 7.3). As community services are developed, it is important to close institutional beds to prevent another generation of long-stay residents being admitted. Indeed, long-stay psychiatric institutions should be closed once there are adequate community alternatives.

FIG. 7.3

Deinstitutionalization involves simultaneously increasing discharges, reducing admissions, and scaling up care in the community
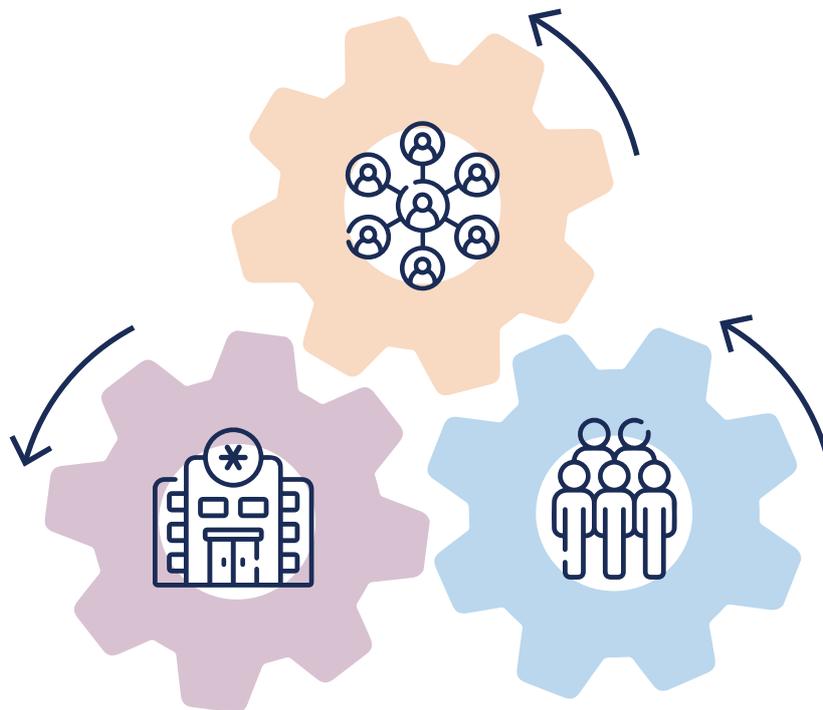
REDUCE ADMISSIONS

Systematically reduce new psychiatric hospital admissions; and enhance the quality of care and rights of people in all inpatient or residential care.

SCALE UP SERVICES

Build up a network of coordinated and linked community-based mental health services and social care to support anyone living with a mental health condition.

INCREASE DISCHARGES

Progressively discharge residents of psychiatric hospitals as community-based solutions to meet their health and social needs become available.

Source: WHO, 2001 *(1)*.

Lessons learned from experience

Deinstitutionalizing mental health care and building community services is a simultaneous process that gradually redirects resources from the institution towards the community. Experience shows that moving people out of custodial psychiatric care can go very well – or very badly *(447, 448)*. Both outcomes offer lessons, and together reveal 10 ingredients for future success.

1. **Support at the highest and broadest levels**. Support is key, not only from political leaders and government officials, but also from community leaders and members, and academia.

2. **Careful planning and implementation.** Moving long-stay residents from institutional to community-based care requires thorough planning and preparation, as well as phased implementation, including shortening stays and preventing new admissions. Transforming institutions should start with changing life within institutions, for example by changing activities, routines and internal dynamics between staff and residents, and by addressing coercion and abuse.

3. **Engagement and empowerment of residents.** Residents must be able to actively participate in the process of change. This means being fully involved in discussions about discharge options and re-introducing skills of daily living. It also means being supported to realize one's rights as citizens, for example to manage one's own resources, make informed decisions on where to live, and choose what clothes to wear, and getting paid for any work in the institution.

4. **Community-based services.** To avoid neglect and homelessness, appropriate community-based services and supports, in line with any resident's individual needs, must be available on discharge. Usually, some residents (or groups of residents from defined geographical areas) will be able to leave the institution before others, depending on their needs and how well-developed the community-based services are in the area where the individual will live.

5. **Temporary additional financial resources.** To deinstitutionalize, both psychiatric hospitals and community mental health services must have parallel funding during the transition period so that institutions can continue to operate while community-based services are being developed.

6. **A committed health workforce.** Health workers and their professional organizations need to be consulted widely, and involved in planning and implementing the process, so that they are committed rather than resistant to change. Typically, when long-stay institutions are scaled down, hospital staff need to be trained to provide care in the community.

7. **Stigma reduction.** Anti-stigma interventions involving leaders, health workers, and the public should form part of any deinstitutionalization programme so as to reduce the chance of mistreatment once people live in the community.

8. **Consent from residents and involvement from families.** Obtaining consent from residents that are to be discharged and, where possible, involving families and loved ones throughout the process is critical.

9. **Attention to both mental health and physical health.** Following up not only on discharged residents' mental health but also on their physical health is crucial to prevent people dying prematurely in the community.

10. **Monitoring and evaluation.** Norms and standards for community care, treatment and rehabilitation must be established. Regular inspections and evaluations must be carried out to ensure that quality care and support is provided to each and every individual who is discharged from the institution.

Timing is key for successful deinstitutionalization (see section 5.2.1 Strengthening political will and engagement: windows of opportunity). Once in place, community-based models of care are not necessarily less or more expensive than institutions, especially after accounting for people's needs and quality of care. In fact, they may be more cost–effective when they deliver better recovery outcomes *(449)*.

In any case, the reason for moving people out of institutions should not just be that it could be cost–effective but that the individuals concerned can live better and more meaningful lives. Experience shows that done well, deinstitutionalization can improve the quality of life for people living with mental health conditions and protect them from a wide range of human rights violations.

For the most part, bed reduction in parallel with substantial investment in community services has successfully transitioned people into comprehensive, community-based care and reintegrated them into communities, preventing long-term institutionalization, homelessness and imprisonment (read Regina's experience in Chapter 2) *(447, 450)*. Reform can be implemented on a small scale, within individual towns or districts, or on a large scale, across whole countries (see Box 7.2 Deinstitutionalizing mental health care in Brazil). In various instances, community placement surveys with long-stay residents have helped plan for their resettlement and continuing care *(451)*.

CASE STUDY

BOX 7.2

Deinstitutionalizing mental health care in Brazil

In the early 1990s, 75% of Brazil's federal funding for mental health went to custodial hospitals operating under poor conditions, with serious human rights violations. In the three decades since, there has been a gradual shift of resources towards care in the community, with people progressively discharged from institutional care. Today, more than 79% of federal funding is invested in a community-based system of care that aims to provide a human rights and recovery-oriented approach.

The new system integrates primary care, general hospitals and crisis care within psychosocial care networks that are coordinated by community mental health centres (CAPS). These operate 24 hours a day, seven days a week. The system includes residential facilities as well as a rehabilitation allowance for people returning home after a long-stay in hospital. It also provides technical and financial support for local initiatives aimed at social rehabilitation, income generation and advocacy.

From 1998 to 2020, the number of CAPS grew from 148 to 2 657, distributed across the country. They now provide the cornerstone of mental health care in Brazil, used by more than half the population diagnosed with a mental health condition. Studies show that CAPS are effective in supporting individuals' autonomy and recovery, reporting high levels of satisfaction by people with lived experience and their families.

Sources: Lociks de Araújo, 2016 *(452)*; Ministério da Saúde, 2020 *(453)*.

In a few cases, where hospital beds have been reduced without investment in community-based alternatives, the quality and quantity of care has suffered badly, leading to highly adverse outcomes for the people concerned. For example, in 2017 at least 144 people died, including from starvation and neglect, after they were discharged from hospitals to underfunded and underskilled community care as part of a rushed and poorly planned programme to deinstitutionalize mental health care in Gauteng, South Africa *(448)*.

Lessons from Gauteng emphasize the need for comprehensive anti-stigma and anti-discrimination interventions. They recall the need for broad consultation across stakeholders and full consent from service users and families. They underline the importance of a planned and phased approach, with carefully established norms and standards for community care, which should be regularly monitored by health authorities.

Where deinstitutionalization has been done responsibly, experience shows that it can also be highly sustainable, enduring over decades. In 1978, Italy started implementing Law Number 180, a law that stopped all new admissions to public psychiatric hospitals. After 40 years without psychiatric hospitals, the Italian mental health system is comparable with other G7 countries, which are all high-income economies *(454)*. Yet Italy has far fewer mental health staff per 100 000 population. In 2019, Italy had no beds in psychiatric hospitals, while in the other G7 countries the number of psychiatric hospital beds ranged from 11 per 100 000 population in Canada to 170 per 100 000 in Japan *(5)*. In Italy there are also fewer beds for acute care in general hospitals but more beds in community residential facilities than in the other G7 countries. And in Italy the number of compulsory admissions declined from more than 20 000 in 1978 to less than 9 000 in 2015 (see Box 7.3 Trieste, Italy: 40 years of community-based mental health care).

CASE STUDY

BOX 7.3

Trieste, Italy: 40 years of community-based mental health care

In Trieste, Italy, community-based mental health care has proven effective for more than 40 years. The Trieste transformation began in the 1970s, with the relocation of people living in the city's asylum to the community. Funds previously used to run the asylum were gradually diverted to develop a comprehensive network of community-based services. Community mental health centres are open 24 hours a day and provide walk-in clinics, home treatment, day care, psychosocial support, medication and overnight crisis care, among other services. There are also rehabilitation and residential services that provide different levels of supported housing and have links with local networks of social cooperatives that offer job opportunities and run cultural and educational activities.

As much as possible, people are supported in their own homes and neighbourhoods, so that they can continue to live their lives in their communities.

Importantly, in Trieste people are active participants in their care. They help develop personalized care plans, which look beyond clinical interventions to consider a wide range of social care needs, from housing support and personal hygiene to finances and work.

The Trieste model of deinstitutionalization has improved user satisfaction, social functioning and health outcomes for people living with mental health conditions. Suicide rates in the city have fallen. So have involuntary admissions. And stigma around mental health has been reduced as people living with mental health conditions have reintegrated into the community. The new model of care is also cheaper, delivered at 37% of the cost of the old asylum in Trieste.

Sources: Barbui et al, 2018 *(454)*; Mezzina, 2018 *(455)*; Mezzina, 2014 *(456)*; Dipartimento di Salute Mentale, 2019 *(457)*.

Deinstitutionalization is ongoing in a number of countries. In Argentina, mental health reform is happening in several provinces. In the province of Buenos Aires, between January 2020 and June 2021 the number of people in institutions fell from 1 810 to 1 391. This was achieved by stopping long-term admissions, giving 381 people a transfer subsidy to support discharge, and providing housing support for 306 discharged residents. Discharged residents are supported by existing community-based mental health services *(458)*.

7.1.4 Scaling up care for people with common conditions

The high prevalence and vast care gap for common mental health conditions such as depression and anxiety mean that countries need to diversify and scale up options for care for these conditions if they are to move towards, or reach, universal health coverage. New funding and effort will be needed to add evidence-based

psychological care to existing health and mental health services as well as to social care settings, the criminal justice system, schools and universities, and online environments.

Sections 7.2–7.4 detail some of the strategies required to make this happen in different services. For example, although any community mental health service will likely cater for common as well as severe mental health conditions, this will not be enough. Delivery of psychological care needs to be expanded in primary health care settings and through community providers. Other key strategies for scaling up evidence-based care for common mental health conditions include enabling self-help and making better use of digital technologies (see Chapter 5, In focus: Harnessing digital technologies for mental health).

Non-specialist counselling

Psychological counselling programmes that recruit, train and deploy non-specialist counsellors to deliver group or individual evidence-based psychological interventions have proven to be highly effective for people with depression and anxiety *(314)*. This form of counselling should not be confused with giving information or advice (as when someone counsels a new mother on how to care for her baby). Psychological counselling programmes can be implemented at scale (see Box 7.4 Lay mental health care workers treat depression in Uganda and Zambia).

Non-specialist counsellors for depression and anxiety can include a wide range of people. They range from community workers, volunteers and peers with as little as ten years of education to people with a university degree but without specialist mental health training (for example nurses or first-degree psychology graduates).

CASE STUDY

BOX 7.4
Lay mental health care workers treat depression in Uganda and Zambia

In Uganda and Zambia, the social enterprise StrongMinds trains lay workers and volunteers in a culturally adapted and locally validated format of interpersonal therapy, and deploys them to treat depression in women and adolescents.

The lay therapists help group participants identify their depression triggers (prolonged bereavement, disputes, loneliness or social isolation and changes in one's life) and design strategies to overcome these. Groups, typically of 12 participants, meet in their local communities for eight or more sessions. Since depression can recur, the skills acquired through therapy have both an immediate and long-term preventive impact.

The organization identifies clients through a mobilization process that includes psychoeducation and outreach in partnership with community leaders, schools, partner nongovernmental

organizations, and government counterparts. The organization also runs public education campaigns via radio and social media.

Over the past eight years, the programme has treated more than 100 000 people. As assessed by the PHQ-9 depression screening tool, more than 80% of individuals treated recover, and the results are sustained six months after treatment. People who have completed therapy report a 16% increase in work attendance, a 28% increase in being socially connected, a 13% increase in families eating regular meals, and a 30% increase in school attendance among their children.

StrongMinds is now scaling up by partnering with governments and nongovernmental organizations, to integrate its mental health intervention into existing livelihood, food security, health, and education programmes.

Sources: StrongMinds, 2021 *(459)*; Bolton et al, 2003 *(460)*.

In all cases, training and ongoing supportive supervision are important to build non-specialist providers' confidence and to monitor competencies (see section 5.4.3 Equipping community providers with mental health care competencies).

Non-specialist psychological counselling can also add substantial value to specialized psychiatric care. For example, in a tertiary mental health care facility in Islamabad, Pakistan, a brief psychological intervention called Problem Management Plus (PM+) was added to routine, mainly pharmacological, care. PM+ and similar interventions are usually implemented outside specialist settings. In Islamabad, the intervention was delivered within the specialist care setting but by non-specialist counsellors, who had completed an undergraduate degree in psychology without any clinical training. Adding the psychological intervention was found to substantially improve outcomes for people with depression and anxiety *(461)*. If more specialized care facilities included such evidence-based non-specialist counselling in their routine care, then they would be well placed to guide and support the roll out of such counselling to primary care and community settings.

Indeed, non-specialist counselling programmes can, and increasingly are, implemented within primary care facilities and other community-based settings, including through stand-alone services run by nongovernmental organizations.

Studies show that these programmes can boost the capacity of frontline mental health services and greatly improve care. For example, one programme in the North West Province of South Africa saw primary care nurses identify people with depression among patients with chronic disease in a collaborative care programme. They referred those with mild to moderate depressive

symptoms to lay counsellors for structured counselling based on cognitive-behaviour therapy. The study found clinically significant reductions in symptoms at 12 months follow up. People reported feeling more empowered and better equipped to deal with social issues *(462)*.

Non-specialist counselling can boost the capacity of frontline mental health services and greatly improve care.

In rural Maharashtra, India, the Atmiyata approach uses trained community volunteers to identify, support and counsel community members with common mental health conditions. These volunteers offer problem solving and behavioural activation techniques. They also facilitate access to mental health care and social (financial) benefits, improve community awareness of mental health issues and promote well-being. Atmiyata offers a service that complements the formal health sector. Its approach has promise in improving the acceptability of care as well as reducing disability and improving quality of life and social participation for people with depression and anxiety *(463, 464)*.

Non-specialist psychological counselling programmes can also be used to reach specific groups of people that may be particularly vulnerable to depression or anxiety, including new parents, refugees or people living with HIV/AIDS (see Box 7.5 Friendship benches for mental health). A recent promising innovation is to use a single intervention approach for common problems that cross a range of mental health conditions (transdiagnostic therapy) *(465, 466)*. This approach has been successfully tested with survivors of violence in countries as diverse as Colombia, Ethiopia, Iraq, Thailand, Ukraine and Zambia.

CASE STUDY

BOX 7.5

Friendship benches for mental health

In Zimbabwe, the Friendship Bench project has been integrating mental health into other health programmes for more than 20 years. The project uses problem-solving therapies delivered by community volunteers, known as "grandmothers", to address "kufungisisa" (which means thinking too much and is a local concept in the Shona language that denotes a range of non-psychotic mental health conditions).

Friendship grandmothers are trained to counsel people for structured 45-minute sessions on wooden benches within the grounds of primary care clinics, where people access services for various medical conditions, including HIV/AIDS, TB, NCDs and NTDs. People are referred to the benches by medical care providers and, after the first session, are invited back by the grandmothers for up to five more sessions. They may also receive home visits, join group therapy or be referred to a specialist, depending on their needs.

The Friendship Bench approach has been shown to significantly reduce symptoms of depression and anxiety compared with the usual standard of care. It is also thought to lead to improvements in co-occurring health conditions, including adherence to antiretroviral therapy for HIV.

Since 2006, more than 600 grandmothers have been trained through the Friendship Bench. They have delivered free therapy to tens of thousands of people in more than 70 communities in Zimbabwe; and can now also be found in a range of other countries.

The model has also been adapted to be more relevant for adolescents, few of whom engaged in the original project, either because they were not using the primary health care clinics where the benches were or because they were embarrassed about being seen seeking help from a grandmother. The Youth Friendship Bench is designed for 16–19 year-olds and uses psychology and sociology student "buddies" to provide problem-solving therapy instead of grandmothers. Counsellor training is the same but with added focus on topics such as drug use, sex and relationships. Buddies reported managing to create alliances with their clients and say they see their work as meaningful and urgent; but more studies are needed to investigate client experiences.

Sources: Chibanda et al, 2016 *(467)*; Wallén et al, 2021 *(468)*.

Self-help

As mentioned in Chapter 5 Foundations for change, self-help can be guided (when a worker helps the person to use materials) or unguided (when the person receives no support or encouragement). Both specialists and non-specialists can have a role in guided self-help interventions for depression and anxiety. For example, they can facilitate discussions, demonstrate techniques and support people to work through self-help materials; and they can do this face-to-face or remotely.

Self-help interventions help equip people with the tools and tactics they need to discuss and manage any mental health problems as they arise (read Nour's experience in Chapter 5). They can be delivered rapidly to large numbers of people, making them particularly useful for scale-up (see Box 7.6 Improving Access to Psychological Therapies (IAPT)), including in countries affected by crisis (see Box 7.7 Step-by-Step: guided self-help for depression in Lebanon).

CASE STUDY

BOX 7.6

Improving Access to Psychological Therapies (IAPT)

Improving Access to Psychological Therapies (IAPT) is a national programme of evidence-based psychological treatments for anxiety and depression in the United Kingdom. Launched in 2008 as a service for adults, the programme has since expanded to include a children and young people's sub-component, including in schools. Receiving around 1.25 million referrals each year, it is by far the largest publicly funded and systematic implementation of evidence-based psychological treatment in the world. The programme has served as a model for developing similar services in Australia, Canada, Japan and Norway.

IAPT adopts a stepped care approach that offers progressively intensive treatments, according to need. People are initially offered low-intensity,

guided self-help based on principles of CBT. The self-help is psychoeducational in nature and is delivered over the phone, via computerized CBT, in large groups or individually. It is delivered by supervised non-specialized helpers called Psychological Well-being Practitioners who provide standardized, evidence-based interventions. Practitioners are guided by associated assessment and treatment competency measures.

People who do not improve after guided self-help are stepped up to receive high-intensity psychological therapies from qualified therapists.

A review of 60 studies found large improvements in depression and anxiety among people attending IAPT services.

Source: Wakefield et al, 2021 *(469)*.

Even unguided self-help books and materials can be useful in scaling up psychological support for common mental health conditions. Research shows that using self-help books can help reduce depressive symptoms in adults, including in the long term *(470)*. Nonetheless, unguided interventions tend to be less effective than guided ones *(471)*. Computer therapy that delivers CBT for depression and anxiety through the Internet has also been shown to be effective, acceptable and practical for those with good digital access. Guided computer therapy based on CBT provides equal benefits to conventional face-to-face CBT *(472)*.

CASE STUDY

BOX 7.7

Step-by-Step: guided self-help for depression in Lebanon

Step-by-Step is a new WHO digital self-help intervention. It provides psychoeducation through a narrated story and uses interactive exercises to teach people to use therapeutic techniques to reduce their depression. It focuses on behavioural activation combined with stress management (slow breathing), increasing social support and relapse prevention.

When Lebanon faced a series of crises in 2020, the Ministry of Public Health and partners tested a culturally adapted version of Step-by-Step called "Khoutweh-Khoutweh" with Lebanese citizens and displaced Syrians. A guided self-help format was used. Supervised non-specialist counsellors provided no more than 15 minutes of remote guidance (by phone or through online messaging) each week to people with symptoms of depression. People who completed the programme said it was relevant, acceptable and beneficial (read Nour's experience in Chapter 5).

Two large randomized controlled trials suggest that the intervention was effective in reducing symptoms of depression and improving functioning and well-being countrywide. The intervention is now offered by government as a routine service.

Source: Cuijpers et al, in press *(472)*.