Mental Health and Substance Use Disorders

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Abstract

This chapter gives countries an orientation on how to develop services for mental and substance use disorders. It outlines key recommendations for the organization and delivery of services and discusses several variables – resources, paradigm, value system, and environment – in terms of how they shape mental health services. The article highlights the need to move from a biomedical model to a biopsychosocial model, aim for recovery, involve people with lived experience in service planning and delivery, strengthen community care, integrate mental health care in primary care, and move psychiatric hospitalization to short-stay units in general hospitals. The article focuses on equity in service design and delivery, and the role that training, mental health policy, and legislation can play in delivering high-quality services that respect human rights.

Key points

- The burden of mental health and substance use disorders is high worldwide
- Mental health and substance use rehabilitation services should be developed and resourced proportionately to the disease burden
- Service systems need to engage in promotion of mental health and prevention
- Service development should focus on communities and involve experts by experience

Introduction

An increasing burden of disease requiring an effective service response

According to the Global Burden of Disease 2019 estimates, 13% of the global population, or approximately 970 million people, were living with mental disorders around the world, most of them in low- and middle-income countries (LMIC). Most common mental disorders included anxiety and depressive disorders with significant variation in the prevalence between men and women and across age groups. In addition, 283 million people had alcohol use and 36 million drug use disorders; and the prevalence of neurological conditions, including dementia with 55 million individuals, was high and increasing due to population aging (World Health Organization, 2022b). Substance abuse is closely interlinked with mental health; around one-third of people who experience a substance use disorder also have a mental health condition.

The disease burden associated with mental, substance use, and neurological conditions is enormous, thus creating a devastating social and economic impact for individuals, families, and governments. In 2019, they were together responsible for 10% of life years lost due to premature death and or disability (disability-adjusted life years, or DALYs), with mental and substance use disorders accounting for 7% of them (Fig. 1) (GBD 2019 Diseases and Injuries Collaborators, 2020; Global Burden of Disease Collaborators, 2022; World Health Organization, 2020).

The contribution of mental, substance use, and neurological conditions to years lived with disability (YLDs) is particularly high: they are responsible for 1 in every 4 years lost due to disability around the world. Mental disorders alone account for 15.6%, substance use disorders for 3.1% of global YLDs. Depression and anxiety disorders are among the 10 leading causes of disability worldwide, accounting for 5.6% and 3.4% of YLDs, respectively (World Health Organization, 2022b).

Mental disorders are not only associated with a high disease burden but also with striking economic costs. Assigning economic values to DALYs suggested that the global losses related to mental disorders could be as high as 4.7 trillion USD in 2019. Expressed as a percentage of economic output, the economic losses due to mental disorders account for between 4% and 8% of the gross domestic product in different world regions, with the lowest relative proportion in Eastern Sub-Saharan Africa and the highest in High-income North America (Arias et al., 2022).

Despite the high disease burden and staggering economic costs, mental health conditions remain largely underserved with a gap between disease burden and service utilization. In a study reporting findings from 28 countries, 29% of the people with mental health or substance use disorders received any treatment and care (Evans-Lacko et al., 2018). In high-income countries, the treatment rate was 37%, in upper-middle-income countries 22%, and in lower-middle-income countries only 14%. The World Mental Health Survey suggested that 16.5% of individuals with major depression received minimally adequate treatment globally: however, only 3.7% in LMIC (Thornicroft et al., 2017). Global service coverage for psychosis was only 29% in 2020 (World Health Organization, 2021). To reduce the treatment gap, mental health data, adequate legislation, and available resources and services are needed. However, according to the World Mental Health Atlas 2020, only 31% of WHO Member States regularly collect mental health data covering the public sector, and even among high-income countries, there were 10% where no mental health data was compiled in the past 2 years before undertaking the survey. The report also suggested that 86% of Member States have a mental health plan or policy either stand-alone or integrated into general health, but only half of the Member States have policies/plans that also align with human rights instruments. Financial and human resources invested in public mental health are low and vary extremely between country income groups. Globally, only 2.1% of government health expenditures are directed to treat and prevent mental health conditions with very large variations in mental health workforce, available facilities, number of hospital beds and outpatient visits between LMIC and high-income countries (HIC) (World Health Organization, 2021).

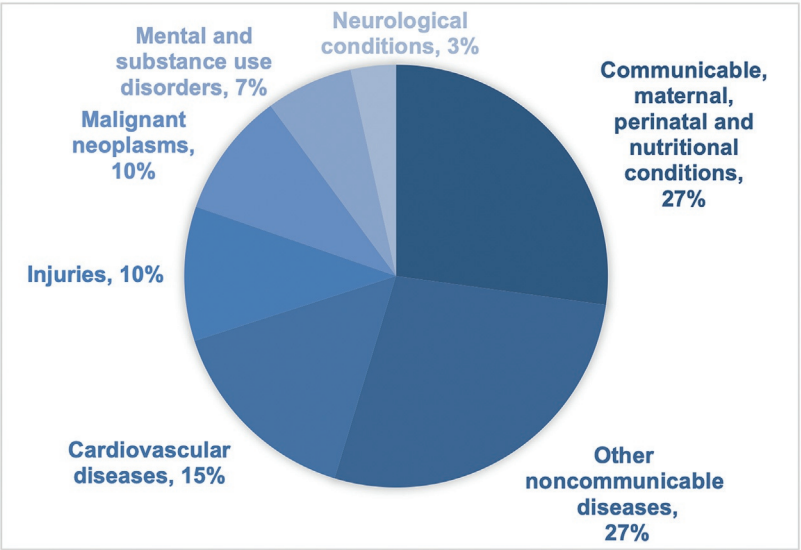

Fig. 1 Distribution of disability-adjusted life years (DALYs) by causes (%). Based on the WHO Global Health Estimates 2020 (World Health Organization, 2020). From World Health Organization (2020). *Global Health Estimates 2020: Disease burden by Cause, Age, Sex, by Country and by Region, 2000-2019.* Geneva: World Health Organization. The WHO gives free access to this figure and data.

Relationship between mental and physical disorders

Mental health is as important as physical health to the overall well-being of individuals. The data to substantiate this important relationship are becoming increasingly evident from studies examining comorbidity between mental and physical health problems.

Mental health and substance use disorders are often comorbid with physical health problems such as cancer, HIV/AIDS, diabetes, tuberculosis, and heart disease among others. For example, the prevalence of depression in people living with HIV/AIDS is found to be 9.4% in HIV-positive vs 5.2% in HIV-negative (Ciesla and Roberts, 2001). In the US, the prevalence of major depression and anxiety disorders in people of both sexes living with HIV was 36% and 16% respectively (Prince et al., 2007). In addition, injection drug use is one of the leading modes of HIV transmission in the world, accounting for up to 10% of HIV cases worldwide (Chandler et al., 2016). In people with tuberculosis, a systematic review by Hayward et al. (2022) reported an increased risk of depression (Hazard Ratio 1.15–2.63) and schizophrenia (Hazard Ratio 1.52 – Relative Risk 3.04). In people who have cancer, the prevalence of depression is up to 27% (Mejareh et al., 2021). For women with diabetes, the prevalence of comorbid depression was found to be 28%, whereas for men it was 18% (Anderson et al., 2001). Inversely, among people with schizophrenia, the prevalence of diabetes was about 15% compared to 2–3% in the general population. Lifestyle factors and the metabolic effects of psychopharmacological treatment might explain this (Prince et al., 2007). People with severe mental disorders were also found to have an increased risk of developing coronary heart disease, with a pooled odds ratio of 1.51; the highest had people with major depressive disorder with an Odds Ratio of 2.52 (De Hert et al., 2018). Furthermore, several studies found a 15–20% risk of major depression in patients before or after coronary artery bypass grafts (Tully and Baker, 2012).

The disability of individuals and the burden on families increase with the number of comorbid conditions. The presence of comorbidity has implications for the identification, treatment, and rehabilitation. For example, knowing that someone has diabetes, or another relevant condition should lead the health provider to conduct a mental health assessment to identify and treat any (previously unidentified) mental disorder. Finally, because mental disorders such as depression significantly reduce treatment adherence, treatment of the mental disorder can lead to improved outcomes of the physical health condition.

For overall health outcomes to be improved on the population level, interventions for mental health and substance use disorders must be accessible to those in need and have to be provided through services in general health care. Providers of these services should be able to identify mental and substance use disorders, understand the links between mental and physical disorders, and have the skills to address both dimensions of health problems.

The link between poverty and mental health

Studies over the last four decades indicate a reciprocal relationship between poverty and mental ill-health (Ridley et al., 2020). Not only can poverty increase the risk of developing a mental disorder but having a mental disorder can be an important factor leading to poverty, leading to a vicious circle (Fig. 2) (World Health Organization, 2001). A recent study shows that 55% of psychiatric

service users in Berlin, Germany, had outstanding debts, loans, or unpaid bills (Schreiter et al., 2021). In a systematic review, Lund et al. (2010) show that people with the lowest incomes in a community are 1.5 to 3 times more likely to suffer from common mental disorders. Among homeless people, the prevalence of any current mental disorder was estimated to be 76% (Gutwinski et al., 2021). During Covid-19, food insecurity related to poverty was associated with a 257% increase in the risk of anxiety and 253% increased risk of depression. Income stability was associated with a 23% reduction in the risk of depression (Fang et al., 2021). Also, parental income has a significant influence on the childhood diagnoses of mental disorders, with a 3- to 4-fold increase in their prevalence in children with parents in the lowest compared with the highest income percentiles. Income inequality is also considered to be an important factor. The risk of depression is 19% higher in populations with higher income inequality (Patel et al., 2018a).

It is therefore crucial that mental health and substance use rehabilitation services are widely accessible to people with mental health conditions including those living in poverty. The provision of effective treatment and care can help people to recover and 'exit' the poverty in which they are living; however, this can only be achieved if services are accessible in terms of both physical reach and affordability. Providing ineffective treatment and care or services that cost more than the affected individuals can afford, may drive people further into poverty. Services should be comprehensive and meet the variety of psychosocial needs of people with mental illness which are also required to bring them out of poverty (employment, education, social services).

Mental health and work

Mental health and work have a complex and intertwined relationship. While approximately 60% of the world's population is working, poor mental health is responsible for 12 billion lost working days annually due to decreased productivity and increased absenteeism (Malik et al., 2023). Decent and meaningful work can be protective for mental health by providing financial resources to make ends meet and creating a sense of belonging, accomplishment, and confidence. On the other hand, no or insecure employment, inadequate pay, hazardous working conditions, and poor interpersonal and managerial relationships at work may jeopardize workers' mental health and wellbeing. There is evidence that psychosocial work exposures such as long working hours, job insecurity, low decision latitude, effort-reward-imbalance, organizational injustice, workplace bullying, and interpersonal violence can lead to a higher risk of depression, anxiety, burnout, and suicidal ideation among employees (Niedhammer et al., 2021).

Comprehensive interventions at organizational, managerial, and individual levels are recommended to address mental health at work (World Health Organization, 2022a). Organizational interventions addressing psychosocial risk factors at work can reduce distress and improve work-related outcomes. Training delivered to managers to strengthen their mental health-related knowledge and skills equips leadership to adequately respond to workers' mental health needs. Individual-level psychosocial or physical activity interventions build skills in stress management and thus reduce distress. For workers with existing mental health conditions, providing reasonable adjustments to working conditions and environments and establishing return-to-work programs for those with illness-related absence can be beneficial (Malik et al., 2023). Due to stigma, discrimination, and lack of knowledge, unemployment among people with severe mental illnesses is particularly high; strategies focusing on economic and vocational inclusion, such as supported employment, are recommended to gain and maintain employment.

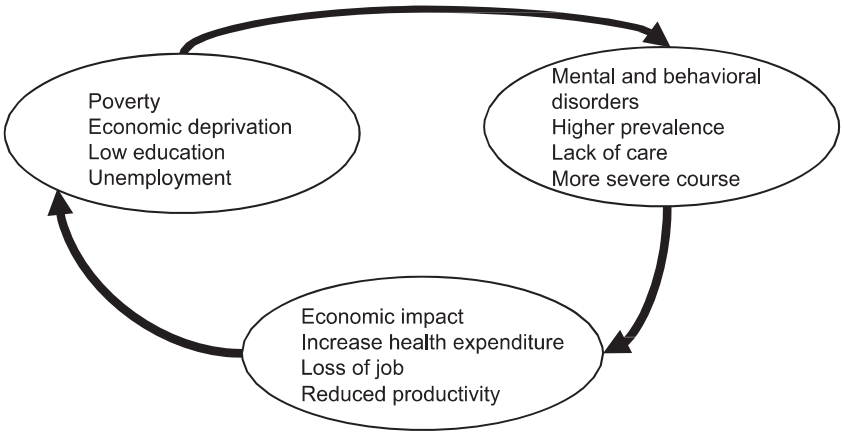

Fig. 2 The vicious circle of poverty and mental disorders, World Health Organization (2001). From World Health Organization (2001) Mental Health: New Understanding, New Hope. *World Health Report 2001*. Geneva, Switzerland: World Health Organization. The WHO gives free access to this figure and data.

Stigma and human rights violations

People with mental and substance use disorders have been stigmatized, excluded from society, and subject to human rights violations which should be ended (Thornicroft et al., 2022). For many people with lived experiences of mental health conditions, the stigma is worse than the condition itself.

Societies, and services for mental health and substance use disorders need to be respectful of human rights and the dignity of people with mental health conditions and be conducive to inclusion and recovery. A rights-based approach is needed as an alternative to coercion in service development (Patel et al., 2023). The treatment, care, and support provided should be comprehensive enough to meet the variety of psychosocial needs of those with mental illness that are required for re-integration into the community. Mental health care should be equally reimbursed and provided at equal quality standards as physical health care.

Mental health service organization

In many communities in countries all over the world, people are not able to access services and many of the available services are of poor quality. In low-income countries, the typical pattern of services is to have one or more psychiatric institutions based in urban areas and some informal community services provided by nongovernmental organizations (NGOs), traditional healers, spiritual healers, or religious groups. In middle and high-income countries, it is not uncommon to find a predominance of institutional care services, although these countries usually have formal community services.

The WHO has developed a pyramid framework (Fig. 3) which conceptualizes an optimal mix of services for mental health. It reinforces the idea that no single service will meet all needs and that an optimal mix of a range of services is needed (Funk et al., 2004). According to this framework, and starting at the top of the pyramid, the least numerous services ought to be mental hospitals and specialist services, for example, psychiatric institutions and long-term residential treatment for alcohol and drug dependence. The second layer includes formal community mental health services (day care centers, outreach services, crisis services, and

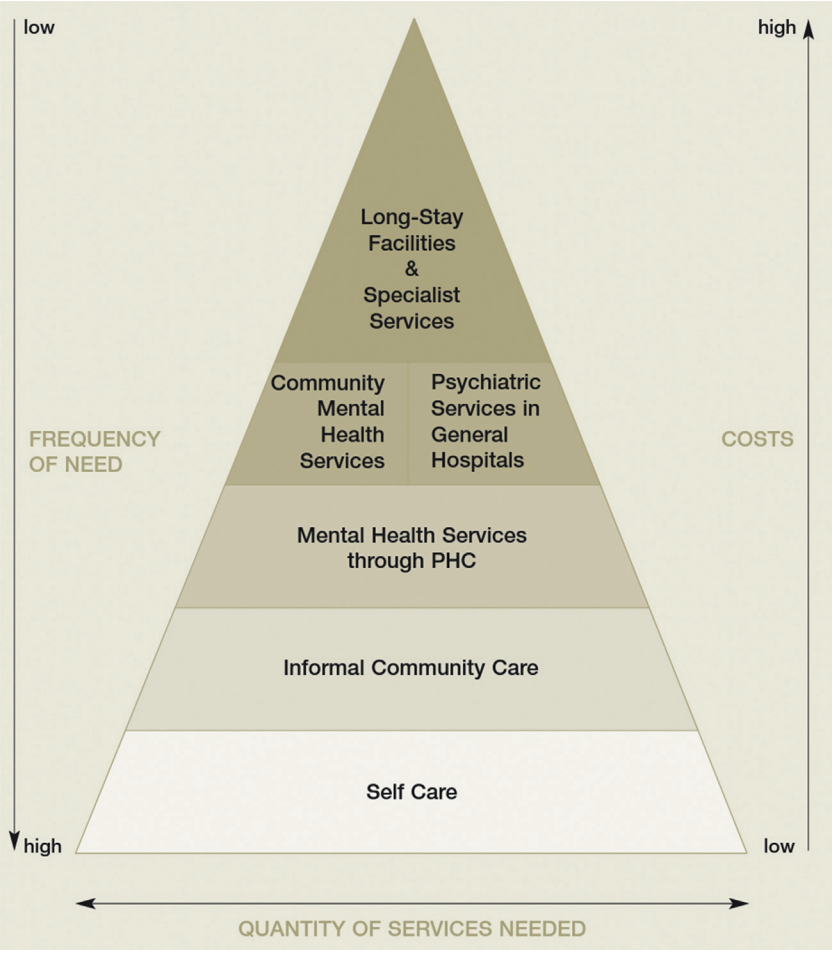

Fig. 3 Service Organization pyramid for an optimal mix of mental health services by the World Health Organization (2003). From World Health Organization (2003) *Organization of Services for Mental Health*. Geneva: World Health Organization. The WHO gives free access to this figure and data.

methadone clinics for opioid dependence patients) and general hospital-based services (psychiatric and substance use disorder treatment units in general hospitals). The third represents mental health services provided through primary health care. The fourth layer represents informal community mental health services, for example, traditional healers, village leaders, schoolteachers, and informal groups such as Alcoholics Anonymous or Narcotics Anonymous. The fifth and final layer involves self-care management, that is, helping people to learn how to take care of themselves. Each of these levels is described in more detail in later sections of the article, including the strengths of and considerations for delivering care at that level.

Psychiatric hospitalization

While psychiatric inpatient beds serve a purpose and inpatient psychiatric beds facilitate management of acute episodes for people experiencing severe symptoms, shifting the locus away from institutional settings toward comprehensive, coordinated networks of services embedded in local communities is imperative. Hospital-based services should promote individual legal capacity, minimize coercive measures, support community inclusion and participation, and align with a recovery-oriented approach. A recommendation of the WHO is to replace psychiatric hospitals with short-stay psychiatric inpatient units in general hospitals and comprehensive community-based networks. The prevalence of psychiatric beds per 100,000 population by WHO region and country income group varies largely as shown in Table 1. A recent study with experts from 40 countries based in all WHO regions established a consensus of an optimum prevalence of 60 beds per 100,000 population (Mundt et al., 2022b). This number should be evaluated based on contextual factors such as whether there is efficient discharge planning with sufficient outpatient and residential services. Also, the mental health budget is another major factor for psychiatric bed planning as lower budgets can account for a shortage and inefficient distribution of mental health beds. The provision of mental health inpatient care can be a major concern, especially in low- and middle-income countries where, in addition to the lack of infrastructure, there may also be insufficient personnel, availability of medications, and equipment to operate existing facilities (Mundt et al., 2022b).

Though most world regions reduced inpatient psychiatric beds, policy directions remain debated. Arguments for further reducing bed numbers cite high costs, potentially prolonged stays, and need for better community integration. However, increasing bed demand and occupancy rates amidst community care gaps have also garnered support for maintaining or expanding capacity (Mundt et al., 2021). Especially in Latin America, a substantial increase of incarceration has been observed when and where psychiatric beds were removed (Mundt et al., 2015; Siebenförcher et al., 2020). An important part of mental health services in general hospitals is consultation liaison services provided. Mental health professionals usually deliver these services to people with mental health problems and hospitalization for other physical health or medical needs.

Strengths

One of the most important advantages of psychiatric hospitalization is that it provides a setting to manage acute episodes of mental disorders. Second, if provided in a general hospital setting, there is the opportunity to simultaneously obtain medical treatment for comorbid physical illnesses, and it also allows access to specialist evaluation and treatment. Third, the hospital can become a base for undergraduate and postgraduate teaching and training for many different types of health professionals, from physicians and nurses to psychiatrists, psychologists, and social workers.

Table 1 Total numbers of mental health beds in inpatient facilities per 100,000 population, by WHO region and World Bank income group (World Health Organization, 2021).

	Mental hospital beds		*Psychiatric beds in general hospitals*	
	2017	***2020***	***2017***	***2020***
Global	12.5	10.8	2.0	2.5
WHO region				
Africa	2.0	3.7	0.6	0.7
Americas	16.7	6.8	1.7	1.4
Eastern Mediterranean	4.2	4.4	0.5	1.2
Europe	35.5	35.0	12.1	12.3
South-East Asia	2.1	3.6	0.8	1.3
Western Pacific	14.8	11.2	4.2	4.6
World Bank income group				
Low	1.5	1.9	0.4	0.4
Lower-middle	4.6	3.8	1.3	0.8
Upper-middle	16.8	17.7	2.6	3.3
High	35.2	28.6	14.1	15.2

From World Health Organization (2021). *Mental Health Atlas 2020*. Geneva: World Health Organization.

Considerations

It is important to keep in mind some of the limitations of these services. Although general hospital services (short-stay wards and consultation-liaison services to other medical departments) can be used to manage acute episodes of mental disorders, they do not provide a solution for people with chronic disorders who end up in admission–discharge–admission cycles (revolving door phenomenon) unless backed up by comprehensive primary health-care services or community services. Access difficulties can also emerge when facilities cluster near urban centers, as transportation barriers prevent rural population utilization. Developing countries notably face infrastructure and resource constraints, with inadequate inpatient staffing, medication supplies, or proper equipment operation compromising service quality and delivery. Still, with robust infrastructure and specialist personnel, these facilities greatly complement community-based networks by managing mental health emergencies. Overall coordination across inpatient, outpatient, and primary care settings remains essential for offering comprehensive, holistic patient-centered care.

Formal community mental health services

Formal community mental health services refer to day centers, rehabilitation services, hospital diversion programs, mobile crisis teams, therapeutic and residential supervised services, and home help and support services that are based in the community.

Residential treatment models that integrate mental health and substance use have positive outcomes for individuals with comorbid disorders. Within a 24-h nonhospital alcohol- and drug-free residential community setting, they provide safe and stable living environments for individuals with severe and complex substance use disorders. The intensity of care and support is graduated according to need and usually lasts from 4 weeks to 12 months (Reif et al., 2014).

Therapeutic communities have specific structured residential treatment settings aimed at longer-term treatment, usually ranging from 6 to 12-month stays (De Leon and Unterrainer, 2020). In this model, treatment focuses on social and psychological causes and consequences of addiction. Responsibility for recovery rests on both the individual and the residential community since patients and staff are considered the primary change agents. The social learning processes and community peer support are generally articulated based on community meetings, encounter groups, facilitation of mutual self-help, stage progression and/or a hierarchical structure (de Andrade et al., 2019).

Strengths

Robust evidence demonstrates community-based services' effectiveness for improving mental health, functioning, and quality of life compared to institutional models. Shifting toward non-custodial care has proven more resource-efficient and aligned with user preferences and rights-based, person-centered principles. These decentralized networks also enhance overall healthcare access, equity, and social inclusion if adequately resourced.

Considerations

Implementing extensive community mental health systems requires considerable specialized expertise and infrastructure, presenting capacity limitations in lower-resourced settings. Prioritization of key services with phased integration of additional supports can aid feasible development. Locally available resources like family assistance should receive acknowledgment and backing when substituting formal provisions. Linkages between community platforms and general healthcare, informal care, and social services remain vital for continuity. Overall coordination, balanced investments across network levels, and context-specific configurations are imperative for cohesive systems meeting diverse needs.

Mental health services in primary health care

Integration of mental health care into primary health care has been a fundamental WHO policy since the Alma Ata Declaration in 1978. Those services refer to mental health care and promotional and preventive activities conducted by health workers at the first level of formal health care; for example, general practitioners, nurses, and other staff providing assessment, treatment, and referral services for mental and substance use disorders. Early identification and management of hazardous and harmful drinking is a good example of an activity at the level of primary health care that, if widely implemented, can have a significant effect on population levels of alcohol-related problems (Whitlock et al., 2004).

Strengths

As discussed concerning general hospital care, providing treatment for mental and substance use disorders in primary health care improves access to mental health services and specialist services for substance use disorders as well as to treatment of comorbid physical conditions. Additionally, stigma is reduced – and acceptability for users improved – when seeking mental health care from a primary healthcare provider. Primary health care has good treatment outcomes, especially in common mental disorders and mild to moderate substance use disorders. From a management perspective, integrating health services for mental and substance use disorders into primary health care can be an important solution to addressing human resource shortages in the delivery of mental health interventions.

Considerations

Integration requires careful planning and there are likely to be several issues and challenges that will need to be addressed, such as investments in the training of staff to detect and treat mental and substance use disorders and strengthening the contents in the general medicine and nursing curricula.

Ongoing supervision is also important, and mental health professionals should be available to primary care staff for consultation as well as guidance on the management and treatment of people with mental and substance use disorders. Time needs to be reserved for this. In many countries, primary healthcare staff are overburdened with work as they are expected to deliver multiple healthcare programs. Governments should consider increasing the number of primary healthcare staff who are either partially or entirely devoted to mental health care.

Informal community mental health services

Informal community mental health services are provided in the community and do not form part of the formal health and welfare system. These may include but are not limited to services delivered by traditional healers and professionals in other sectors (social and village/community workers, teachers, police) as well as services delivered by nonprofessional organizations or lay persons (such as consumer and family associations, advocacy groups, and NGOs).

Strengths

In many countries, informal community services are the first point of contact for a majority of persons with mental and substance use disorders and sometimes they represent the only available service. These services can play an important supportive role in improving outcomes for persons with mental health conditions. They can help maintain community integration and provide a supportive network which reduces the risk of relapse. These services enjoy high acceptability and there are few barriers to access as they are nearly always based in the community. The high degree of community acceptability also reduces the likelihood of stigma associated with using these services.

Considerations

Informal service quality varies greatly - from lacking regulation or evidence-base to perpetuating serious ethical violations. Informal community mental health services should not replace the mental health service provision and countries would be ill-advised to depend solely on these services. Rather they form a useful complement to formal mental health services and can form useful alliances with such services. Integrating informal and formal sectors through partnerships and referral pathways promotes oversight and service reach/continuity.

Peer support

Peer support mental health services provide valuable support through sharing lived experiences of mental health conditions and recovery. Services are managed and delivered by peers – people with lived experience supporting others on their recovery journeys. Participation is voluntary and based on informed choice and consent. Peer support facilitates the creation of understanding, non-judgmental social connections and networks otherwise challenging to develop. It is a key pillar of many people's recovery. Peer support approaches emphasize hope, experience sharing, finding meaning, and empowerment. They also promote respect for legal capacity and avoidance of coercion. Peer services take varied organizational forms and integrate diverse activities like emotional support, education, assisting social inclusion and access to opportunities, advocacy, and awareness raising. Overall, peer support uniquely provides compassionate partnership and inspiration through relatable expertise on navigating mental health challenges. Evaluations indicate peer services improve quality of life, social functioning and hope. Greater investment is still required to expand access to quality peer support and evaluate its benefits (World Health Organization, 2023).

Self-care

The level of self-care refers to individuals' knowledge and skills to manage their mental health disorders on their own or with the help of family and friends.

Strengths

The service level of self-care acknowledges the role and autonomy of individuals (and families) to deal with their own psychological or mental health problems given access to the right information and guidance. Low-cost resources – for example, written materials or radio programs – can be used to promote self-care in the community.

Considerations

Problems related to mental health and substance use vary widely in complexity and severity, and medical and other professional expertise are essential for some of the more severe and complex conditions. However, in all cases, the provision of information and support goes a long way in helping people take control of their illnesses and reduce their dependence on the health system.

Key principles for organizing services

Even if the proposed framework for the optimal configuration of the mental health services model depicted in Fig. 3 is adopted, it would still not be sufficient to cover the needs for care of people with mental and substance use disorders. Given the limited availability of specialized mental health services, and the significant treatment gap observed globally across all countries (Evans-Lacko et al., 2018), a set of key 'principles' have been proposed for transforming current practices in mental health and addressing the mental health crisis (Patel et al., 2023). These principles include the need to target harmful social environments across the life course, ensure that care is not contingent on a categorical diagnosis but aligned with the staging model of mental illness, empower diverse front-line providers to deliver psychosocial interventions, embrace a rights-based approach that seeks to provide alternatives to violence and coercion in care, and center people with lived experience in all aspects of care.

Principle 1: Target harmful social environments across the life course

A shift in focus is required, away from exclusively treating diagnosed mental health conditions toward prioritizing the prevention of mental health problems and the promotion of mental health. Treatment availability alone will not be sufficient to substantially reduce the global burden of mental ill health, as the prevalence of common mental disorders persists at the same levels, despite increased treatment provision in high-income countries (Jorm et al., 2017). Therefore, a shift in focus is needed, instead of continually increasing budgets for treating diagnosed mental health conditions, emphasis should be placed on the prevention of mental health problems. Interventions should target individual and social determinants that are known to impact mental health, such as poor physical health, emotional and physical neglect during childhood, lack of education, abuse and violence, social exclusion, poverty, and income inequality (Arango et al., 2021; World Health Organization, 2022b). Prevention starts in the pre-natal environments, ensuring access to quality antenatal care and promoting responsive caregiving. Adverse experiences, including violence or neglect, should be averted through these measures (World Health Organization, 2018). Throughout childhood and adolescence, interventions should promote the development of social and emotional skills, including self-regulation and coping. Habits and coping strategies that enable mental health, include healthy sleeping patterns, regular exercise, problem-solving and interpersonal skills (Laurenzi et al., 2023). Many risk behaviors, such as use of substances, start during adolescence and can be particularly harmful to mental health. Thus consciousness and action is required from trusted adults in interactions with adolescents like sports, mentoring programs, child protective services, and juvenile justice settings (Nelson et al., 2022). Beyond the early years, effective interventions to prevent mental health conditions include couples' interventions to reduce intimate partner violence, workplace programs to increase job security and promote positive working environments (Harvey et al., 2017). Economic risk factors, such as poverty and more specifically, income volatility or food insecurity can be mitigated through cash transfers, food subsidies and housing support (Graif et al., 2016; McGuire et al., 2022). Loneliness, a significant factor increasing the likelihood of depression, must be addressed through social support programs, especially in older adults (Liu et al., 2016). Not least since the pandemic, loneliness must also be considered as a highly prevalent risk factor in younger generations, particularly in young adults (Horigian et al., 2021). Overall, individual and structural factors are not static or unchangeable, and a range of intermediate risk factors can be addressed through interventions, effectively lowering the risk of developing mental health conditions along the course of life.

Principle 2: Care is determined by a person's needs, not the diagnosis

Diagnostic categories in clinic practice traditionally describe specific mental disorders, implying that these categories can be isolated and remain static. However, a growing body of evidence suggests that mental health problems should be perceived as a dynamic system rather than fixed syndromes. This acknowledges the dynamic changes an individual may undergo and the heterogeneity experienced by different individuals with the same mental health condition (Fried, 2022; Patel et al., 2023). Mental health is not a binary state, of having or not having a mental disorder. Instead, it can be conceptualized as a system of dynamic processes that are specific to each individual (Lahey et al., 2022; Wright and Woods, 2020). Importantly, a continuum of mental wellbeing exists alongside a spectrum of symptoms of mental health conditions, and mental wellbeing can be low even when an individual does not exhibit symptoms of (World Health Organization, 2022b).

The model recognizes different stages in the evolution of a mental health condition in a person. This allows interventions to be adapted to each specific stage, from mild and non-specific symptoms with minimal impairment of functioning up to persistent experience of a mental health condition associated with enduring disability (Shah et al., 2020). Refer to Fig. 4 for an overview of all stages. This approach facilitates the development of a system with different providers and forms of provision adapted to the needs of individuals at each stage. Furthermore, it supports the implementation of a continuous care model, crucial for managing many mental and substance use disorders, particularly those with a chronic course or with a recurrent pattern.

Therefore, care should not be contingent on a categorical diagnosis but aligned with the staging model of mental health. Mental health services must be designed on a needs-led basis rather than on a service-led basis, that assigns treatments solely on diagnostic categories. This means having in place flexible services, adapting to users' needs, and not the other way around. While diagnostic categories can guide treatment selection and prognosis, they need to be recognized as idealizations and reductions of individual elements of mental disorders. This underscores the need for mental health practitioners to consider the complex within-person

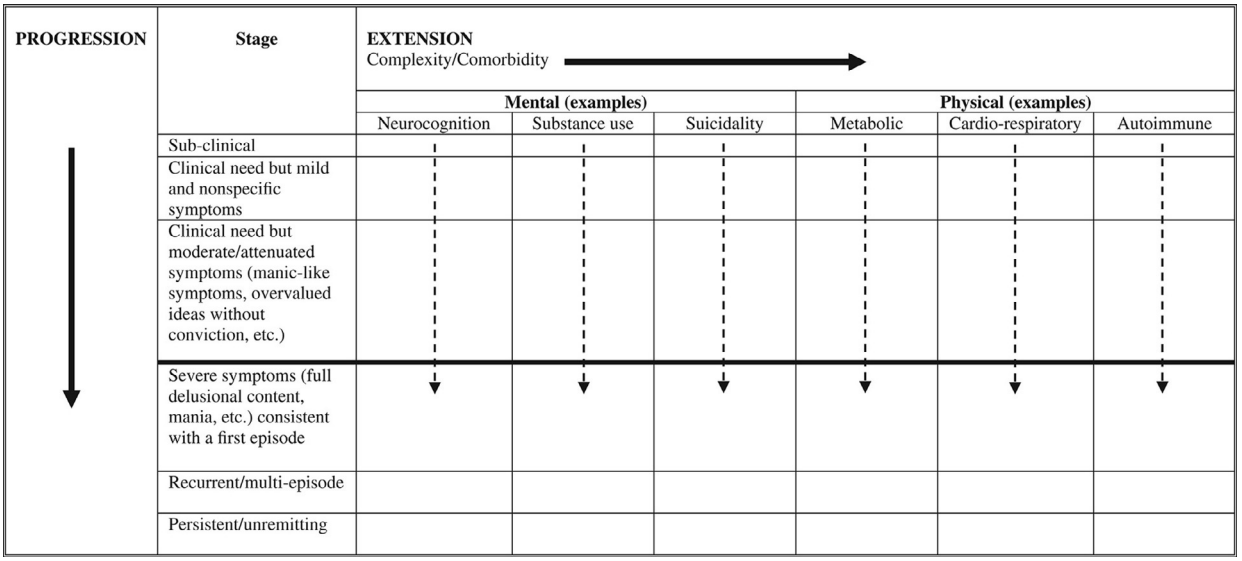

Fig. 4 A revised multidimensional staging model for mental health by Shah et al. (2020). From Shah JL, Scott J, McGorry PD, Cross SPM, Keshavan MS, Nelson B, Wood SJ, Marwaha S, Yung AR, Scott EM, Öngür D, Conus P, Henry C, and Hickie IB (2020) Transdiagnostic clinical staging in youth mental health: A first international consensus statement. *World Psychiatry: Official Journal of the World Psychiatric Association* **19**, 233–242, doi: https://doi.org/10.1002/wps.20745. Permission provided by Prof. Mario Maj.

processes and interconnected systems of biological, psychological, and social elements. Effective diagnosis and treatment require and understanding of these processes, and methods from network and systems sciences can help increasing our current knowledge (Fried, 2022).

Principle 3: Empower front-line workers to deliver evidence-based psychosocial care

In recent decades, mental health care has centered around acute psychiatric episodes, often neglecting prevention and long-term care. This has resulted in patients' hesitating to seek care until a condition becomes severe, leading to short-term intervention results and multiple admissions for the same problem. The focus on specialty care has also contributed to high costs and the unavailability of services in many regions. The much-needed integration of mental health services into general hospitals, primary care and social welfare services is widely missing. A comprehensive, long-term perspective should encompass various sectors such as social services, housing, education, and employment. Collaboration with other sectors is essential in this regard. Several authors advocate for a shift in focus to non-specialist providers that can expand the mental health care workforce. Evidence supports the effectiveness of brief psychosocial interventions, which can be delivered within the community, including primary care, schools, and social services. Establishing a well-organized training and supervision network, supported by specialists, is needed to effectively scale these interventions while ensuring their quality (Kohrt et al., 2020; Patel et al., 2022). The inclusion of digital or hybrid formats is needed to train healthcare workers, such as the EMPOWER training program or the Electronic mhGAP Intervention Guide (EMPOWER, 2021; Taylor Salisbury et al., 2021). Digital apps can serve as a tool to ensure the continuity of specialist mental health services, by promoting self-care, monitoring mental health care, and practicing skills learned during therapy (Torous et al., 2021). Scaling up non-specialist mental health workers is essential to address limited resources and integrate services into the community. However, a strategy for collaboration with mental health specialists is needed to establish referral pathways and support for the non-specialist providers (Mangurian et al., 2022; McGorry et al., 2022; Park and Zarate, 2019; Read and Kohrt, 2022). To ensure sustainable systems and long-term commitment of front-line workers, adequate training, recognition and remuneration are needed.

Principle 4: Embrace a rights-based perspective for mental health care

Basic human rights need to be respected while providing services for people with mental health conditions. People with mental and substance use disorders have the same civil, economic, political, social, and cultural rights as every other member of the community and these rights should be upheld. Collaborative efforts of clinicians, health system administrators, service users and their families are essential to aligning mental health care services with the same quality and rights associated to physical health care. Monitoring, evaluation, and necessary actions to protect against rights violations must happen to prevent rights violations. The WHO Quality Rights initiative serves as a valuable guideline for promoting rights in mental health (Funk and Bold, 2020). Institutions where human rights violations are more likely to occur should receive particular attention and governments must enforce legal protection for people living with mental health conditions. All admissions for crisis intervention should be handled by trained front-line

providers and must aim to secure supported decision-making. Substituted decision-making can be considered as a last resort, with strict limits and independent oversight to ensure its appropriateness (Patel et al., 2023).

International human rights norms and standards must be respected when providing services for people with mental health conditions. People with mental and substance use disorders have the same civil, economic, political, social, and cultural rights as everyone else in the community and these rights should be upheld.

Principle 5: Place people with lived experience at the center of the care system

Individuals with lived experience of mental health conditions are gradually gaining greater involvement across different levels within the mental health system. This participation spans from the personal level, influencing one's own health care planning through shared decision-making, to the community level, including training for health care staff or public awareness campaigns, and the strategic level, actively participating in shaping mental health policies (World Health Organization, 2022b). Prioritizing the perspective of service users and their families as the main factor in structuring and evaluating mental health services is pivotal to improving outcomes for those affected. Alternative interventions to involuntary treatment and coercion must be provided to promote supported decision-making and reduce power imbalances whenever appropriate to the context (Sugiura et al., 2020). Outcome measures should be patient-rated, to ensure they capture the lived experience of individuals, and the negative effects of treatment should be simultaneously taken into account (Crawford et al., 2011). Moreover, people with lived experience can play a crucial role in the training of health care professionals, particularly in initiatives to integrate mental health care into primary and community care programs, fostering the understanding of care needs for health workers without previous mental health care experience.

People with lived experience also play a key role in fostering understanding in the general population about mental health conditions. Addressing stigma and discrimination against people with mental health conditions remains crucial, as these issues still affect job prospects, housing and social contacts across the world (Thornicroft et al., 2022).

These fundamental principles align with previous reports, including the latest World Mental Health Report (World Health Organization, 2022b), which acknowledges the commitment of its member states to the *'Comprehensive mental health action plan 2013-2030'* and the Lancet Commission on global mental health and sustainable development (Patel et al., 2018b). Additionally, delivering a high standard of mental health treatment and care requires the implementation of an integrated system of service delivery that ensures accessibility and equity, continuity of care and evidence-based service development.

Principle 6: Equity

Equity means that all segments of the population can access services and that possible differences in prevalence are taken into account for planning the density of services. For most policymakers, the improvement of equity involves working toward greater equality in outcomes or status among individuals, regardless of the income group to which they belong or the region in which they reside.

Populations with specific difficulties in accessing services need special consideration for service development. Such difficulties may include prohibitive distance and transport costs, unaffordable fees, lack of culturally appropriate care, discriminatory attitudes among providers, and other barriers that frequently leave certain groups underserved. Mental health services must proactively identify and reduce obstacles to access, while meeting the unique needs of marginalized communities.

Imprisoned people

Imprisoned people need special consideration given the high prevalence of severe mental health and substance use disorders (Baranyi et al., 2022, 2019; Mundt et al., 2018), especially at intake to prison (Mundt et al., 2016). People with severe mental disorders present a high vulnerability for human rights violations within the prison system, especially in poorly resourced prison settings (Almanzar et al., 2015). This population faces specific difficulties in accessing adequate care (Fovet et al., 2023). In many countries, services are scarce in prison. Diversion from prison and access to forensic psychiatric care are not always available for people with psychosis and criminal justice involvement. There are very high barriers to accessing services outside of prisons because of the need for accompanying prison staff and transport, scarce resources in many countries. Furthermore, it is still often perceived as part of the punishment to underserve the mental health needs of imprisoned people. Nevertheless, access to health care is a fundamental right that should be independent of imprisonment according to the Nelson Mandela Rules (United Nations Office on Drugs and Crime, 2015). Mental health conditions are often neglected in practice and research, especially in LMIC regions (Beigel et al., 2023; Forrester et al., 2023).

Migrant populations

Worldwide, more people are on the move now than ever before, yet many refugees and migrants face poorer health outcomes than the host populations (World Health Organization, 2022c). Addressing their health needs is, therefore, a global health priority and integral to the principle of the right to health for all. A whole host of determinants influences mental health outcomes. However, some groups of refugees and migrants face additional determinants such as precarious legal status; discrimination; social, cultural, linguistic, administrative, and financial barriers; lack of information about health entitlements; low health literacy; and fear of

detention and deportation. Refugee, asylum seeker and irregular migrant children, in particular, display a higher prevalence of mental health issues compared with host populations (Sangalang et al., 2019).

Migrants and refugees can be exposed to various stress factors that affect their mental health and psychosocial well-being before and during their migration journey and during their settlement and integration (World Health Organization, 2022c). A wide range of mental health conditions may present, including depression, anxiety, PTSD, suicide, self-harm, and psychotic disorders. The prevalence of these conditions is highly variable as it depends on social and environmental factors, in addition to access to mental health services and diagnosis (Priebe Rocha et al., 2022). Depression and anxiety can be highly prevalent among refugees and migrants at different stages of the displacement and migration experience, based on various individual, social, and environmental risks (Erausquin et al., 2020). Also, conflict- and war-affected refugees and migrants display higher levels of PTSD and other mental health issues, particularly younger migrants and adolescents (Solmaz et al., 2021). The COVID-19 pandemic was also challenging to many migrants and refugees globally, with an increased prevalence of mental health problems (Blukacz et al., 2022). Hence, migration is not per se a risk factor for poor mental health, but risks and vulnerabilities experienced during the migration stages can influence the appearance of poor mental health outcomes in some of these populations (Carreño et al., 2020).

There is significant evidence indicating that many migrants and refugees lack access to mental health services or experience barriers in accessing these (Carreño-Calderon et al., 2020). They also face disruptions in the continuity of care (Uphoff et al., 2020). As stated by international experts, the mental health needs of migrants and refugees should be addressed by organizing inclusive and accessible promotion and prevention programs; strengthening mental health as part of general health services; and ensuring timely diagnosis, treatment and rehabilitation (World Health Organization, 2022c).

Children and adolescents

Child and adolescent mental health remains a critically under-resourced area globally. As per the WHO Mental Health Atlas 2020, only 53% of responding countries reported having a stand-alone or integrated policy or plan specifically for children and adolescents (World Health Organization, 2021), indicating significant policy gaps to strategically prioritize youth mental health.

The provision of specialist mental health services for youth was remarkably scarce. Globally, there were only 3.4 mental health workers per 100,000 youth (including 0.3 psychiatrists and 0.1 psychologists per 100,000 population), along with 3 psychiatric beds and 1.1 outpatient facilities per 100,000 population (World Health Organization, 2021). Low and middle-income countries had less than 1 mental health worker focused on youth mental health per 100,000 population, highlighting massive human resource gaps (World Health Organization, 2021).

This dearth of youth mental health services persists despite extensive evidence on the effectiveness of early intervention. Half of all mental illnesses begin by age 14, but go undetected and untreated (Gore et al., 2011). Neuroscientific advances showcase how early adversity and trauma compound across the lifespan via biological embedding (Patel et al., 2018b). Later identification and care become less effective and more resource-intensive (Gore et al., 2011; Patel et al., 2018b).

As the youth population expands, the burden of mental disorders is projected to rise in the coming decade (Das et al., 2016; Shonkoff et al., 2012). Hence strategic investments in youth mental health policy, programming, and resourcing are now critical (Patel et al., 2018b). Governments must prioritize these areas through health systems strengthening and cross-sectoral coordination (Das et al., 2016).

Several imperatives exist for transforming child and adolescent mental health systems. First, mental health services must be widely accessible to children and adolescents, available across settings like schools, pediatric clinics, child welfare programs and juvenile justice systems. Schools play a vital role for prevention, early intervention and removing barriers to care (United Nations Children's Fund (UNICEF) and the World Health Organization, 2022). Second, a developmental perspective is needed that addresses risks and provides care across developmental stages, requiring coordination across child services sectors. Third, care should empower non-specialist providers, including teachers and community workers, to deliver psychosocial support to youth under specialist supervision. Fourth, and most fundamentally, the voices and perspectives of children and adolescents should be integrated across mental health systems, from service delivery to policy, reducing the power differential between youth and adult providers (World Health Organization and United Nations, 2023).

The UNICEF-WHO Joint Programme on Mental Health and Psychosocial Well-Being and Development of Children and Adolescents presents a vital framework for action (United Nations Children's Fund (UNICEF) and the World Health Organization, 2022). It focuses on four key outcomes: national implementation of multisectoral strategies; enhanced access to integrated quality care; provision of nurturing environments and skills-building opportunities; and improved data systems and evidence utilization (United Nations Children's Fund (UNICEF) and the World Health Organization, 2022). Aligned strategies prioritize leadership, service delivery, mental health promotion and prevention, and research across community and national platforms (United Nations Children's Fund (UNICEF) and the World Health Organization, 2022).

Realizing these goals demands urgent, sustained and multisectoral commitments by governments and donors to deliver evidence-based strategies. The field needs a renewed vision that recognizes child rights and wellbeing as imperative to global health, social, and educational policy agendas (Das et al., 2016; Patel et al., 2018b).

Variables influencing service organization and provision

The organization of mental health services depends on several wider contextual variables related to the country's social, cultural, political, and economic contexts. In this section, we define a 'model' in which different, but sometimes interrelated, wider societal

variables interplay to influence service organization for mental health. The model has several implications, one of which is that changing the mental health system toward that described in the WHO service organization pyramid will require some paradigm shifts. These paradigm shifts and interventions to support them are discussed in the next section.

The model defines four important groups of variables. The first group refers to the level of resources of a country at large and the resources specifically devoted to the mental health system. Resources and economic development can differ considerably within countries, leading to vast differences in service systems, for example, between different states and between urban and rural areas. Adequate resourcing is the foundation for effective mental health systems. Low-income countries often lack basic infrastructure, specialized personnel, medications and equipment for responsive care. Middle-income countries also frequently under-prioritize and under-fund mental health compared to other health priorities. Furthermore, although low economic development is a barrier to a well-functioning mental health system, some poor countries or poor areas within countries have been able to develop some innovative services. Often these make use of 'freely' available resources in the community as opposed to 'more costly' services available in the formal health system.

The more resources a country has to invest in its mental health system, the more influential other variables, such as the prevailing paradigm for mental health, become in shaping that system.

The prevailing paradigm for mental health, the second group of variables in this model, will greatly influence the formation of mental health service providers and clinical practice in countries. There have been two distinct approaches: the biomedical approach and the biopsychosocial approach. The biomedical approach has been the predominant and continues to influence service delivery structures in many parts of the world. Its influence is seen in an over-reliance on hospital care at secondary and tertiary levels. The psychosocial approach, in contrast, recognizes that successful treatment requires attention to biologically based treatments within the context of a broader approach to aim for social inclusion, integration into the community, and recovery from illness. In countries with a biopsychosocial orientation or model in place, the mental health system tends to be better geared toward the lower end of the pyramid (Fig. 3), that is, community mental health services, primary health care, and informal community services.

The third group refers to the value system of countries, for example, the relative importance given to individual rights and collective norms and the degree to which value systems are directed toward human rights, equality, and equity. Countries in which social control is an important feature and in which individual needs are seen as insignificant are more likely to provide a mental health system reliant on institutional care. In this case, services as well as clinical practice are based more on ideology than evidence. The problem may not the absence of care –mental healthcare facilities and providers can be numerous – but the care provided is limited to institutions emphasizing control and containment rather than rehabilitation. The WHO discourages this type of care system. Countries with value systems that emphasize human rights as well as equality and equity tend to provide mental health systems that are more (1) protective of individuals and their rights; (2) responsive to individual needs; and (3) likely to have structures in place to offer some degree of protection against violations and discrimination.

The fourth group of variables refers to the environment, for example, the degree to which both the political and economic environments provide long-term stability or instability. Countries undergoing rapid change, economic and political crisis, and civil war are likely to experience disruptions to the existing mental health service system, and in serious conflict situations destruction of the existing care system, at a time when mental health needs are likely to be greatest. This can lead to chaos, lack of coordination, and unregulated care, with a greater emphasis on informal community services, and a greater reliance on the private sector, NGOs, and aid programs. Rebuilding care systems following crises also opens up opportunities to leave behind the inefficient aspects of older care systems, such as historical funding patterns.

Changing the paradigm—Important roles of training, policy, and legislation

The knowledge base for putting in place a comprehensive mental health system is now available (Patel et al., 2023). Systems limited to a few large psychiatric hospitals in the main urban areas, disconnecting hospitalized people with mental health conditions from their family and community, and run by a small number of overburdened health workers, are no longer acceptable. Mental health care systems have undergone considerable changes toward community-based care in some countries during the past 50 years, however, in many others, they are still in transition. Worldwide, there remains a widespread need to shift models of mental health care, not only in terms of the practical organization of services but in terms of the mental healthcare paradigm itself. Introducing new models of training, policy, and legislation can help to promote the required paradigm shift.

Shift to multidisciplinary teams

To take into account the many dimensions of mental health, treatment, and care should no longer be delivered by any one mental health professional alone but by a multidisciplinary team, which, depending on the country, might include psychiatrists, psychologists, nurses, general practitioners, occupational therapists, and community/social workers sharing their expertise and working in collaboration, each with their own roles and responsibilities. There also needs to be collaboration between mental health teams and other non-health providers in health, welfare, employment, criminal justice, and education sectors in order to meet the range of needs that people with mental health conditions might have.

Reforming education and training models

Reforming or introducing new models of training can help promote the required paradigm shift. In many high-income countries and low- and middle-income countries, the education curriculum for health and allied health professionals contains limited content in mental health. Much of what is provided is focused on institutional models of care, the diagnosis of disorders, and the administration of medication while neglecting the psychosocial aspects of mental health treatments. Outdated teaching curricula reinforce existing and outdated mental health paradigms.

Essential to building a qualified workforce for mental health is the incorporation of mental health into the education of a wide spectrum of health workers and professionals, with mental health concepts introduced early, reinforced, and expanded throughout the curricula, and developed through experiential learning opportunities. Education and training should be informed by evidence for the mental health and service requirements of the country. In most countries this requires the reorientation of the treatment framework from custodial institutional models of mental health care to community-based treatment, emphasizing the integration of mental health into general health care and the development of community care. In addition to building knowledge and skills, for example, communication and interpersonal skills training also needs to promote fundamental changes in the attitudes and beliefs of those being trained and the promotion of a human rights approach to treatment and care.

Changes to policy and legislative framework

The necessary reform of services and the required paradigm shift in the attitudes, beliefs, and values of policymakers and planners can be promoted by the introduction of modern national policies and legislation in line with best practice and international human rights standards. The mental health policy of a government is the official guideline for a number of interrelated strategic directions for improving the mental health of a population, including an important focus on service delivery. A policy provides the overall direction for mental health in a country by defining the vision for the future, and the values and principles on which the vision is based, and by establishing objectives and a model for action (World Health Organization, 2005). A mental health plan is the operational arm of the policy and details the strategies and activities that will be implemented to achieve the objectives of the policy (Mundt et al., 2022a).

Both strategies and activities are complementary and useful tools to (1) promote development of mental health services or their reform, such as the integration of mental health into primary health care, development of community mental health services, and deinstitutionalization; (2) promote access to services in urban, rural, and poor areas and to underserved populations in a way that is affordable; and (3) improve the overall functioning of services – by, for example, committing to put in place a well-equipped workforce, good-quality treatment practices, and mental health and substance abuse information systems.

Mental health policies and plans should promote effective preventive and treatment interventions for substance use disorders within the health system; however, in addition, public health policies aimed at controlling alcohol and other substances are also required.

Mental health legislation is also a powerful tool in that it can be used to legally reinforce these policy objectives. In addition, because it is legally enforceable and penalties can be applied it can be an effective mechanism to reduce human rights violations and discrimination, promote human rights in services and the community, and encourage the autonomy and liberty of people with mental health conditions (World Health Organization and United Nations, 2023).

In 2020, 86% of the 170 responding countries to the WHO Mental Health Atlas had a standalone mental health policy or plan, other 11% had it integrated in the general health plan, and only 3% didn't have any policy or plan. Nevertheless, there is a significant gap between policy and practice. Only 39% of the countries reported human resources in line with the mental health plan/policy and 34% of the countries reported sufficient financial resources to implement the mental health plan/policy. In addition, 65% of the countries have a standalone mental health law, and another 25% have their mental health legislation integrated into general health or disability law. 27% of these countries have mental health legislations that are older than 10 years and 70% of these countries have some authority or independent body that assesses the compliance of mental health legislation with international human rights instruments (World Health Organization, 2021).

Beyond health systems capacities and care paradigms, transforming mental health services relies on enabling policy environments and implementation research. Forward-looking governance can harness innovations in digital technology to greatly strengthen access, quality and efficiency (Naslund et al., 2017). Hybrid care models blending virtual solutions with specialized supports suit low-resource settings but require testing. Regional networks allowing rapid transfer of expertise on effective community-based models can catalyze rapid gains. Overall, a blend of political commitment, implementation research, accountability mechanisms and global solidarity can synergize with health systems strengthening to achieve responsive, balanced and equitable mental health care for all.

Fundamentally reshaping mental health systems requires interlinked efforts across multiple domains. Comprehensive, community-based networks of formal and informal biopsychosocial supports should be strengthened, shifting care away from institutions toward localized, coordinated services respecting preferences and rights. Task-sharing evidence-based psychological interventions with supported non-specialists can rapidly address unmet needs for common conditions. Explicitly prioritizing mental health within universal health coverage packages makes care affordable and accessible for all. Throughout, empowering people with lived experience as partners transforms design and delivery toward collaborative, holistic, recovery-oriented models. No single solution suffices, but combining strategies to integrate services, diversify the workforce, guarantee accessibility, and promote participation sets countries firmly on the path toward mental health for all.

Conclusion

Given the increasing burden of disease attributed to mental and substance use disorders and their connections with education, work, physical health and disability, human rights, and poverty, our exploration advocates for a transformative shift in mental health service organization. This shift implies the adoption of a comprehensive biopsychosocial framework. This paradigm shift is pivotal for equipping health systems, medical professionals, and societies to achieve improved mental health outcomes.

A fundamental principle in this transformation involves moving beyond exclusively treating diagnosed mental health conditions to prioritizing prevention and mental health promotion, addressing individual and social determinants across the lifespan. Embracing a staging model for mental health, emphasizing interventions at different stages, recognizes the dynamic nature of mental health and promotes needs-led rather than diagnosis-led care. A long-term perspective involving non-specialist providers is essential, with brief psychosocial interventions within the community, supported by specialist-led training and digital tools, to bridge the treatment gap and ensure continuous care.

Involving individuals with lived experiences at all levels enhances mental health services, fostering shared decision-making, reducing coercion, and addressing stigma. Equity is paramount, ensuring access for all segments of the population, with particular considerations for differences in prevalence. Special attention is needed for populations facing difficulties in access, including imprisoned individuals, migrant populations, and children and adolescents. Strategies must address barriers and promote inclusion, recognizing the unique needs of marginalized communities in mental health service development.

Mental health service organization requires context-specific approaches, combining institutional and community-based services, peer support, and self-care, for a holistic and inclusive system. Hospital-based services, offering advantages such as acute episode management, medical treatment for comorbidities, and educational opportunities, should be available for specific groups. Simultaneously, community mental health services, encompassing various community-based programs addressing rehabilitation, crisis intervention, and home help, prove effective and aligned with user preferences. However, their implementation requires specialized expertise and careful planning. Informal community mental health services, provided outside formal health systems, play a crucial role as the first point of contact in many countries. Peer support services, managed and delivered by individuals with lived experiences, offer partnerships and enhance recovery, yet greater investment is needed for wider access.

Recognizing the need for paradigm shifts, our analysis underscores the importance of training, policy, and legislation in reshaping mental health systems. Transitioning from large psychiatric hospitals to community-based care is crucial. Multidisciplinary teams, including psychiatrists, psychologists, nurses, and non-medical personnel, should collaboratively address the multidimensional aspects of mental health. Reforming education and training models is needed, and promoting a human rights approach. These initiatives, aligned with principles of equity, contribute to a transformative vision for global mental health services.

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