Technical package

Community mental health centres

Promoting person-centred and rights-based approaches

World Health
Organization

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QualityRights

Community mental health centres: promoting person-centred and rights-based approaches

(Guidance and technical packages on community mental health services: promoting person-centred and rights-based approaches)

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Foreword

Around the world, mental health services are striving to provide quality care and support for people with mental health conditions or psychosocial disabilities. But in many countries, people still lack access to quality services that respond to their needs and respect their rights and dignity. Even today, people are subject to wide-ranging violations and discrimination in mental health care settings, including the use of coercive practices, poor and inhuman living conditions, neglect, and in some cases, abuse.

The Convention on the Rights of Persons with Disabilities (CRPD), signed in 2006, recognizes the imperative to undertake major reforms to protect and promote human rights in mental health. This is echoed in the Sustainable Development Goals (SDGs) which call for the promotion of mental health and wellbeing, with human rights at its core, and in the United Nations Political Declaration on universal health coverage.

The last two decades have witnessed a growing awareness of the need to improve mental health services, however, in all countries, whether low-, medium- or high-income, the collective response has been constrained by outdated legal and policy frameworks, and lack of resources.

The COVID-19 pandemic has further highlighted the inadequate and outdated nature of mental health systems and services worldwide. It has brought to light the damaging effects of institutions, lack of cohesive social networks, the isolation and marginalization of many individuals with mental health conditions, along with the insufficient and fragmented nature of community mental health services.

Everywhere, countries need mental health services that reject coercive practices, that support people to make their own decisions about their treatment and care, and that promote participation and community inclusion by addressing all important areas of a person's life – including relationships, work, family, housing and education – rather than focusing only on symptom reduction.

The WHO Comprehensive Mental Health Action Plan 2020–2030 provides inspiration and a framework to help countries prioritize and operationalize a person-centred, rights-based, recovery approach in mental health. By showcasing good practice mental health services from around the world this guidance supports countries to develop and reform community-based services and responses from a human rights perspective, promoting key rights such as equality, non-discrimination, legal capacity, informed consent and community inclusion. It offers a roadmap towards ending institutionalization and involuntary hospitalization and treatment and provides specific action steps for building mental health services that respect every person's inherent dignity.

Everyone has a role to play in bringing mental health services in line with international human rights standards – policy makers, service providers, civil society, and people with lived experience of mental health conditions and psychosocial disabilities.

This guidance is intended to bring urgency and clarity to policy makers around the globe and to encourage investment in community-based mental health services in alignment with international human rights standards. It provides a vision of mental health care with the highest standards of respect for human rights and gives hope for a better life to millions of people with mental health conditions and psychosocial disabilities, and their families, worldwide.

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Executive summary

Mental health has received increased attention over the last decade from governments, nongovernmental organizations (NGOs) and multilateral organizations including the United Nations (UN) and the World Bank. With increased awareness of the importance of providing person-centred, human rights-based and recovery-oriented care and services, mental health services worldwide are striving to provide quality care and support.

Yet often services face substantial resource restrictions, operate within outdated legal and regulatory frameworks and an entrenched overreliance on the biomedical model in which the predominant focus of care is on diagnosis, medication and symptom reduction while the full range of social determinants that impact people's mental health are overlooked, all of which hinder progress toward full realization of a human rights-based approach. As a result, many people with mental health conditions and psychosocial disabilities worldwide are subject to violations of their human rights – including in care services where adequate care and support are lacking.

To support countries in their efforts to align mental health systems and services delivery with international human rights standards, including the Convention on the Rights of Persons with Disabilities (CRPD), the WHO Guidance on community mental health services: Promoting person-centred and rights-based approaches calls for a focus on scaling up community-based mental health services that promote person-centred, recovery- oriented and rights-based health services. It provides real-world examples of good practices in mental health services in diverse contexts worldwide and describes the linkages needed with housing, education, employment and social protection sectors, to ensure that people with mental health conditions are included in the community and are able to lead full and meaningful lives. The guidance also presents examples of comprehensive, integrated, regional and national networks of community-based mental health services and supports. Finally, specific recommendations and action steps are presented for countries and regions to develop community mental health services that are respectful of peoples' human rights and focused on recovery.

This comprehensive guidance document is accompanied by a set of seven supporting technical packages which contain detailed descriptions of the showcased mental health services

1. **Mental health crisis services**
2. **Hospital-based mental health services**
3. **Community mental health centres**
4. **Peer support mental health services**
5. **Community outreach mental health services**
6. **Supported living for mental health**
7. **Comprehensive mental health service networks**

Key messages of this guidance

- **Many people with mental health conditions and psychosocial disabilities face poor-quality care and violations of their human rights, which demands profound changes in mental health systems and service delivery.**
- **In many parts of the world examples exist of good practice, community-based mental health services that are person-centred, recovery-oriented and adhere to human rights standards.**
- **In many cases these good practice, community-based mental health services show lower costs of service provision than comparable mainstream services.**
- **Significant changes in the social sector are required to support access to education, employment, housing and social benefits for people with mental health conditions and psychosocial disabilities.**
- **It is essential to scale up networks of integrated, community-based mental health services to accomplish the changes required by the CRPD.**
- **The recommendations and concrete action steps in this guidance provide a clear roadmap for countries to achieve these aims.**

Introduction

Reports from around the world highlight the need to address discrimination and promote human rights in mental health care settings. This includes eliminating the use of coercive practices such as forced admission and forced treatment, as well as manual, physical or chemical restraint and seclusion[a] and tackling the power imbalances that exist between health staff and people using the services. Sector-wide solutions are required not only in low-income countries, but also in middle- and high-income countries.

The CRPD recognizes these challenges and requires major reforms and promotion of human rights, a need strongly reinforced by the Sustainable Development Goals (SDGs). It establishes the need for a fundamental paradigm shift within the mental health field, which includes rethinking policies, laws, systems, services and practices across the different sectors which negatively impact people with mental health conditions and psychosocial disabilities.

Since the adoption of the CRPD in 2006, an increasing number of countries are seeking to reform their laws and policies in order to promote the rights to community inclusion, dignity, autonomy, empowerment and recovery. However, to date, few countries have established the policy and legislative frameworks necessary to meet the far-reaching changes required by the international human rights framework. In many cases, existing policies and laws perpetuate institutional-based care, isolation as well as coercive – and harmful – treatment practices.

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[a] Strategies to end seclusion and restraint. WHO QualityRights Specialized training. Course guide. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/bitstream/handle/10665/329605/9789241516754-eng.pdf).

Providing community-based mental health services that adhere to the human rights principles outlined in the CRPD – including the fundamental rights to equality, non-discrimination, full and effective participation and inclusion in society, and respect for people's inherent dignity and individual autonomy – will require considerable changes in practice for all countries. Implementing such changes can be challenging in contexts where insufficient human and financial resources are being invested in mental health.

This guidance presents diverse options for countries to consider and adopt as appropriate to improve their mental health systems and services. It presents a menu of good practice options anchored in community-based health systems and reveals a pathway for improving mental health care services that are innovative and rights-based. There are many challenges to realizing this approach within the constraints that many services face. However, despite these limitations, the mental health service examples showcased in this guidance show concretely – it can be done.

Examples of good practice community mental health services

In many countries, community mental health services are providing a range of services including crisis services, community outreach, peer support, hospital-based services, supported living services and community mental health centres. The examples presented in this guidance span diverse contexts from, for example, the community mental health outreach service, Atmiyata, in India, to the Aung Clinic community mental health service in Myanmar and the Friendship Bench in Zimbabwe, all of which make use of community health care workers and primary health care systems. Other examples include hospital-based services such as the BET unit in Norway, which is strongly focused on recovery, and crisis services such as Tupu Ake in New Zealand. This guidance also showcases established supported living services such as the KeyRing Living Support Networks in the United Kingdom and peer-support services such as the Users and Survivors of Psychiatry groups in Kenya and the Hearing Voices Groups worldwide.

While each of these services is unique, what is most important is that they are all promoting a person-centred, rights-based, recovery approach to mental health systems and services. None is perfect, but these examples provide inspiration and hope as those who have established them have taken concrete steps in a positive direction towards alignment with the CRPD.

Each mental health service description presents the core principles underlying the service including their commitment to respect for legal capacity, non-coercive practices, community inclusion, participation and the recovery approach. Importantly, each service presented has a method of service evaluation, which is critical for the ongoing assessment of quality, performance and cost-effectiveness. In each case, service costs are presented as well as cost comparisons with regional or national comparable services.

These examples of good practice mental health services will be useful to those who wish to establish a new mental health service or reconfigure existing services. The detailed service descriptions in the technical packages contain practical insights into challenges faced by these services as they evolved, and the solutions developed in response. These strategies or approaches can be replicated, transferred or scaled up when developing services in other contexts. The guidance presents practical steps and recommendations for setting up or transforming good practice mental health services that can work successfully within a wide range of legal frameworks while still protecting human rights, avoiding coercion and promoting legal capacity.

Significant social sector changes are also required

In the broader context, critical social determinants that impact people’s mental health such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, and lack of access to housing, social safety nets, and health services, are factors often overlooked or excluded from mental health discourse and practice. In reality, people living with mental health conditions and psychosocial disabilities often face disproportionate barriers to accessing education, employment, housing and social benefits – fundamental human rights – on the basis of their disability. As a result, significant numbers are living in poverty.

For this reason, it is important to develop mental health services that engage with these important life issues and ensure that the services available to the general population are also accessible to people with mental health conditions and psychosocial disabilities.

No matter how well mental health services are provided though, alone they are insufficient to support the needs of all people, particularly those who are living in poverty, or those without housing, education or a means to generate an income. For this reason, it is essential to ensure that mental health services and social sector services engage and collaborate in a very practical and meaningful way to provide holistic support.

In many countries, great progress is already being made to diversify and integrate mental health services within the wider community. This approach requires active engagement and coordination with diverse services and community actors including welfare, health and judiciary institutions, regional and city authorities, along with cultural, sports and other initiatives. To permit such collaboration, significant strategy, policy and system changes are required not only in the health sector but also in the social sector.

Scaling up mental health service networks

This guidance demonstrates that scaling up networks of mental health services that interface with social sector services is critical to provide a holistic approach that covers the full range of mental health services and functions.

In several places around the world, individual countries, regions or cities have developed mental health service networks which address the above social determinants of health and the associated challenges that people with mental health and psychosocial conditions face daily.

Some of the showcased examples are well-established, structured and evaluated networks that have profoundly reshaped and reorganized the mental health system; others are networks in transition, which have reached significant milestones.

The well-established networks have exemplified a strong and sustained political commitment to reforming the mental health care system over decades, so as to adopt a human rights and recovery-based approach. The foundation of their success is an embrace of new policies and laws, along with an increase in the allocation of resources towards community-based services. For instance, Brazil’s community-based mental health networks offer an example of how a country can implement services at large scale, anchored in human rights and recovery principles. The French network of East Lille further demonstrates that a shift from inpatient care to diversified, community-based interventions can be achieved with an investment comparable to that of more conventional mental health services.

Finally, the Trieste, Italy network of community mental health services is also founded upon on a human rights-based approach to care and support, and strongly emphasizes de-institutionalization. These networks reflect the development of community-based mental health services that are strongly integrated and connected with multiple community actors from diverse sectors including the social, health, employment, judiciary and others.

More recently, countries such as Bosnia and Herzegovina, Lebanon, Peru, and others, are making concerted efforts to rapidly expand emerging networks, and to offer community-based, rights-oriented and recovery-focused services and supports at scale. A key aspect of many of these emerging networks is the aim of bringing mental health services out of psychiatric hospitals and into local settings, so as to ensure the full participation and inclusion of individuals with mental health conditions and psychosocial disabilities in the community. While more time and sustained effort is required, important changes are already materializing. These networks provide inspiring examples of what can be achieved with political will, determination and a strong human rights perspective underpinning actions in mental health.

Key recommendations

Health systems around the world in low-, middle- and high-income countries increasingly understand the need to provide high quality, person-centred, recovery-oriented mental health services that protect and promote people's human rights. Governments, health and social care professionals, NGOs, organizations of persons with disabilities (OPDs) and other civil society actors and stakeholders can make significant strides towards improving the health and well-being of their populations by taking decisive action to introduce and scale up good practice services and supports for mental health into broader social systems while protecting and promoting human rights.

This guidance presents key recommendations for countries and organizations, showing specific actions and changes required in mental health policy and strategy, law reform, service delivery, financing, workforce development, psychosocial and psychological interventions, psychotropic drugs, information systems, civil society and community involvement, and research.

Crucially, significant effort is needed by countries to align legal frameworks with the requirements of the CRPD. Meaningful changes are also required for policy, strategy and system issues. Through the creation of joint policy and with strong collaboration between health and social sectors, countries will be better able to address the key determinants of mental health. Many countries have successfully used shifts in financing, policy and law as a powerful lever for mental health system reform. Placing human rights and recovery approaches at the forefront of these system reforms has the potential to bring substantial social, economic and political gains to governments and communities.

In order to successfully integrate a person-centred, recovery-oriented and rights-based approach in mental health, countries must change and broaden mindsets, address stigmatizing attitudes and eliminate coercive practices. As such, it is critical that mental health systems and services widen their focus beyond the biomedical model to also include a more holistic approach that considers all aspects of a person's life. Current practice in all parts of the world, however, places psychotropic drugs at the centre of treatment responses whereas psychosocial interventions, psychological interventions and peer support should also be explored and offered in the context of a person-centred, recovery and rights-based approach. These changes will require significant shifts in the knowledge, competencies and skills of the health and social services workforce.

More broadly, efforts are also required to create inclusive societies and communities where diversity is accepted, and the human rights of all people are respected and promoted. Changing negative attitudes and discriminatory practices is essential not just within health and social care settings, but also within the community as a whole. Campaigns raising awareness of the rights of people with lived experience are critical in this respect, and civil society groups can play a key strategic role in advocacy.

Further, as mental health research has been dominated by the biomedical paradigm in recent decades, there is a paucity of research examining human rights-based approaches in mental health. A significant increase in investment is needed worldwide in studies examining rights-based approaches, assessing comparative costs of service provision and evaluating their recovery outcomes in comparison to biomedical-based approaches. Such a reorientation of research priorities will create a solid foundation for a truly rights-based approach to mental health and social protection systems and services.

Finally, development of a human rights agenda and recovery approach cannot be attained without the active participation of individuals with mental health conditions and psychosocial disabilities. People with lived experience are experts and necessary partners to advocate for the respect of their rights, but also for the development of services and opportunities that are most responsive to their actual needs.

Countries with a strong and sustained political commitment to continuous development of community-based mental health services that respect human rights and adopt a recovery approach will vastly improve not only the lives of people with mental health conditions and psychosocial disabilities, but also their families, communities and societies as a whole.

What is the WHO QualityRights initiative?

WHO QualityRights is an initiative which aims to improve the quality of care and support in mental health and social services and to promote the human rights of people with psychosocial, intellectual or cognitive disabilities throughout the world. QualityRights uses a participatory approach to achieve the following objectives:

1

Build capacity to combat stigma and discrimination, and to promote human rights and recovery.

- WHO QualityRights face to face training modules
- WHO QualityRights e-training on mental health and disability: Eliminating stigma and promoting human rights

2

Improve the quality of care and human rights conditions in mental health and social services.

- WHO QualityRights assessment toolkit
- WHO QualityRights module on transforming services & promoting rights

3

Create community-based and recovery-oriented services that respect and promote human rights.

- WHO guidance and technical packages on community mental health services: Promoting person-centred and rights-based approaches
- WHO QualityRights guidance module one-to-one peer support by and for people with lived experience
- WHO QualityRights guidance module on peer support groups by and for people with lived experience
- WHO QualityRights person-centred recovery planning for mental health and well-being self-help tool

4

Support the development of a civil society movement to conduct advocacy and influence policy-making.

- WHO QualityRights guidance module on advocacy for mental health, disability and human rights
- WHO QualityRights guidance module on civil society organizations to promote human rights in mental health and related areas

5

Reform national policies and legislation in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards.

- WHO guidance currently under development

For more information visit the WHO QualityRights website

About the WHO Guidance and technical packages on community mental health services

The purpose of these documents is to provide information and guidance to all stakeholders who wish to develop or transform their mental health system and services. The guidance provides in-depth information on the elements that contribute towards the development of good practice services that meet international human rights standards and that promote a person-centred, recovery approach. This approach refers to mental health services that operate without coercion, that are responsive to people's needs, support recovery and promote autonomy and inclusion, and that involve people with lived experience in the development, delivery and monitoring of services.

There are many services in countries around the world that operate within a recovery framework and have human rights principles at their core – but they remain at the margins and many stakeholders including policy makers, health professionals, people using services and others, are not aware of them.

The services featured in these documents are not being endorsed by WHO but have been selected because they provide concrete examples of what has been achieved in very different contexts across the world. They are not the only ones that are working within a recovery and human rights agenda but have been selected also because they have been evaluated, and illustrate the wide range of services that can be implemented.

Showing that innovative types of services exist and that they are effective is key to supporting policy makers and other key actors to develop new services or transform existing services in compliance with human rights standards, making them an integral part of Universal Health Coverage (UHC).

This document also aims to highlight the fact that an individual mental health service on its own, even if it produces good outcomes, is not sufficient to meet all the support needs of the many people with mental conditions and psychosocial disabilities. For this, it is essential that different types of community-based mental health services work together to provide for all the different needs people may have including crisis support, ongoing treatment and care, community living and inclusion.

In addition, mental health services need to interface with other sectors including social protection, housing, employment and education to ensure that the people they support have the right to full community inclusion.

The WHO guidance and technical packages comprise a set of documents including:

- ***Guidance on community mental health services: Promoting person-centred and rights-based approaches –*** This comprehensive document contains a detailed description of person-centred, recovery and human rights-based approaches in mental health. It provides summary examples of good practice services around the world that promote human rights and recovery, and it describes the steps needed to move towards holistic service provision, taking into account housing, education, employment and social benefits. The document also contains examples of comprehensive, integrated networks of services and support, and provides guidance and action steps to introduce, integrate and scale up good practice mental health services within health and social care systems in countries to promote UHC and protect and promote human rights.

- ***Seven supporting technical packages on community mental health services: Promoting person-centred and rights-based approaches* –** The technical packages each focus on a specific category of mental health service and are linked to the overall guidance document. The different types of services addressed include: mental health crisis services, hospital-based mental health services, community mental health centres, peer support mental health services, community outreach mental health services, supported living services for mental health, and networks of mental health services. Each package features detailed examples of corresponding good practice services which are described in depth to provide a comprehensive understanding of the service, how it operates and how it adheres to human rights standards. Each service description also identifies challenges faced by the service, solutions that have been found and key considerations for implementation in different contexts. Finally, at the end of each technical package, all the information and learning from the showcased services is transformed into practical guidance and a series of action steps to move forward from concept to the implementation of a good practice pilot or demonstration service.

Specifically, the technical packages:

- showcase, in detail, a number of mental health services from different countries that provide services and support in line with international human rights standards and recovery principles;
- outline in detail how the good practice services operate in order to respect international human rights standards of legal capacity, non-coercive practices, community inclusion, participation and the recovery approach;
- outline the positive outcomes that can be achieved for people using good practice mental health services;
- show cost comparisons of the good practice mental health services in contrast with comparable mainstream services;
- discuss the challenges encountered with the establishment and operation of the services and the solutions put in place to overcome those challenges; and
- present a series of action steps towards the development of a good practice service that is person-centred and respects and promotes human rights and recovery, and that is relevant to the local social and economic context.

It is important to acknowledge that no service fits perfectly and uniquely under one category, since they undertake a multitude of functions that touch upon one or more of the other categories. This is reflected in categorizations given at the beginning of each mental health service description.

These documents specifically focus on services for adults with mental health conditions and psychosocial disabilities. They do not include services specifically for people with cognitive or physical disabilities, neurological conditions or substance misuse, nor do they cover highly specialized services, for example, those that address eating disorders. Other areas not covered include e-interventions, telephone services (such as hotlines), prevention, promotion and early intervention programmes, tool-specific services (for example, advance planning), training and advocacy. These guidance documents also do not focus on services delivered in non-specialized health settings, although many of the lessons learned from the services in this document also apply to these settings.

How to use the documents

Guidance on community mental health services: Promoting person-centred and rights-based approaches is the main reference document for all stakeholders. Readers interested in a particular category of mental health service may refer to the corresponding technical package which provides more detail and specific guidance for setting up a new service within the local context. However, each technical package should be read in conjunction with the broader Guidance on community mental health services document, which provides the detail required to also integrate services into the health and social sector systems of a country.

These documents are designed for:

- relevant ministries (including health and social protection) and policymakers;
- managers of general health, mental health and social services;
- mental health and other health and community practitioners such as doctors, nurses, psychiatrists psychologists, peer supporters, occupational therapists, social workers, community support workers, personal assistants, or traditional and faith based healers;
- people with mental health conditions and psychosocial disabilities;
- people who are using or who have previously used mental health and social services;
- nongovernmental organizations (NGOs), and others working in the areas of mental health, human rights or other relevant areas such as organizations of persons with disabilities, organizations of users/survivors of psychiatry, advocacy organizations, and associations of traditional and faith-based healers;
- families, support persons and other care partners; and
- other relevant organizations and stakeholders such as advocates, lawyers and legal aid organizations, academics, university students, community and spiritual leaders.

A note on terminology

The terms "persons with mental health conditions and psychosocial disabilities" as well "persons using mental health services" or "service users" are used throughout this guidance and accompanying technical packages.

We acknowledge that language and terminology reflects the evolving conceptualization of disability and that different terms will be used by different people across different contexts over time. People must be able to decide on the vocabulary, idioms and descriptions of their experience, situation or distress. For example, in relation to the field of mental health, some people use terms such as "people with a psychiatric diagnosis", "people with mental disorders" or "mental illnesses", "people with mental health conditions", "consumers", "service users" or "psychiatric survivors". Others find some or all these terms stigmatizing or use different expressions to refer to their emotions, experiences or distress.

The term "psychosocial disability" has been adopted to include people who have received a mental health-related diagnosis or who self-identify with this term. The use of the term "disability" is important in this context because it highlights the significant barriers that hinder the full and effective participation in society of people with actual or perceived impairments and the fact that they are protected under the CRPD.

The term “mental health condition” is used in a similar way as the term physical health condition. A person with a mental health condition may or may not have received a formal diagnosis but nevertheless identifies as experiencing or having experienced mental health issues or challenges. The term has been adopted in this guidance to ensure that health, mental health, social care and other professionals working in mental health services, who may not be familiar with the term ‘psychosocial disability’, nevertheless understand that the values, rights and principles outlined in the documents apply to the people that they encounter and serve.

Not all people who self-identify with the above terms face stigma, discrimination or human rights violations. a user of mental health services may not have a mental health condition and some persons with mental health conditions may face no restrictions or barriers to their full participation in society.

The terminology adopted in this guidance has been selected for the sake of inclusiveness. It is an individual choice to self-identify with certain expressions or concepts, but human rights still apply to everyone, everywhere. Above all, a diagnosis or disability should never define a person. We are all individuals, with a unique social context, personality, autonomy, dreams, goals and aspirations and relationships with others.

1.

Introduction

Community mental health centres provide care and support options for people with mental health conditions and psychosocial disabilities in the community. These centres are intended to provide support outside of an institutional setting and in proximity to people's homes.

The range of support options provided in these centres varies depending on size, context and links to the overall health system in a country. However, all of the good practices showcased in this document provide consultation services, including individual or group sessions in which a person can be supported to begin, continue and/or stop different forms of care such as counselling, therapy, or medication.

To support the people they serve, these services also emphasize the importance of social inclusion and participation in community life, and take actions to achieve these goals. In this context, peer support, and support in accessing employment and training opportunities, education, and social and leisure activities are important features. Many mental health centres actively take on a coordinating role in referring people to different services and supports in the community. The examples provided in the following section reflect the diversity of some of these different roles and activities.

It is important to note that all mental health centres showcased in this technical package take a holistic, person-centred approach to care and support, attempt to reduce power asymmetries between staff and the people using the service, and consider support beyond medical treatment.

In some countries, these community mental health centres are a fundamental pillar in the mental health system. Not only do they provide essential, community-based care and support, they also serve as a cornerstone for coordination and continuity of care. Ensuring that they provide care and support that is community-based, rights-oriented and focused on the recovery approach is therefore paramount.

The services described in this technical package were chosen following an extensive search and screening of services identified through literature reviews, a comprehensive internet search, an e-consultation and with input from existing WHO networks and collaborators. A detailed description of the methodology is provided in the annex of Guidance on community mental health services: Promoting person-centred and rights-based approaches. The selection process was based on the five human rights and recovery criteria, namely: respect for legal capacity, non-coercive practices, participation, community inclusion, and the recovery approach. Services from low-income contexts and under-represented geographical regions were prioritized where possible and/or appropriate, as well as services with evaluation data. One of the key challenges identified in reviewing the services was the lack of robust evaluation data. This challenge was encountered across all service categories. The need for greater investment in evaluating services is one of the recommendations made in the section on guidance and action steps in Guidance on community mental health services: Promoting person-centred and rights-based approaches. The services described in this technical package are not intended to be interpreted as best practice, but rather to illustrate what can be done and to demonstrate the wider potential of community-based mental health services that promote a person-centred, rights-based, recovery approach.

Providing community-based mental health services that adhere to human rights principles represents considerable shifts in practice for all countries and sets very high standards in contexts where insufficient human and financial resources are being invested in mental health. Some low-income countries may assume that the examples from high-income countries are not appropriate or useful, and equally, for high-income countries looking at the examples showcased from low-income countries. New types of services and practices may also generate a range of questions, challenges, and concerns from different stakeholders, be it policy makers, professionals, families and carers or individuals who use mental health services. The intention of this guidance is not to suggest that these services be replicated in their entirety, but rather to take and learn from those principles and practices that are relevant and transferrable to one's own context in providing community-based mental health services that are person-centred and promote human rights and recovery.

2.

Community mental health centres – description and analysis

2.1

Aung Clinic

Yangon, Myanmar

Primary classification: **Community mental health centre**

Other classifications:

☐ Community mental health centre ☑ Community outreach ☐ Peer support

☑ Crisis service ☐ Hospital-based service ☐ Supported living service

Availability in different locations:

☐ Yes ☑ No

Evidence:

☐ Published literature ☑ Grey literature ☐ None

Financing:

☐ State health sector ☐ State social sector ☐ Health insurance

☑ Donor funding ☐ Out-of-pocket payment

Context

Myanmar is a low-income country *(1)*, and one of the poorest countries in Southeast Asia. Yangon, with a population of seven million, is the largest city. Myanmar is ethnically diverse with over 135 distinct ethnic groups recognized by the government, the largest of which are the Bamar who make up almost 70% of the population. For decades, the country has witnessed considerable internal conflict with damaging consequences for people's mental health and the community *(2)*.

In 2017, Myanmar's spending on health care represented only 1% of GDP *(3)* – one of the lowest rates in the world. At the same time, its infant and maternal mortality rates are among the highest in Southeast Asia *(4)*.

Two psychiatric hospitals operate in the country (in Yangon and Mandalay) as well as 22 inpatient mental health units attached to general hospitals. A total of 120 beds exist in forensic mental health units *(5)*. In addition, 35 outpatient mental health clinics are based at general hospitals, seven of which are located in Yangon. These clinics operate 1-2 days per week providing assessments, diagnosis, prescriptions, support and follow-up.

The Aung Clinic is an innovative community-based mental health service located in Yangon. It is the only service of its nature in the country and collaborates with local government services as well as several national NGOs.

Description of the service

The Aung Clinic provides a range of interventions aimed at helping people with mental health conditions and psychosocial disabilities, outside of an institutional setting. The service is based on a holistic, person-centred approach to care which avoids a biomedical understanding of mental health. With this in mind, the use of medicalized language is avoided (words such as 'disease', 'disorder', 'syndrome') as well as stigmatizing labels such as 'lunatic', 'unsound person', and 'idiot'.

The clinic team is composed of a psychiatrist and a medical doctor who is also an art therapist, as well as five paid peer support workers. It is open from 09:00 until 17:00 daily, but also provides outreach services to individuals and families in their own homes, along with follow-up by telephone and online support if needed. Emergencies are responded to at weekends, wherever necessary.

Overall the clinic supports over 200 individuals and their families. It caters for a wide range of people with mental health conditions and psychosocial disabilities, as well as those with intellectual disabilities. No diagnostic group is excluded; individuals using the service include those who have received diagnoses of PTSD, psychosis, bipolar disorder, anxiety and depression, substance use, and people experiencing suicidal ideation. People are welcome to attend during the day, including those who are homeless, but there are no overnight stays. By spending daytime hours at the clinic, people in crisis are often able to avoid hospitalization.

Anyone is welcome to attend the clinic, but people intoxicated with drugs or alcohol are excluded while intoxicated. People who present with an acute physical health condition are referred to the general hospital and are welcomed back when they have improved. Anyone who is violent towards another person is referred to the local authorities, including the police if necessary. Every effort is made to de-escalate the situation, but if these attempts are not successful, people may be referred to the psychiatric hospital. Those service users presenting with suicidal ideation can be accommodated at the clinic if they are accompanied by a caregiver who can stay with them.

The service provides a full range of interventions including mental health assessments, individual counselling, group therapy, medication, vocational skills training, peer support groups, and support groups for families. Various forms of therapies are provided such as talk therapy, family therapy, mindfulness, occupational and vocational therapy. Art therapy is also provided *(6)*, which sometimes involves an income generation aspect through art exhibitions *(7)*. This initiative allows people who use the service to participate in sharing the profits from the sale of their art. Other interventions include help with reading skills, basic money management, mathematics, general life skills, training in carpentry and cooking, through a weekly cooking club.

Upon first attending the clinic, clients are assessed by the psychiatrist and a treatment plan is developed with the person, in line with their preferences. External support networks are explored and involved in the therapeutic process where possible (including family and close friends), but only with the consent of the person using the service. People choose to attend the clinic for various lengths of time – some for just a few visits and others for months or years.

The service has an active peer support group of 30 members which focuses on capacity-building, advocacy and improvement of the rights of people with mental health conditions and psychosocial disabilities. In addition, a family peer support group meets monthly. Through the work of these groups, people attending the clinic and their families learn their rights under the UN Convention on the Rights of Persons with Disabilities (CRPD) and are also supported to advocate for better treatment.

The clinic collaborates with other NGOs in Yangon, including the Myanmar Autism Association *(8)*, and the organization Future Stars *(9)*, which supports individuals with intellectual disabilities and their families.

Work with ethnic minorities

The team from the Aung Clinic has held training workshops with health workers from the Back Pack Health Worker Team (BPHWT) *(10)*, who provide health services to displaced ethnic minority communities such as the Karen, Kayan, Kachin, Chin, Shan, Palaung, Pa'O, Mon and Rakhine. Their work is conducted through community clinics and community-based interventions. To date, the BPHWT has provided support to around 80 people with mental health conditions and their families, in their communities.

The Aung Clinic staff have also helped with mental health education and training of general practitioners, junior psychiatrists and other mental health workers, and have promoted a human-rights agenda and holistic care approach in this work. Sometimes trainee health-care workers have been through traumatic and difficult experiences themselves, particularly those from ethnic minority groups, such as the Karen. Additional sensitivity is needed in the training work with these health workers.

Beyond its therapeutic and educational activities, the Aung Clinic advocates for the rights of people with mental health conditions and psychosocial disabilities, through working with schools, employers, and local organizations, to ensure that that they can participate in all aspects of life.

Core principles and values

Respect for legal capacity

Aung Clinic works to promote the voice, will and preferences of people with mental health conditions and psychosocial disabilities. Through its therapeutic activities, it seeks to empower people who would otherwise be at risk of institutionalization. The clinic aims to help people be more confident and have an increased sense of control over their lives. Those attending the clinic are encouraged to make their own choices and decisions about which treatments will be provided as part of their care plan, after discussion of the different options available. People can ask for help and support with decision-making, but advance plans are not used.

Prior consent is always sought if medication is to be considered, and information about the potential side-effects and limitations of the treatment is provided to service users. People attending the clinic receive help to reduce the amount of medication they are taking if they are experiencing disabling side-effects, and sometimes, they are able to cease taking medication altogether and rely solely on non-medical inputs.

While no formal supported decision-making strategies have been introduced, staff are careful not to impose their views and values to influence the decisions that people make concerning treatment and their life. In this regard, the Aung Clinic recognises that the power differential between staff members and the people using the service has the potential to influence decisions. Any new staff member is trained to recognize such dynamics and work to reduce them. People attending the peer support groups are encouraged to express their will and preferences, which are documented to ensure that treatment and support provided are consistent with their wishes.

Non-coercive practices

All clinic services are offered on a voluntary basis. No coercion is used in the clinic; people are not forced to take medication or to undergo any intervention without their consent. The staff make every effort to talk with people who are agitated in order to understand their needs and support them, so as to avoid the use of coercion and forced hospital admissions. Training is in place to help Aung Clinic staff members deal with tense situations through de-escalation measures. This training uses role-play to demonstrate the different ways in which people can react to situations, and to show how coercive responses can be hurtful and damaging.

However, people may sometimes be taken to a hospital where coercion is used. Extensive discussion takes place with the person and their family before referral to try to negotiate a non-hospital outcome. If this is not possible, a voluntary admission is sought with the agreement of the person involved. If an involuntary admission goes ahead, the Aung Clinic staff advocate against coercion and strive to have the person discharged as quickly as possible so they can be supported in the community.

Community inclusion

Aung Clinic also works intensively towards community capacity building, promoting the idea that people with mental health conditions or psychosocial disabilities should not be discriminated against in education or employment. The clinic itself seeks to be a model of community inclusion by creating a welcoming, supportive and all-inclusive culture at the clinic and also offering options to provide support to people in their homes. The clinic helps people find work by engaging with families and communities and advocating for people to be employed or re-employed. Its art therapy project has also created income generating opportunities. However, the service does not have specific interventions in the areas of housing or employment outside the clinic itself. In post-conflict areas, the service helps to build positive relationships in the community by participating in community development and political dialogues, which can help create the conditions for employment, educational and other opportunities for people with mental health conditions.

Participation

Through the peer support groups, the clinic creates a space for people who use the service to learn to articulate their wishes and preferences without power asymmetries, promoting a culture of empowerment of service users. Several peer support workers have been trained in basic counselling skills, in the management of meetings, and in basic writing and organizational skills. They have also received education about the CRPD. This group of peers is now paid for their support and development work in the organization, and the group members are part of the Aung Clinic's decision-making processes. They have liaised with other NGOs such as the Myanmar Federation of Persons with Disabilities, Future Stars and the Bethzatha Disabled Development Organization. Five women in the peer support group are leading advocacy efforts for women's rights. At present, two of them receive payment for this work, and it is anticipated that they will all receive payment in the future. Finally, informal feedback is actively sought from people who use the service and is then used to inform the clinic's practices.

Recovery approach

Recovery planning involves short-term and long-term goals, crisis planning, family input, medical input, specific therapies to be used, ways in which the person can help themselves, and advocacy needs. The clinic's approach aims to maintain the focus on solutions rather than the problems. In doing so, the staff seek to identify an individual's strengths and to work with these in order to help the person regain a sense of control over their life. Through this approach the clinic helps people to communicate more easily and with more confidence, and to find a sense of empowerment, meaning and hope. The service also seeks to help people find a role for themselves in society and promotes personal responsibility in order to achieve a positive identity.

Service evaluation

In 2020 an unpublished qualitative evaluation was conducted by an external counsellor. The evaluation involved three focus groups and five individual interviews *(11)*. The 20 participants reported positive gains from their attendance at the clinic and placed particular value on the art therapy and group therapy sessions. They spoke of finding 'acceptance' at the clinic and many said that they felt more able to manage their mental health problems since attending. In turn, this had led to a reduction in conflicts with family members and neighbours. One woman said: "I fought with my sons before and then I ran away from home. Now it does not happen anymore, because I can control myself". Another said: "Sometimes, we [my family] sit around like in group therapy, and we talk about what is inside our hearts. We appreciate each other".

Costs and cost comparisons

The Aung Clinic is a non-profit service and its services are provided free of charge to its users. It opened in 2010 without external funding and underwent an expansion in recent years with financial input from the Open Society Foundations. Between 2015 and 2016, The Aung Clinic received US$ 25,000 from the Open Society Foundations *(12)*, which increased to US$ 176,000 for the period October 2018 through to September 2020.

Challenges and solutions

Changing negative perceptions

One of the challenges in setting up the service was the widespread belief held by individuals, families, mental health professionals and the community that mental health conditions and psychosocial disabilities can only be addressed through the biomedical model. Another related challenge faced during the establishment of the clinic was the extensive social stigma about mental health conditions in the community.

Working with a person-centred and recovery-oriented approach yielded positive results which challenged preconceptions about mental health conditions as solely medical issues, as well as other negative misconceptions. Ongoing conversations and discussions with families and professionals have been important to explain the benefits of this approach. Providing the service in a non-clinical setting with a diverse workforce engaged in art therapy, peer support counselling, group therapy, amongst other activities, has also helped to shift misconceptions.

As a way of addressing stigma, the clinic works with the local media to advocate for social inclusion and the provision of better mental health care. The clinic also reaches out to workplaces to find employment opportunities for people with mental health conditions and psychosocial disabilities, which helps change negative community perceptions. Outreach work is also carried out in remote areas with the aim of reaching people from different minority ethnic communities.

One of the major achievements of the Aung Clinic has been the cultural change it has initiated through its educational work. The training provided by Aung Clinic has influenced the outlook of the staff working in the psychiatric hospital, making them more receptive to a new way of working. This educational element may help to offset the resistance to innovative approaches that is often found in individuals and organizations that benefit from the status quo.

Overcoming financing restraints

While the clinic would still exist without external funding, the range of interventions currently offered would not be possible. With increased funding the service could expand to other cities and communities in Myanmar.

One of the challenges currently faced by Aung Clinic is that the success of its work has led to more and more people seeking its support. At present, the clinic is able to offer its services free of charge thanks to external funding, and also subsidizes travel for individuals and families who have to travel long distances to attend.

To meet the growing demand, the service is contemplating the introduction of a sliding-scale payment structure as it is possible that some service users could afford to partly cover the costs. The clinic is also considering introducing fees for some of its educational work in the future. Future sales of art being produced in the clinic may also help to subsidize the programme. These solutions would serve to make the service more independent and financially sustainable in the longer term.

Another factor that has contributed to the financial sustainability of the service is its capacity to involve service users in the daily functioning of the clinic. The 30 peer support group members regularly volunteer to assist new people attending the service to sit, talk and cook together. People who use the service can continue to be engaged in the service's activities as peer supporters and stay involved in decision-making, often keeping in touch for many years.

Still, funding of the service remains an ongoing challenge. In August 2019, heavy rains caused severe flooding in Yangon and the clinic was badly damaged. Many of the rooms were flooded and required substantial repair work at a considerable cost.

Improving access

Access to the service was a challenge for people from outside the capital, Yangon, especially since the clinic does not offer overnight accommodation. As a solution, the clinic engaged with churches, monasteries and other sources of accommodation in Yangon, which meant that people from outside the capital could also come and access the service while staying overnight in one of these settings.

Addressing power asymmetries

The language used by health professionals often has an intimidating effect on people with mental health conditions and psychosocial disabilities, their families and people from ethnic communities. This can have the effect of undermining their confidence to speak about the things that they find helpful or unhelpful. It also undermines the gains that can be made through a recovery approach and the peer support work.

To overcome this obstacle, the clinic encourages people to have confidence in their own way of speaking about mental health and healing, and not to be intimidated by professional approaches, helping people to express themselves in their own words.

It can also be challenging to integrate new ideas about mental health (such as the recovery approach) with the ways that people already conceptualize their mental health and healing. The clinic has found ways of incorporating a person-centred and recovery-orientated approach with already existing cultural practices, such as meditation and art.

Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- using international frameworks to embed and promote the work of the service, for example, health as a human right, the CRPD, UHC and the Sustainable Development Goals (SDGs);
- embracing a long-term vision, persistence and patience;
- employing a strategic combination of therapeutic interventions, advocacy and educational work;
- emphasizing simplicity, flexibility and accommodation of the service to the needs of people with long term mental health conditions and psychosocial disabilities;
- focusing on partnerships and collaborations with other services and initiatives;
- creating positive relationships with other mental health services, including the state psychiatric hospitals, especially through the provision of training;
- remaining open to use whatever resources are available to help people find a path to recovery, such as art and cooking; and
- promoting the participation of the younger generation researchers (such as PhD students, counsellors and psychiatrists) in research and evaluation of human rights-based recovery-oriented services.

Additional information and resources:

Website:
https://www.aungclinicmh.org

Videos:
Myint Myat Thu. Healing Images: Exhibition Showcases Works by Art Therapy Patients. 2019. (In Burmese)
https://burmese.voanews.com/a/myanmar-mental-health-arts/5487323.html

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2.2

Centros de Atenção Psicossocial (CAPS) III

Brasilândia, Brazil

Primary classification: **: Community mental health centre**

Other classifications:

☐ Community mental health centre

☑ Community outreach

☑ Peer support

☑ Crisis service

☐ Hospital-based service

☐ Supported living service

Availability in different locations:

☑ Yes

☐ No

Evidence:

☑ Published literature

☑ Grey literature

☐ None

Financing:

☑ State health sector

☐ State social sector

☐ Health insurance

☐ Donor funding

☐ Out-of-pocket payment

Context

Mental health care in Brazil is provided under the Unified Health System (*Sistema Único de Saúde* (SUS) through a diverse range of services including community-based mental health centres – *Centros de Atenção Psicossocial* (CAPS) *(13)* – which are well integrated at the primary care level. CAPS provide care and support to individuals with severe or persistent mental health conditions and/or psychosocial disabilities, including during challenging and crisis situations. They were developed to replace the role traditionally played by psychiatric hospitals.

The various types of CAPS services are classified according to the size of the population area covered. CAPS I services serve the adult population in catchment areas of over 15,000 people, CAPS II in areas of over 70,000 and CAPS III in areas of over 150,000 people. CAPSi serve children and adolescents, and CAPSad provide support for problems and needs associated with substance use. Alternative configurations are also possible: for example, while CAPS I and CAPS II services mainly serve the adult population, they may also provide care and support to children and adolescents to ensure access to community-based support where a CAPSi is not available. CAPSi III services cater for adults as well as children and adolescents with mental health conditions and psychosocial disabilities, in areas with a population of over 150,000. Most CAPS operate weekdays during regular hours, but CAPS III services operate 24 hours a day, seven days per week, providing overnight accommodation if needed *(13)*.

This service description focuses on CAPS III Brasilândia, which serves a population of 430,000 people in the Municipality of Sao Paulo, Brazil. The centre's catchment area has a high prevalence of favelas and experiences high levels of urban violence and social vulnerability.

The Brasilândia region benefits from a diverse network of mental health services comprising a variety of community-based services. For example, the region has a CAPSi II for children and adolescents and a CAPSad III for adults with problems and needs associated with substance use. Also linked to CAPS

III Brasilândia are three independent living facilities (*Serviços Residenciais Terapêuticos* (SRTs) and 19 community-based primary health centres (*Unidade Básica de Saúde* (CBHC). The CBHC are the first point of contact in the healthcare system in Brazil, providing basic community care. Thirteen of the CBHCs in Brasilândia host Family Health Teams which provide outreach services, creating stronger links between the community and the CBHC.

The region's network of mental health services also includes five Family Health Support Centres (*Núcleo Ampliado de Saúde da Família* (NASF) *(14)* which support the Family Health Teams and CBHCs. NASF centres house multidisciplinary teams with specialist expertise, including in the area of mental health. They may provide support through discussing clinical cases, doing shared consultations with the Family Health Teams and CBHC teams, collaborating in the development of person-centred recovery plans, and delivering prevention and health promotion activities. They also work closely with CAPS services, referring and discussing mental health cases.

This integration of and linkages between the primary health and mental health care networks in the region within the SUS, has received substantial support and input from social movements, professionals, service users and family members *(15)*. As a result, the services and programmes implemented in the region have historically placed an emphasis on practical actions, reaching the community, and learning about people's histories and needs *(16)*. This approach is particularly reflected in how CAPS III Brasilândia has developed its practices, with the aim of stopping admissions to psychiatric institutions.

Description of the service

CAPS III Brasilândia began in 2002 as a CAPS II service and in early 2020 became a CAPS III, operating 24 hours a day, seven days per week. The service is managed by the Family Health Association (*Associação Saúde da Família*), a social organization.

As a CAPS III service, the centre provides continuous, tailored and comprehensive community-based mental health care and support to people with mental health conditions and psychosocial disabilities, including during challenging and crisis situations. The service uses a rights-centred and people-centred approach with value-driven actions based on the principles of freedom first and deinstitutionalization. Its primary goals are to provide psychosocial care, promote autonomy, address power imbalances and increase social participation. Rather than expecting people to adapt to pre-established service practices, the centre adapts its practices to meet service users' demands and needs through continuous engagement.

The centre follows the standard design and goal of all CAPS centres, that is, to create a structure and environment similar to that of a house. Staff do not wear uniforms and the decoration of the centre is done with the participation of service users and family members. The centre has an open and transient daily life with service users, team members, professionals and family members using the space in a relaxed and informal manner. Members of the community who are not service users may also access the centre, for example, to visit the clothing bazaar the centre holds as part of one of its employment and income generation projects.

Structurally, CAPS III Brasilândia has indoor and outdoor common areas for socializing and interacting with others, a dining area, space for individual counselling, a room for group activities, a pharmacy, and female and male dorms, each with four beds. Activities are held not only within the centre but also in the community using public spaces such as parks, community leisure centres and museums. Activities may be planned (such as the regular Hearing Voices meeting) or may be simply in response to a specific interest or request from the individuals that use the service. A designated staff member is available at a set time each day for this type of activity.

The centre has 58 paid staff members working in shifts including: a manager, three psychiatrists, a clinical physician, four psychologists, social assistants, physical educators, a pharmacist and pharmacy technicians, nurses and nursing assistants, occupational therapists, workshop professionals, administrative assistants and a receptionist.

Approximately 400 individuals attend the centre on a regular basis every month and on average, 60 new individuals per month attend first consultations. Some people use the service more often and others less, according to individual needs. CAPS III Brasilândia serves a total of 1174 people.

Accessing the centre

As a CAPS service, the centre has an open-door policy and there are no restrictions on who can use the service. Individuals in acute crisis can be welcomed and supported, and there is no involuntary admission or forced use of the centre. The centre has processes in place to ensure that no one is refused access based on centre capacity. Designated staff are available to handle first appointments daily, and the service links with other CAPS III services for accommodation if it is full. People may walk in without an appointment to have a first meeting, or they may be referred by another service, or can be visited at home.

At a first meeting, called "*Acolhimento*" (meaning "welcoming"), the aim is to create a welcoming and positive dynamic, and meet an individual's needs in that specific moment. The welcoming team member explains the service and together they begin the process of identifying whether the centre is the right service for that individual. Team members listen to understand the needs and wants of the individual, their personal history, their social and support network and general mental health. Information from the first meeting is recorded, and the service user has access to this information at any time.

A formal mental health diagnosis is not required to access the service. Instead a broader interpretation of need is used, based on personal history, mental health needs, social network available to the individual, social relations and social vulnerability. After the first meeting people are offered to be registered at a CAPS if they are experiencing significant suffering and social vulnerability or if living with a severe or persistent mental health condition and/or psychosocial disability. However, if their needs are different and can be met by another service in the network, the person is directed to that service. There may also be a further period of mutual evaluation, during which people are encouraged to get to know the service better by attending activities, to form a better understanding as to whether the centre will best meet their needs.

Supporting the individual

The ongoing care and support provided by the CAPS is based on the current circumstances of the individual (home life, relationships, work, school etc.) as well as a person-centred, individual recovery plan written by each individual (*Projeto Terapêutico Singular* (PTS), with the support of their reference practitioner and sometimes family as well *(13, 17)*. Reference practitioners are the designated team members who become most familiar with the service user's personal history, needs, wishes and interests. The use of a reference practitioner is a strategy commonly implemented at CAPS to ensure that every service user has strong relationship with at least one team member.

Developing a PTS is seen as a strategy to empower people to take charge of their own recovery process *(18)*. It is a tool for the service to relate to the person using the service and engage in a single coordinated care pathway and is reviewed and updated on a regular basis. The PTS is goal oriented and covers various dimensions of the person's life including personal history, the individual's wants and needs, social relationships, current life context, challenges, strengths, life goals, and diagnosis. In developing their PTS, service users are encouraged to reflect on their future and take appropriate positive risks. The PTS also focuses on promoting an individual's rights and supporting them to exercise and enjoy these rights, including those related to housing, work and social networks (for example, living independently but in a comfortable and safe home; or working but with fair remuneration).

Wide-reaching community approach

As a community-based service, like all CAPS III centres, CAPS III Brasilândia strives to fully engage with and understand the community as well as the individuals who live there. In practice, this can mean talking to people in the community to understand the social dynamics and map the frequent problems that most impact people's lives and mental health (for example, police violence, threats from drug trafficking, social vulnerability, economic hardship, lack of adequate housing, lack of employment, etc.) to gain a better understanding of possible mental health demands and psychosocial needs. CAPS III Brasilândia team members also identify and activate community resources and create partnerships with people and services to carry out mental health care initiatives. One such example from the CAPS network in Brasilândia are the public debates held to discuss the problem of police violence against black people. São Paolo has one of the highest rates of police murder of youth, most of which are black *(19)*. Holding such meetings to discuss community issues is a way of recognizing the mental health impacts on service users who experience racism and discrimination.

All CAPS services, including CAPS III Brasilândia, engage with the community more specifically through actions to reduce stigma around mental health, promoting the rights of people living with mental health conditions and psychosocial disabilities, and creating positive opportunities for them to engage in the community. The Touring CAPS initiative (*CAPS Itinerante*) developed by CAPS III Brasilândia is an example of such community engagement. Through this initiative the centre visits isolated areas within its catchment area and holds events in public spaces to promote awareness of the centre, reduce stigma and promote a better understanding of mental health at a community level. The centre may also provide consultations during these visits. Local community leaders are involved, local performing artists are invited to perform, and refreshments are provided. The centre also proactively builds positive relationships with local businesses, institutions and services to create positive opportunities for social engagement, for example through local Carnival parades and participation in football championships involving teams of CAPS network users and community members.

CAPS III Brasilândia supports service users to actively participate in the community through accompanying them on their daily activities and supporting them to explore and participate beyond their immediate community. It helps them to work through conflicts in interpersonal relationships, including with families, and to gain the skills and motivation to autonomously and independently engage in their community. To support the community's needs, CAPS III Brasilândia also holds monthly meetings with the regional health network and mental health network. The centre works on the basis that the community's needs are the collective responsibility of all services in the network. If there is a challenge for any one service in the network, finding a solution is everyone's responsibility.

In-centre stays

Service users have the option to stay at CAPS III Brasilândia, either in a time of crisis or as a form of respite, or if an individual feels they may benefit from additional, constant support. Up to eight people can be accommodated at the centre and stays are limited to a maximum of 14 days (this period can be extended if necessary, but the centre is proactive in avoiding this). There are no restrictions as to how often a person can stay at the centre, and individuals who use drugs are not required to abstain from drug use to access the centre at night.

Rights-oriented working groups

To support its work, the service relies on five working groups aligned with its principles, four of which include service users:

- ✓ **Housing working group *(Moradia)* –** The housing working group promotes the right to have an adequate standard of living and includes service users. It is responsible for the link between CAPS III Brasilândia and the independent living facilities (SRT) in the region. The SRT are effectively houses located in the community, designed for people who have previously been hospitalised in psychiatric or custody hospitals for at least 2 years but who require housing support to live in the community. Every SRT is linked to a dedicated CAPS for the use of its residents. Each individual's PTS is developed jointly between the individual, the CAPS team and the SRT workers. This working group is also responsible for identifying other housing strategies (for example, shared accommodation) for service users who are homeless, for making improvements to dignify homes of people who live in houses with high levels of precariousness and vulnerability, and for working with the housing sector to identify the best ways to access adequate housing.
- ✓ **Work and income generation working group *(Geração de trabalho e renda)* –** This working group promotes the right to work and includes service users. It focuses on developing and running work and income generation projects, and presenting supported job opportunities in the common market, mediating, if needed, between service users and potential employers. The working group considers that the right to work is linked to guaranteed income. It supports the service users to deal with the challenges in maintaining income generation activities and employment, and to overcoming stigma and discrimination in the work environment.
- ✓ ***Territory-community* working group *(Território)* –** This working group promotes the right to live independently and be included in the community, and includes service users. It is responsible for mapping and understanding the community's resources, services, associations, social relations and culture, and creating bridges with the service and social support networks. Actions include identifying positive spaces beyond the centre such as public parks, neighbourhood associations associated with defending rights, or a community music group. With this information the team can facilitate group access to community activities and help improve social relationships. This working group is also responsible for promoting cultural activities in conjunction with other services and resources in the network.

- ✓ **Crisis working group *(Crise)* –** The Crisis working group promotes the right to receive care and support in a community context in any situation. Its actions are based on the theoretical and practical principles of deinstitutionalization and Open Dialogue (for more information see Mental health crisis services*: Promoting person-centred and rights-based approaches*). Members of this working group provide additional support in addressing crisis situations and are rotated daily from the centre's team members. In the event that a service user is facing a more complex situation, a member of this working group works together with the reference practitioner of that individual to provide additional support and input.
- ✓ **Art and culture working group *(Arte e cultura)* –** This group focuses on the promotion of diversity, the development of opportunities for interaction, and increasing the power of service users within the service. It includes both staff and service users. The service sees cultural projects as an important tool in the recovery process, in that they provide diverse ways for people to express themselves, to participate in building up the centre with artistic interventions, and to form social connections. Through participation in the working group, members have the opportunity to engage in different experiences, engage and interact with others, increase their confidence and power within relationships, and to develop skills that are important to daily life, including during challenging or crisis situations. Members also identify cultural activities in São Paulo that they can participate in, and host art and culture workshops that are open to all users of the service.

Providing proportional and responsive support

The service uses a vulnerability rating (*Classificação de vulnerabilidade*) to provide an overview and framework for assessing the complexity of people's situations and care and support needs. It takes into consideration an individual's social vulnerability, social support network and any risks to this support network, severity of mental health symptoms and risk of hospitalization. The table is updated regularly to reflect the individual's change in circumstances and well-being. Using such a tool helps the service to actively provide support proportional to an individual's needs, and at the service level, to support management of the centre and its resources.

The service also uses a framework that maps out and provides an overview of service users in challenging and crisis situations. To ensure responsive support, the team meets daily to review the framework and discuss service users facing challenging and crisis situations, agreeing actions and related timelines. Two further daily meetings are held for updates and sharing the working process. This structured process provides a safety net for those who are in a particularly vulnerable position on any given day, to ensure they receive any support needed. A weekly meeting is held for continuous training, further discussion of service users' care paths and review of working processes.

Reducing admissions to psychiatric institutions

The centre does not refer people to psychiatric hospitals and aims to reduce admissions to psychiatric institutions. Concretely, the team checks the local emergency health service bed map daily to monitor if any CAPS users (registered or non-registered) have been taken to the emergency services due to mental health reasons. If so, a member of the team meets with the person (and/or a family member if needed) at the emergency service, to discuss the support and care needed and to try to arrange appropriate care in the community. .

Core principles and values underlying the service

Respect for Legal capacity

Recognition and promotion of the legal capacity of individuals with mental health conditions and psychosocial disabilities is at the core of the CAPS services, and this is reflected in the centre's method of working and the practices of its team members.

The centre supports service users to exercise their legal capacity in everyday life, promoting autonomy and encouraging and supporting people to make their own decisions. Attending the centre is voluntary, and individuals cannot be referred to or receive treatment at the centre without their consent. Each person develops and mutually agrees their individual PTS. The centre acknowledges and seeks to increase each individual's contractual power, which refers to the power of every person to be recognized and valued in social relationships and to be able to communicate and to negotiate in real-life settings (for example, opening a bank account, shopping, getting a job, etc.). Strategies and actions are developed within the community to increase an individual's social participation, autonomy and self-confidence in decision-making, to empower people and create opportunities for social exchanges.

Non-coercive practices

Promoting non-coercive practices is a key principle of the CAPS model. Seclusion has never been used at CAPS III Brasilândia. The service is guided by the principle that violence towards any individual at the service and the use of restraints is unacceptable. However, the service reported three instances of using mechanical restraints in the period from February 2019 to February 2020. On each occasion, a team member remained with the individual and the restraints were used for less than one hour. After each occurrence, the service met to identify where and why the service has failed.

All support practices and care for individuals, including medication, are discussed and mutually agreed. If an individual does not wish to take medication, other care strategies, such as daily home visits, can be offered. An individual in crisis is never referred to another service where coercive practices could be used. In crisis or challenging situations, team members seek to understand the wider context of the situation rather than focusing solely on a person's presenting state or symptoms, and the crisis working group is available to provide additional support if required.

Efforts to end coercive practices are further supported by an everyday focus on power imbalances and their consequences. Staff members are encouraged to establish horizontal and reciprocal relationships with those that use the centre and actively work together to address power imbalances. For example, service users may freely enter and use all the centre's facilities including the staff room.

Community inclusion

At an individual level, service users at CAPS are supported to actively identify their community inclusion goals in their PTS. Each CAPS promotes care and inclusion strategies in the community, in dialogue with service users and according to the resources of the community. The centres' activities in the wider community also bring the individual into the community in positive ways. The Territory-community working group identifies positive community locations such as welcoming cafes or groups that can support an individual's inclusion in the community. If there is conflict in the community involving someone who attends the centre, the CAPS III Brasilândia assumes that it is not an individual problem, but a service or community issue that needs to be addressed. This approach ensures that community inclusion is not solely the responsibility of the individual, but that it concerns the community and mental health service network as a whole.

Participation

As a CAPS III service, the involvement of individuals with lived experience is a fundamental underlying principle. The service holds a daily assembly (*Grupo Bom Dia*) bringing together team members and service users to discuss the day ahead and decide if the planned activities need adjustments. A weekly assembly is also held during which all service users are encouraged to express their points of view about the service's practices and guidelines, identifying problems and finding common solutions. It is also an opportunity to deal with power imbalances and to discuss common social problems, such as stigma and violence. About 60 people, including service users, family members and professionals, participate in the assembly each week.

As another method of encouraging participation, service users are represented on three of the four working groups. CAPS III Brasilândia also encourages service users to take an active role in leading group meetings, including the Hearing Voices group and the Peer Support group. These activities are organized by service users with the support of team members. Service users can also participate in the Management Council, a consultation group for high-level public policy decisions developed in all health services under the Unified Health System. This is a practice regulated and common to every CAPS service. A similar practice across CAPS is the consultation of and engagement by service users in municipal, regional and national level mental health conferences on the development and implementation of mental health public policy and guidelines.

Recovery approach

The principles and philosophy of the person-centred recovery approach in CAPS III Brasilândia are evident in the way its services are provided. For example, individuals take an active role in articulating their own PTS *(17, 20)*. Through this process they are empowered to take charge of their own recovery process and are supported to identify their needs and wants, discuss life projects, and agree care and support strategies with shared responsibilities *(18)*. The community focus of CAPS III Brasilândia further ensures that an individual's recovery journey is actively supported beyond the centre. By creating positive social opportunities and by supporting a person in daily life, the service supports and equips that person to actively and autonomously engage and integrate in the community.

Service evaluation

Since 2002, a total of 12,333 people have used the CAPS III Brasilândia service. An evaluation of the service *(21)* took place in August 2020 using the World Health Organization's QualityRights assessment toolkit *(22)*. The evaluation was announced to the staff and included observation, a review of service documentation and interviews with four service users and four staff members, based on the five themes of the QualityRights assessment toolkit drawn from the CRPD. The service users interviewed included two men and two women with different care pathways and different enrolment times at the service. One of the interviewees used the night service. The evaluation found a service approach consistent with a human rights and recovery-oriented approach to community-based mental health care. All five themes of the QualityRights assessment toolkit were fully achieved.

Theme 1: The right to an adequate standard of living and social protection (Article 28 of the CRPD)

The standards for this theme were achieved in full. The physical structure of the service incorporated elements of home life including comfortable and clean indoor facilities with no restrictions in terms of access of rooms, a large outdoor space, fruit trees and barbeque for shared use. The facilities were well maintained, and snacks and meals were provided daily to those in the service. Further, the service has developed practices so that together, service users and staff can reinvent the physical structure and decoration of the service, rethinking the use of each environment. The day-to-day service is supported by practices of "doing together" and "being together". The individuals who use the service confirmed the observation's findings and described the space as "pleasant", "airy", adding that they felt "at home" and "at ease" in the space.

Theme 2: The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD)

The standards for this theme were achieved in full. Individuals who used the service were found to be supported in both their mental and physical health through individual person-centred plans (PTS), multidisciplinary staffing and support, and service and community initiatives. The service users confirmed being supported to meet their mental and physical health needs for example, receiving support to renew a prescription, at times of crisis and during difficult personal circumstances, to maintain contact with their social network, and to encourage independent living in the community. Individuals reported having access to medication and described open discussion and collaboration amongst professionals and service users regarding medication use (for example, regarding potential side-effects). While the service links to other service, ensuring access to comprehensive health care, it was reported that service users encountered barriers in accessing other general health services, due to stigma and prejudice.

Theme 3: The right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD)

The majority of the standards for this theme were fully achieved. Observations and interviews with service users confirmed team members' respectful approach toward the individuals who use the service. In particular, the service users were seen to be actively engaged and respected in their opinions and preferences regarding the service, their use of the service, and treatment options (for example, choosing to receive treatment at a convenient time, or receive medication orally rather than by injection, and receiving clear information on the differences). Individuals interviewed also confirmed that they are given the option to not take medication; but that if the service understands that medication is an important care resource for the person, staff discuss with the person potential benefits for its use. Service users were able to express and discuss their opinions in interactions with staff and others in the assembly and the Management Council, and also had free access to the Coordinator's room. Admission and treatment are based on the informed consent of the individuals who use the service; however, this is based on a verbal agreement. The evaluation found that the practices of the centre are based on the principle of freedom first. The interviews indicated that this principle is responsibly implemented through the fundamental reciprocity of the relationship between staff members and service users, which supports quality relationships based on open dialogue. Although the service does not use advance directives, the wishes and preferences of people are reflected in their PTS and are respected.

Theme 4: Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD)

The standards for this theme were achieved in full except for one which was partially achieved. Service records showed that regular meetings are held to prevent all instances of abuse. The Crisis Situation Panel was observed to undertake diverse actions to provide support to people experiencing a crisis situation. When supporting an individual, the person's preferred methods of intervention are respected, for example, if they prefer to be treated at home, or to have the presence of a team member but be given space. The main aim is to find a safe solution which is acceptable to the person in crisis. During observation of the service and in interviews, no service user was seen or was reported to be subjected to verbal, physical, sexual or mental abuse. The service records any significant events or needs of individuals as part of a hand-over process between team members. On inspection, no situation had been reported as disrespectful or violent in the previous year. The evaluation found that seclusion and restraint are not used in the service.

Theme 5: The right to live independently and be included in the community (Article 19 of the CRPD)

The majority of the standards for this theme were achieved in full. The service was found to promote community participation through informing and supporting individuals to access housing and financial resources; facilitating work and participation in an income generation group; and supporting job searches and applications. The service also provided a range of group activities to inform and support users in diverse areas including social, cultural, religious and leisure activities. However, there was no specific initiative focused on providing access to formal education (primary, secondary or post-secondary education).

While the evaluation included a comprehensive review of documentation and a period of observation, the interviews were based on a small sample of service users and staff. Despite this limitation, the evaluation did provide sufficient information so as to validate the service description provided above.

From a broader perspective, Campos et al. found service users and their families to have high levels of confidence in CAPS III services at a time of crisis and psychosocial rehabilitation *(23)*. This finding supports the general approach taken by CAPS III services in providing a community alternative to hospitalization or institutionalization, in terms of both continuous support, and support at times of crisis.

Costs and cost comparisons

CAPS III Brasilândia was established as part of a wide psychiatric services reform in Brazil, with resources reoriented from psychiatric hospitals to community-based mental health services, to develop a community-based mental health care network. CAPS services are delivered and financed entirely through the SUS, funding for which is protected by law with contributions from federal, state and municipal entities. Operational costs of CAPS services are covered by the federal government (50-70% of total cost of service) with the remaining amount provided by the municipality.

In 2020, CAPS III Brasilândia had a monthly cost of approximately 500,000 Brazilian Real (roughly equivalent to US$ 91,500)[b]. On a per person basis this equates to an approximate cost of R$ 1,100 (US$ 200)[b] per person using the centre in an average month, which is lower than the cost of hospitalization in a psychiatric hospital in Brazil. As a benchmark of the typical costs in Brazil, hospitalization for periods of less than 30 days in psychiatric hospitals costs R$ 1,700-2,400 (approximately US$ 300-430)[b]. For periods greater than 90 days, this value decreases to R$ 1,200-1,900 (approximately US$ 200-350)[b] *(24)*.

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[b] Conversion rate as of January 2021.

It is also important to note that because of the nature of CAPS services and their broad range of activities (for example, partnerships with other services, mental health promotion and prevention, activities to combat stigma and prejudice, community events, etc.), there is a wider set of beneficiaries than those who access the service directly. This wider benefit is not reflected in the above service cost per person calculation.

There is no cost to the individual to use the service, because CAPS services are delivered under the public health system, free of cost at the point of services.

Challenges and solutions

Changing the dominant mental health culture

Since their inception, CAPS services have faced a dominant mental health culture based on psychiatric hospitals, violation of human rights and power asymmetries. To address this challenge, CAPS services undertake continuous dialogue and negotiation with health and intersectoral networks, and have established agreements among people and services, developing shared working processes aimed at deinstitutionalization and guaranteeing rights across the public mental health network. Further, CAPS services invest in the development and strengthening of strategies and opportunities to democratize participation in the service, seeking to overcome power imbalances.

Identifying community health needs

Another challenge common to all CAPS services is the lack of knowledge about community mental health needs and demands, and the available resources in the community. In response, CAPS services make constant, proactive efforts to understand and get closer to the community, learn about its particularities, its culture and social relations, mapping and activating services and resources in the community and taking responsibility for the mental health demands of the catchment area.

Addressing insufficient training

CAPS services also face the general and ongoing challenge of personnel insufficiently trained in practices aligned with mental health public policy and CAPS principles and guidelines. To overcome this obstacle, CAPS services undertake continuous collective training based on practice and critical thinking, focusing on: public quality care, respect for human rights, the principle of freedom first, and CAPS principles and guidelines.

Avoiding institutional inertia

At times CAPS III Brasilândia faces moments of institutional inertia and standstill when the service finds itself less open to reinvention and to critically rethinking power relations and its own practices.

To avoid and overcome this risk the organization puts into practice deliberate strategies including:

- holding assemblies to facilitate open discussions, deal with conflicts and question power relations;
- engaging stakeholders in mental health forums and movements to promote broad and democratic participation in building up the service and the mental health network;
- critically reassessing practices and services through dialogue;

- continuously involving and engaging stakeholders and networks in dialogue to deinstitutionalize practices, knowledge and attitudes, and build a culture of rights;
- providing ongoing training and capacity building based on the practice of deinstitutionalization; and
- placing service users at the center of all service policies and practices, expanding participation so that the quality of relationships between people can guide the service in the practices of freedom first.

Facing insufficient funding

CAPS services in general face insufficient financial investment in public health and community mental health services. Continued government commitment and ongoing availability of the necessary public funds are critical to sustain the CAPS and other community-based mental health services.

Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- developing all practices with the recognition of people's citizenship and the principle of freedom first as a starting point;
- putting people's needs at the center of all practices, including the needs for a home, work and social relationships;
- critically reflecting on practices, paying attention to the dynamics of power asymmetry and developing critical and innovative strategies to deal with challenges;
- reinventing the service regularly, proposing new transforming policies and practices through deinstitutionalization;
- establishing partnerships with the community-based service network and the community itself, building dialogues and activating resources;
- investing heavily in human resources and training, as people are key resources to deliver good quality mental health care; and
- moving towards a diverse and multidisciplinary workforce within a wider mental health network to meet the evolving mental health needs of a community.

A further discussion of CAPS services and the mental health network is included in *Mental health service networks: Promoting person-centred and rights-based approaches.*

Additional information and resources:

Website:
https://www.prefeitura.sp.gov.br/cidade/secretarias/saude/atencao_basica/index.php?p=20424

Videos:
Projeto coletivo de geração de trabalho, renda e valor - Ô da Brasa (Work, income and values generation collective project - Ô da Brasa)
https://www.youtube.com/watch?v=5v0jki3GaBw&feature=youtu.be

Contacts:
Coordination of the Technical Area of Mental Health, Municipal Health, Secretariat,
São Paulo, Brazil.
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2.3

Phoenix Clubhouse

Hong Kong Special Administrative Region (SAR) China

Primary classification: **Community mental health centre**

Other classifications:

☐ Community mental health centre ☐ Community outreach ☑ Peer support

☐ Crisis service ☐ Hospital-based service ☐ Supported living service

Availability in different locations:

☑ Yes ☐ No

Evidence:

☐ Published literature ☑ Grey literature ☐ None

Financing:

☑ State health sector ☑ State social sector ☐ Health insurance

☐ Donor funding ☑ Out-of-pocket payment

Context

Hong Kong SAR is a city of over seven million people and is classified as a Special Administrative Region of the People's Republic of China. The government funded Hospital Authority is the main provider of mental health services in the city. It provides hospital-based in-patient and outpatient services, as well as community-based mental health services, in collaboration with the Social Welfare Department, NGOs and other stakeholders in the community *(25)*.

In 1998, to provide ongoing support for people in contact with the mental health service, the Queen Mary Hospital Department of Psychiatry together with the University of Hong Kong, established the Phoenix Clubhouse. The service is part of the Adult Psychiatric Day Hospital of Queen Mary Hospital, and is financed and managed by Queen Mary Hospital under the Hospital Authority. The aim of establishing this service was to provide a community-based rehabilitation service based on the clubhouse approach, which first emerged in the United States.

The Clubhouse approach incorporates a strong element of peer support and first began in New York in 1944 with the creation of Fountain House *(26)* in Manhattan *(27)*. The Fountain House mission is to provide opportunities for men and women with mental health conditions and psychosocial disabilities to live, work, and learn together while contributing their talents through a community of mutual support, with the aim of helping people stay out of hospital while achieving their social, financial, and vocational goals *(28)*.

Phoenix Clubhouse is now one of 326 clubhouses around the world that are affiliated with Clubhouse International. Clubhouses exist in 33 countries and 36 states across the USA *(29)*. Clubhouses use a social franchise approach *(30)* and rely on both government and philanthropic funding. Each Clubhouse is organized as an independent centre, linked to Clubhouse International (the network's coordinating centre in New York) via an annual membership fee and a formal accreditation programme *(31)*.

The Clubhouse model is organized around an internationally agreed set of standards *(32)* (the International Standards for Clubhouse Programs) *(33)*. These best practice standards include all aspects of the operation of a clubhouse, including membership, the physical structure, location, daily functioning, access to employment and education, funding, and governance. Clubhouse International coordinates a comprehensive training programme which delivers a consistent approach to the functioning of clubhouses. The training is delivered through 12 authorized training centres globally: two in Asia (including Phoenix Clubhouse), six in North America, three in Europe, and one in Australia *(34)*. In 2005, Phoenix Clubhouse began offering orientation programmes for others wanting to set up a similar service. In 2016, it became a Clubhouse International Training Base and is currently the only Training Base for Chinese speaking communities. In total, 21 organizations have attended the training, of which 25% are now accredited by Clubhouse International.[c]

Description of the Service

Membership vs service-users

Of great importance to the Clubhouse Model is the fact that the people using the service are considered members, rather than service-users. Membership of the Clubhouse can be lifelong. This encourages a sense of ownership and long-term commitment on the part of those who use the Clubhouse. Longer term members of Clubhouse are able to support newer members on their journey.

Phoenix Clubhouse members are people between the ages of 18 and 64 who have been referred by psychiatrists at Queen Mary Hospital and the Western Psychiatric Centre. Phoenix Clubhouse is an open service in that there are no exclusion criteria (with the exception of violent behaviour). The service currently has nearly 600 members, 150 of whom are active members, in that they use the facility at least once a month. The average attendance level is 54 members per day *(35)*. Most of the people who attend are residents of Hong Kong Island and the outlying islands.

Clubhouse staff

A total of nine staff are employed by Phoenix Clubhouse; three are professional staff deployed from the Occupational Therapy Department of Queen Mary Hospital, and six are general staff with care or administration-related experience. A group of volunteers also supports the work of the Clubhouse, assisting with in-house training and social programmes.

The recruitment process for general staff involves both members and staff, with the support of hospital management. Members are involved in discussions regarding candidate requirements and take part in recruitment meetings for shortlisted candidates, alongside staff. An open forum is held afterwards, in which staff and members discuss the performance of each candidate. The final selection is made based on the consensus of staff, members, the Clubhouse Director and representatives from the Human Resources Department. Before new staff commence their work at Phoenix Clubhouse, they meet with the members who introduce them to the Clubhouse services.

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[c] The interventions offered by Phoenix Clubhouse closely follow the international guidelines and this is reflected in the sources used for this service description.

The Clubhouse programme

The Phoenix Clubhouse programme is based around a work-ordered day and its members participate in consensus-based decisions regarding all important aspects of the running of the service. Opportunities for employment are created through a structured vocational rehabilitation programme and the Clubhouse also provides supported education opportunities. The service facilitates access to immediate mental health support and other health services if needed. It organizes evening, weekend and holiday social and recreational programmes and provides a wellness and healthy lifestyle education programme. Finally, the Clubhouse provides assistance as needed in securing safe, decent and affordable housing.

A work-ordered day

Through the work-ordered day, the talents and abilities of members are recognized, encouraged and utilized within the daily routines of Clubhouse activity. Clubhouse members work together with staff to ensure the day-to-day operation of the Clubhouse and participate in areas including administration, research, intake and orientation, outreach, hiring, training, evaluation of staff, public relations, advocacy, and evaluation of the Clubhouse. This internal work is structured around four units: the Administration Unit, Clerical Unit, Environmental Protection and Tuck Shop Unit and the Food Services Unit. Members are not paid for any Clubhouse work. Instead, their voluntary participation is intended to support them to regain skills and confidence and improve their ability to achieve vocational, educational, and housing goals *(28)*.

Consensus-based decision-making

Members' recovery is enhanced by a work-focused environment and the members' active participation in all aspects of the Clubhouse programme through consensus-based decision-making, which differs from the traditional model of clinical therapy and treatment-oriented programmes. Members and staff work side-by-side as colleagues; all of the work in the Clubhouse is for the Clubhouse itself, and not for any outside agency or business.

Opportunities to obtain paid employment in the local labour market

All Clubhouses feature an employment support programme that allows members to progress from working in the clubhouse to group placement, to positions in transitional employment, supported employment, or independent forms of work.

Group Placement (GP) is a supportive type of transitional employment. Jobs offered through GP are usually project-based or seasonal in nature. When job opportunities arise, one of the staff accompanies a group of four to six members to accomplish the job. The nature of the work is usually packaging or mass mailing – relatively uniform tasks – and the members are paid at the end of each working day. GP is intended for members with greater vocational challenges and low job maintenance. Productivity is judged for the group rather than the individuals. The Phoenix Clubhouse staff help in setting up the work, and provide quality control, problem solving and help with additional productivity. Many members gain confidence through this initial step, before upgrading to transitional employment.

In the Transitional Employment (TE) programme, members work at a place of business in the community and are paid at the prevailing wage rate, directly by the employer *(28)*. The job tasks are entry level and the placements are part-time, generally 15 to 20 hours a week, to fit members' needs as a first step towards re-entering the working world. Clubhouse staff or members provide training and on-site coaching to support the member. Working members are encouraged to return to Clubhouse after work for continuous support and reviewing of recovery goals and plans. Importantly, TE jobs are held in trust for the Clubhouse and these placement opportunities are available to members regardless of their success or failure in previous positions *(28)*. Every six to nine months, the working member moves to a new position or they can choose to return to a Clubhouse work activity of their choice, while another member rotates in to fill the vacant job. Importantly, it is the Clubhouse who decides which person will fill the position, rather than the employer. Once employed in such a position, the Clubhouse member enrols with the employer's personnel department and is paid on an hourly basis. The employer decides whether to provide a benefit package, in compliance with local labour law. Examples of TE jobs include administrative clerk, document control clerk, or mailroom operator *(36)*. When a member is ready, they are supported by the Clubhouse to seek independent work or to attend school.

In contrast, Clubhouse Supported Employment (SE) is not designed to be time-limited and jobs may be full or part-time. The Clubhouse provides support either onsite or offsite upon the member's request. While the Clubhouse often has some relationship with the employer, these jobs are not held in trust for the Clubhouse and there is a competitive element to the application process *(29)*. SE jobs may include, for example, dish washer for a catering company, office assistant, or even Learning & Development Administration Coordinator for a law firm.

With Independent Employment, there is no formal relationship between the employer and the Clubhouse and no on-site support. Support can still be provided to the member at the Clubhouse, on a group basis or individually, by Clubhouse staff. To be in Independent Employment, members must undergo a fully competitive interview *(29).*

At present, the Clubhouse has partnerships with 18 corporations (both local and multinational). Through these partnerships, 34 TE and SE positions are available for members. A biennial Employer's Reception serves to strengthen the relationship with these employers.

Supported education and community-based education opportunities

Many of the members at Phoenix Clubhouse have had an interrupted education. The Clubhouse offers members supported education opportunities and assistance in accessing community-based education opportunities and resources, including university, adult education classes, etc. It provides information about courses in the community and assistance in applying for these. Specific courses are held in-house, such as computer courses, English language courses, and Putonghua (Chinese language) courses. Computers are provided, giving members access to the internet and various software programmes, such as Microsoft Office, Adobe InDesign, Adobe Photoshop, Corel Draw, and both Chinese and English typing software. The Clubhouse holds regular meetings in which members share their experiences in education, and some longer-term members become tutors for the newer members. Educational achievements of members are acknowledged and celebrated at the Clubhouse.

Access to mental health interventions and other health services if needed

Members are provided with in-house health check-ups *(35)* and advice is available on services relating to substance use. Every new member has a designated member of staff to support them, known as the responsible staff member, who provides support allowing members to, for example, discuss their personal recovery plan *(37)* or to access community support. Members can also request support from psychiatrists, nurses and medical social workers. Their responsible staff member can help to arrange a medical appointment and accompany the member. Members are also encouraged to maintain contact with the mental health service or the psychiatrist who referred them to Phoenix Clubhouse, and any other relevant medical facilities, such as primary care. If more immediate help is needed, the staff support the member to contact their health care provider as appropriate.

Social, recreational, wellness and healthy lifestyle programmes

Evening, weekend and holiday activities are provided at the Clubhouse, and include table tennis, badminton, movie watching, computer classes, hiking, day camps, day trips, and celebrations of national festivals. Decisions on activities are made by consensus between members and staff *(35)*. Phoenix Clubhouse also has a number of in-house programmes relating to diet, exercise and other health-related activities. Members can participate in community-based physical activities, such as organised walks and runs.

Assistance to secure and maintain safe, decent and affordable housing

Phoenix Clubhouse actively supports members with housing issues. When new members join the Clubhouse, the responsible staff member makes enquiries about their living conditions. Regular discussion continues, regarding members' personal goals and needs, including housing needs. During the daily unit meetings, the personal, physical, psychological, employment, education and housing needs of members are discussed, and staff and other members offer support. Interventions provided by the Clubhouse can include assistance with selecting housing, moving, checking the premises before moving, accessing information, and advising the member on their appropriate rights. When members face housing problems, they can access housing information through a Community Resource file and attend Community Support Meetings with staff. There are a range of accommodation possibilities, including public housing, supported hostels, halfway houses, long-stay care homes and residential respite services. However, members make their own decisions, in discussion with Clubhouse staff, or other person of choice.

Core principles and values underlying the service

Respect for legal capacity

Phoenix Clubhouse promotes a culture of members being in control, and their choices are fully respected. Members often choose to be assisted with decisions about their lives by other members and staff, based on naturally developing, trust-based relationships. Membership is voluntary, and without time limit or screening process. When new members join, an orientation programme helps the member to experience the Clubhouse culture and job tasks in the different work units. Afterwards, they can decide whether or not to join the Clubhouse. If they decide to join, their responsible staff, work units and work tasks are chosen based on their preferences. These decisions can be changed, however, based on the person's wishes. Members decide about the way they would like to utilize the Clubhouse. During morning and afternoon meetings, they select job tasks on the task board. They are encouraged and supported to take a proactive approach to their work choices, but there are no mandatory activities, rules or contracts, and the Clubhouse will never force a member to work.

Members are also supported in their interactions with clinical teams in the public mental health system outside of the Clubhouse. Should a member find it difficult to explain their status to the clinical team, Clubhouse staff support the member to clarify their thoughts and needs beforehand, to be better prepared before the appointment. Since April 2019, to align with the general reporting system within the hospital and to improve communication between Clubhouse members and the clinical teams, Phoenix Clubhouse is now included in the hospital's electronic documentation system, which provides a progress report comprising the member's recovery plans, advance plan and staff observations. This system enables feedback about the member's progress to be shared with the clinical team, and crucially, also enables the member to ensure that their wishes and opinions are communicated to teams. Members are also free to state their disagreement in the report if they find the Clubhouse's staff observations fail to accurately describe their perceived status. The e-documentation system is an English-based platform, so staff offer interpreting assistance as needed.

Non-coercive practices

The culture of the Clubhouse emphasizes positive relationships between members and staff, with the idea that they are akin to friends, teammates, siblings or mentors. When a good rapport is established it is often possible for the staff to recognize when a member is struggling, and interventions can be made to avoid crises. Staff are trained in crisis management as part of their induction. A drill on crisis intervention and emergency handling is performed annually, with the assistance and observation of all staff and members. A real case scenario is put in practice and after the drill, evaluations, early warning signs, common de-escalation techniques and safety issues are discussed. The avoidance of future crisis situations is also discussed when personal recovery plans are reviewed, as described below.

Force is never used; there is no use of seclusion or restraint. There are no involuntary aspects to the programmes. In a crisis situation staff first seek to understand and assess the member's situation and offer supportive counselling. If needed, staff may support the person to seek medical advice by arranging early follow-up, or may accompany them to the Accident and Emergency Department (AED).

If a member acts in an aggressive way (for example using vulgar language, quarrelling, fighting, sexually harassing someone, or making others uneasy) staff and other members who witness such behaviour try to mediate and adopt de-escalation methods. If attempts to address any violent behaviour are unsuccessful the Clubhouse may request help from the premise's security guard or the police. Because Clubhouse staff and members have a relationship with the AED and hospital security, staff can play an active role in advocating for the member. Any decision to involuntarily admit a person to hospital is made by the AED staff in consultation with the person concerned and does not involve Clubhouse staff or members.

It is the member's decision as to whether to use or not use prescribed medication, and failure to take prescribed medication is not a reason for exclusion from the Clubhouse. The same applies to the member's use, or non-use, of any other prescribed intervention, such as counselling or psychotherapy. Staff explore the pros and cons of interventions with members and discuss management of the condition and relapse prevention. Members are encouraged to discuss medication side-effects or related problems with their clinical team. Staff advise members to monitor their mental health for worsening condition or increased frequency of symptoms, and to notify their mental health professional if that happens. The staff remain in contact with the member's family, with the member's consent.

Community inclusion

The Clubhouse model has always promoted the importance of community engagement. Phoenix Clubhouse supports its members to access employment, education, health and social services, and recreational activity, within the wider community in Hong Kong SAR. Members live in the community, and the Clubhouse is committed to helping each person live an integrated life within their local communities.

With regard to career support, the Clubhouse assists members to make use of community resources including government programmes such as the Interactive Selective Placement Service, the Employees Retraining Scheme and the Enhancing Employment of People with Disabilities through Small Enterprise programme. In promotion of equal opportunities, members receive information about the rights of employees with disabilities in relation to statutory minimum wage and disability discrimination. People are helped to access education in traditional spaces such as universities and adult education programmes in the city, and are helped to access employment opportunities with local businesses and employers as described above.

The Clubhouse provides information on community medical resources, including dental hospitals, Chinese medical clinics, Western medical clinics, and an Integrated Community Centre for Mental Wellness. Members are also offered advice on financial issues and government benefits, such as the Comprehensive Social Security Assistance and Disability Allowance. Social and recreational activities are often held in different venues in the community. Members attend sporting and cultural events as part of the programme, and the Clubhouse collaborates with other NGOs and the government in organizing community events advocating for mental health and promoting wellness.

Participation

The Clubhouse movement has very clear guidelines and concrete means for the inclusion of people with lived experience (the members). For example, all Clubhouse meetings are open to both members and staff. There are no formal member-only or staff-only meetings *(33)*. Responsibility for the overall operation of the Clubhouse lies with members, staff, and ultimately with the Clubhouse Director. The active engagement of members is central in all aspects of Clubhouse operation *(33)*. Staffing levels are deliberately kept low and the ethos is centred on encouraging the talents, skills and initiative of the members. They are involved in decisions about policies, programmes and services, and in planning future directions for the Clubhouse. They are trained alongside staff members and participate in the hiring of new staff and evaluation of their work. Members also sit on the Advisory Committee and on all working committees. Peer support is at the heart of the Clubhouse model, but there are no paid roles designed specifically for people with lived experience. Many Clubhouses throughout the world employ people with lived experience on their staff teams, but not if that person is a current member.

Recovery approach

Clubhouses are built on the belief that every member has the potential to lead a personally satisfying life as an integrated member of society, according to their own will and decisions. The Clubhouse model has a strong focus on meaningful activities, such as work and/or education and training. It promotes a sense of community, in which members help themselves and other members to achieve their goals. At Phoenix Clubhouse, there is a strong emphasis on choice, and each member is actively helped to identify and pursue recovery opportunities in the areas of friendships, shared work, healthcare, education, employment, wellness, and engagement in the wider community.

Each member has a personal recovery plan which facilitates their participation and supports them to realize their goals. It can include, but is not limited to, a person's physical health, mental health, spiritual health, social needs, education, employment, and engagement in the wider community. The personal recovery plan is solution-focused, individualized, and guided by the strengths of the member. Members can discuss their plan with a staff member of their choosing, and generally, staff and members meet every one to three months to discuss their personal recovery plan. An attempt is always made to involve the member's support network when plans are being made. An example would be helping a person who hears voices when they are nervous, to identify their own coping skills to plan how to access support from others when this happens.

A growing body of research literature indicates resonance between the International Clubhouse philosophy and the recovery approach *(29)*. This philosophy emphasizes the importance of people making their own choices, which can lead to a sense of empowerment *(38)* and thus to regaining control over their life and identity. The Clubhouse approach does not work with a medicalized vocabulary, and members and activities are not organized by diagnosis. There is a deliberate focus on the person's strengths, rather than on their symptoms *(39)*. The three keystones of the model are: meaningful relationships, meaningful work tasks, and a supportive environment *(40)*. The focus is on establishing a sense of community and solidarity *(41)* and specific efforts are made to support members to regain, or achieve for the first time, a meaningful, satisfied life. A recent comprehensive review of the international literature on the Clubhouse approach concluded that: "The Clubhouse Model is consistent with recovery practices with its emphasis on member choice, self-determination, community integration, equal partnerships with members and staff working side-by-side, offering hope, and helping individuals live a meaningful life" *(29).*

Service evaluation

Phoenix Clubhouse evaluates its own effectiveness through internal surveys on an annual basis. In the 2019 Satisfaction Survey, 84% of members reported feeling satisfied or very satisfied with the Clubhouse. As an evaluation metric the service also tracks rates of employment of active members (people who attend at least once per month). The proportion of active members engaged in outside work rose significantly over the last 18 years from 72% in 2001 (46 people) ([Leung, F], [Phoenix Clubhouse], unpublished data, [2001]) to 92% (135 people) in 2019 ([Leung, F], [Phoenix Clubhouse], unpublished data, [2019]). As of September 2019, 13 members were in Transitional Employment, 21 were in Supported Employment and 101 were in Independent Employment.

The success of Phoenix Clubhouse was recognized in 2014 when, in an internal, organization-wide survey of Queen Mary Hospital in 2014, the Clubhouse was praised as exhibiting extraordinary achievement in the areas of inclusion of people using the service, ongoing care, and the involvement of people using the service, carers and community in planning, delivery and evaluation of services ([Leung F], [Phoenix Clubhouse], personal communication, [2020]).

An extensive body of international research literature evaluates the Clubhouse model more generally. The most comprehensive review of this literature was published in 2018 by Colleen McKay and colleagues from the Clubhouse Research Program from the Center for Mental Health Services Research within the Department of Psychiatry at the University of Massachusetts Medical School *(29)*.

McKay et al reviewed research in six outcome domains comprising: *(1)* employment – including transitional, supported, and independent employment; *(2)* hospitalization/recidivism; *(3)* quality of life/satisfaction; *(4)* social relationships; *(5)* education; and *(6)* health promotion activities. These six domains were selected as they have been examined in published literature, they represent the most commonly reported quantitative outcomes from Clubhouses, and they reflect the core goals of the Clubhouse model *(29).* McKay et al found supporting evidence for the benefits of the Clubhouse programme across all these outcome domains. However, they made the case that more systematic studies are needed for a full evaluation of the Clubhouse benefits.

The use of transitional employment by the Clubhouse movement has been questioned by some researchers. It has been suggested that this can serve to keep members in a dependent relationship with staff and undermine their ability to progress to full paid employment *(42)*. However, this may miss the important role that transitional employment plays within Clubhouses, in terms of the creation of a flexible and non-threatening environment around work, and in allowing people to choose the programme that best suits their preferences and needs.

Costs and cost comparisons

As the governing body, Queen Mary Hospital finances the entire operating budget of the Clubhouse including staff costs. It also helps with recruitment, financial management and maintenance. The annual operations cost is about HK$ 140,000 per year (approximately US$ 18,000)[d]. Annual staff salaries amount to about HK$ 2,900,000 (approximately US$ 373,000)[d].

Phoenix Clubhouse members are not charged a fee if they are using only the Clubhouse, and none of the other mental health system services. However, by paying a flat fee of HK$ 60 per day (approximately US$ 8)[d] they can access the full range of mental health services provided through the mental health system of Hong Kong SAR, including Phoenix Clubhouse and all its programmes.

In Hong Kong SAR, there is no mandatory medical insurance to cover public medical services. Although the government subsidizes a large portion of medical fees, citizens are still required to pay a small portion directly. Approximately 85% of those who attend Phoenix Clubhouse receive Comprehensive Social Security Assistance or other hospital waivers, which allows for day hospital fees to be waived. Citizens who can afford the medical fee and don’t meet the requirements of social security are charged a small portion of the fees required to access day hospital services.

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[d] Conversion rate as of March 2021.

Challenges and solutions

Securing start-up support

As Phoenix Clubhouse is completely funded and managed by a public sector hospital, a major challenge during the start-up stage was to secure support for the establishment of the Clubhouse from the administrators and executives of the Queen Mary Hospital. The original proposal came from an occupational therapist in a psychiatric day hospital, who encouraged the manager of the Occupational Therapy Department to visit an established Clubhouse overseas to see what had been achieved. The manager was inspired by the visit and found that the Clubhouse Model could be an alternative to the existing service. With the support from Department of Psychiatry of Queen Mary Hospital and funding granted from SK Yee Foundation through the University of Hong Kong, the conventional Adult Day Hospital facilities were renovated to eventually become Phoenix Clubhouse. The funding also supported Clubhouse accreditation and allowed staff and members to attend overseas training.

Changing the dominant mental health culture

Another challenge faced in the beginning stages was the resistance of some frontline staff to embrace the Clubhouse philosophy. They were more comfortable with the traditional, authoritative and risk minimizing approach when interacting with people using the service and were hesitant to change to a more egalitarian model that involved seeking members' opinions, sharing facilities and responsibilities with members and treating members as equals. To address this challenge, much time was spent educating frontline staff on the potential gains of a different way of working, building trust towards members, sharing responsibilities with members, and helping members establish a sense of responsibility towards their own recovery. Eventually, the benefits of empowerment and more equal relationships became clear.

Overcoming language barriers

Phoenix Clubhouse also had to meet start-up challenges related to language and culture. The form and language of the Clubhouse Standards were initially challenging as they had been developed in a different country with a different language, and in a different cultural context. To help overcome this obstacle, the Clubhouse International organization provided help in identifying the essential principles underlying the Clubhouse Standards, and meetings were held, with the members, to translate the essence of the Standards into Chinese.

Sustaining vocational support in times of economic hardship

Phoenix Clubhouse also faced the challenge of developing new Transitional Employment positions and sustaining posts already developed, during periods of economic downturn. The service has tried to create a 'win-win' set-up with employers, by actively providing on-site vocational support and coverage for members who are absent, which helps sustain positive relationships with employers.

Dealing with new management

Another challenge is that periodic changes in management structures have meant that, at times, people who are unfamiliar with the Clubhouse model have become administrators for the service. To deal with this situation, new administrators are invited to meet with members to learn first-hand about the positive impact of the service. Sometimes arrangements are made for new administrators to attend training events overseas.

Securing ongoing funding

The Clubhouse continues to receive core support from Queen Mary Hospital and the University of Hong Kong, but securing additional funding for events and training presents an ongoing challenge. The established, strong relationships with senior management and with the Finance and Human Resources Department of Queen Mary Hospital have helped to mitigate this issue and secure additional funding when needed.

Most Clubhouses in other countries are located in their own physical space rather than in a public healthcare and social services complex, like Phoenix Clubhouse. However, real estate costs were an important consideration for Phoenix Clubhouse due to its Hong Kong SAR location where the cost of real estate is prohibitive and available space is limited. In large part, Phoenix Clubhouse has succeeded because it has sought support from the Queen Mary Hospital. In the language of the Clubhouse movement, it is an "auspiced" Clubhouse *(43)*, meaning that it is ultimately funded and managed by a larger organization.

Key considerations for different contexts

Key issues to consider for the establishment or expansion of this service in other contexts include:

- engaging a leader who believes strongly in the principles of the service in the early stages;
- having a core team of actively involved Clubhouse members;
- ensuring members are involved in any evaluation of the service;
- attending training events at other Clubhouses and at international gatherings to broaden horizons and motivate staff and members;
- continuing the regular accreditation process through Clubhouse International every three years, to allow a comprehensive self-evaluation process and an element of external peer-review;
- promoting and marketing the service, including distributing flyers, leaflets, various publications, arranging welcoming visits from other health care professionals or supporters as well as gaining exposure though press and media; and
- undertaking research and evaluation to demonstrate the benefits of the service and make the case for funding and support.

Additional Information and resources:

Website:
Hong Kong Phoenix Clubhouse: http://www.phoenixclubhouse.org
Clubhouse International: https://clubhouse-intl.org

Videos:
Clubhouse International, members' stories: https://clubhouse-intl.org/news-stories/videos/

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3.

Moving forward: from concept to good practice community mental health centres

The purpose of this section is to provide readers with some key practical steps and recommendations that will facilitate the process of conceptualizing, planning and piloting a good practice community mental health centre that aligns with human rights standards. It is not meant as a comprehensive and complete plan for setting up the service since many context-specific factors, including socio-cultural, economic and political factors, play important roles in this process. Further detail on integrating the service into health and social sectors is provided in the guidance and action steps section in *Guidance on community mental health services: Promoting person-centred and rights-based approaches.*

Action steps for setting up or transforming a community mental health centre:

- **Set up a group of different stakeholders** whose expertise is crucial for setting up or transforming the service in your social, political and economic context. These stakeholders can include but are not limited to:
  - policymakers and managers from health and social sectors, people with lived experience and their organizations, general health and mental health practitioners and associated organizations, legal experts, politicians, NGOs, OPDs, academic and research representatives and community gatekeepers such as local chiefs, traditional healers, leaders of faith-based organizations, carers and family members.
- **Provide the opportunity for all stakeholders to thoroughly review and discuss the good practice services** outlined in this document to get an in-depth understanding of the respective services. This is an opportunity to identify the values, principles and features of the good practice services that you would like to see incorporated into your country's services given the social, political and economic context.
- **Establish contact with the management or providers of the service(s)** that you are interested in to get information and advice on setting up or transforming a similar service in your context and to understand the nuances of the service. Ask specific questions about how these services operate keeping in mind the local context in which the services would be developed. This can be done via a site visit to the good practice service and/or video conference.
- **Provide training and education on mental health, human rights and recovery** to the groups who will be most relevant for setting up or transforming the service using WHO QualityRights face-to-face training materials (https://www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools) and e-training platform. Changing the attitudes and mindsets of key stakeholders is crucial to reduce potential resistance to change and to develop attitudes and practices in line with the human rights-based approach to mental health.
- **Research the administrative and legal regulations** concerning setting up or transforming the service.

Questions specific to setting up or transforming community mental health centres:

- Are you aiming to transform an existing community mental health centre, establish a new centre or integrate mental health into an existing centre?
- Who are the beneficiaries of the service: will anyone will be excluded? How the service will be accessed?
- Are you planning to have a small number of beds available to accommodate people who may be experiencing a crisis, and will these be operational 24/7?
- Are you planning to have a walk-in service where anyone can come without an appointment, appointments only, or a mixed approach?
- Are you planning to offer treatment and support at peoples' homes?
- What treatments and interventions are you planning to provide? Options may include:
    - assessments of support needs and diagnosis if agreed by a person
    - trauma informed therapy
    - person-centred recovery planning
    - psychotherapy, e.g. Cognitive Behavioural Therapy
    - problem solving and behavioural activation/activity scheduling
    - individual and group based supportive counselling/therapy
    - psychotropic and other medication (including prescribing medication, as well as support for withdrawing safely from medication)
    - dialogue/meetings with families, friends and supporters (with the agreement of the person using the service)
    - transitional support for people returning to their home and community
    - crisis hotline phone-in
    - peer support
    - other.
- How will your service assess, provide for or refer people for any physical health conditions they may have?
- What human resources will be required (such as doctors – including psychiatrists, general practitioners and others, psychologists, nurses, social workers, peer support workers, occupational therapists, outreach workers, community/lay workers, administrative staff, etc.) and what sort of skills and training will be required for them to provide quality and evidence-based service in line with human rights?
- What will be the interrelationship between this service and other services, supports and resources in the community, including upward and downward referral systems?
- What strategies and training are you planning to put in place to realize legal capacity, non-coercive practices, participation, community inclusion and recovery orientation?[e]

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[e] For more information see section 1.3 in *Guidance on community mental health services: Promoting person-centred and rights-based approaches.*

Legal capacity

- How will the service ensure that mechanisms for supported decision-making are in place so that that decisions are made based on the will and preference of the person?
- How will the service approach informed consent by service users in relation to treatment decisions?
- How will the service ensure that people are:
  - able to make informed decisions and choices among different options for their treatment and care; and
  - provided with all critical information relating to medication, including its efficacy and any potential negative effects?
- What processes will the service put in place to systematically support people to develop advance plans?
- What kind of mechanisms will the service put in place to ensure that people can make a complaint if they need to?
- How will the service facilitate access to legal advice and representation by its users who may need of this type of service (e.g. pro bono legal representation)?

Non-coercive practices

- How will the service ensure the systematic training of all staff on non-coercive responses and de-escalation of tense and conflictual situations?
- How will the service support people to write individualized plans to explore and respond to sensitivities and signs of distress?
- How will the service create a “saying yes” and “can do” culture in which every effort is made to say “yes” rather than “no” in response to a request from people who are using the service?
- How will the service establish a supportive environment?
- Will the service have a crisis response team?

Participation

- How will people with lived experience be an integral part of the service team as staff, volunteers or consultants?
- How will people with lived experience be represented in the high-level decision-making in your service?
- How will the service systematically collect feedback from service users and integrate this into your service?
- How will people using the service be linked with peer networks in the community?

■ Community inclusion

- How will the service support people to find work and income generation opportunities, for example through a transitional employment programme, supported employment programme or through independent employment as appropriate?
- How will the service facilitate access to housing services?
- How will the service facilitate supported education and assistance in accessing community-based education opportunities and resources to continue education?
- How will the service facilitate access to social protection benefits?
- How will the service facilitate access to social and recreational programmes?

■ Recovery

- How will the service ensure that people will be considered in the context of their entire life and experiences, and that care and support will not solely focus on treatment, diagnosis and symptom reduction?
- How will the service ensure that the five dimensions of recovery: (1) connectedness, (2) hope and optimism, (3) identity, (4) meaning and purpose and (5) self-empowerment, are integral components of service provision?
- How will people be supported to develop recovery plans; that is, to think through and document their hopes, goals, strategies for dealing with challenging situations, managing distress, strategies for keeping well, etc.?

- Will the service provide training and support activities regarding the human rights-based approach in mental health to other stakeholders and in the community?
  - » Will the service provide training and support to organizations in the community, including civil society groups?
  - » Will it provide training and support to staff of other health and social services, including non-specialized health services?

- Awareness-raising and advocacy
  - » Will the service undertake awareness-raising on mental health and human rights, including with families, schools, employers, local organizations and other community settings?
  - » Will the service undertake advocacy actions on mental health and human rights for the rights of people with mental health conditions and psychosocial disabilities and create positive opportunities for individuals to engage in the community with the ultimate aim of creating a community whereby individuals can live autonomously? This includes actions to reduce stigma around mental health and creating positive opportunities for community engagement.
  - » Will the service seek to understand the social dynamics of the local community and map the frequent problems that most impact people’s lives and mental health (for example, police violence, threats related to drug trafficking, economic hardship)?

- **Prepare a proposal/concept note** that covers process issues, detailing the steps for setting up the service, the vision and operation of the service network based on the full range of services that will be provided, covering the following:
    - human resource, training and supervision requirements;
    - how this service relates to other local mental health and social services;
    - strategies to ensure that human rights principles of legal capacity, non-coercive practices, community inclusion, and participation will be implemented, along with a recovery approach;
    - details about the monitoring and evaluation of the service; and
    - information on costs of the service and how this compares with the previous services in place.
- **Secure the required financial resources** to set up or transform the service, exploring all options including government health and social sectors, health insurance agencies, NGOS, private donors, etc.
- **Set up and provide the service** in accordance with administrative, financial and legal requirements.
- **Monitor and evaluate the service on a continual basis and publish research** using measures of service user satisfaction, quality of life, community inclusion criteria (employment, education, income generation, housing, social protection), recovery, symptom reduction, assessment of quality and human rights conditions (for example, by using the QualityRights assessment toolkit), and rates of coercive practices (involuntary treatment, mechanical, chemical and physical restraints).
- **Establish dialogue and ongoing communication with key stakeholders and members of the public** by holding public forums and hearings with these groups to allow people to openly express their views, ideas, and concerns about the service, and to address these concerns.
- **Advocate and promote the service** with all relevant stakeholder groups (politicians, policy makers, health insurance agencies, media, people with lived experience, families, NGOs, OPDs and the community at large). This also involves actively reaching out through both traditional and social media. Having the successes of the service highlighted publicly can be a good strategy to bring people on board.
- **Put in place the strategies and systems** required to ensure the sustainability of the service.

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