Accepted Manuscript

1 Intersectoral and multisectoral approaches to enable recovery for people with severe mental
2 illness in LMICs: A scoping review

3 Authors

4 André J van Rensburg*

5 Centre for Rural Health, University of KwaZulu-Natal, Durban, South Africa

6 jansevanrensburga@ukzn.ac.za

7 Carrie Brooke-Sumner

8 Alcohol Tobacco and Other Drug Research Unit, South African Medical Research Council, Cape Town, South Africa

9 Carrie.Brooke-sumner@mrc.ac.za

10

11 **Topic**: Policy and Systems

12 **Sub Topic**: Services Integration

13

14 Impact statement

15 Despite a large body of work on recovery for people living with severe mental illness, and its
16 implicit embeddedness in collaboration across sectors, little systematic description has been
17 undertaken of its implementation in low-and middle-income countries. Our review fills this
18 gap by providing a synopsis of how multi- and intersectoral collaboration in supporting
19 recovery occur in these contexts. It highlights examples that involve collaboration between
20 healthcare and community support systems, collaboration in providing supported housing
21 and supportive community spaces for recovery, and linkages between biomedical and social
22 spheres of care. There are, however, barriers to collaborating across sectors, including the

This peer-reviewed article has been accepted for publication but not yet copyedited or typeset, and so may be subject to change during the production process. The article is considered published and may be cited using its DOI.

10.1017/gmh.2023.10

This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is unaltered and is properly cited. The written permission of Cambridge University Press must be obtained for commercial re-use or in order to create a derivative work.

dominance of mental health professions in delivering care, community-based stigmatising attitudes towards SMI, and a discomfort of some healthcare workers to work beyond the professional boundaries of healthcare. Multi- and intersectoral collaboration for SMI recovery needs to be driven by formal structures and financing, including both on macro and micro levels of engagement.

Abstract

Background: The needs of people with severe mental illness are complex, and require a range of services embedded in well-coordinated systems of care to enable recovery, promote well-being and optimise social integration. The concept of recovery is strongly rooted in the centrality of multi and intersectoral systems of care, and, while multi and -intersectoral dimensions of mental health systems have been highlighted in analyses focusing on high-income regions, little has been elaborated in terms of these approaches in the recovery of people with severe mental illness in LMICs.

Aim: The aim of this review was to identify and describe multi and intersectoral approaches underpinning community-based SMI recovery interventions in LMICs.

Methods: A scoping review was carried out following the following steps: 1) Objectives for the review were developed and refined; 2) A systematic search of databases (EbscoHost, PubMed, Google Scholar) and previous reviews were undertaken from 2012-2022, where relevant papers were identified; 3) Papers with a focus on SMI and recovery, a specific description of an intervention, located in LMICs, with explicit linkages between sectors, and published in English, were selected for inclusion; 4) Data were extracted and charted; and 5) Findings were analysed and reported thematically. Conclusion: Thirty-six papers were included for analysis, from 18 countries, including qualitative studies, trials, desktop and secondary data reviews, and case studies. Examples of multi- and intersectoral action included collaboration between healthcare and community support systems, collaboration in providing supported housing and supportive community spaces for recovery, and linkages between biomedical and social spheres of care. Barriers included the dominance of mental health professions in delivering care, community-based stigmatising attitudes towards SMI. Multi- and intersectoral collaboration for SMI recovery requires investments in financing, education, and coordination by a governing body.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

53 ## Introduction

54 People living with severe mental illness (SMI) have substantially increased relative mortality
55 risk compared to the general population, related to cardiovascular disease (Ali et al., 2022,
56 Lambert et al., 2022), and in Low and Middle Income Countries (LMIC) particularly related to
57 poverty that leads to poor health status (e.g. undernutrition) (Jenkins et al., 2011, Tirfessa et
58 al., 2019). While symptoms of the illness play a role in course and outcomes, globally and in
59 LMIC particularly, people with SMI may experience social and economic adversities and
60 human rights abuses that can create a social environment that hampers clinical and personal
61 recovery (Patel, 2015, Brooke-Sumner et al., 2014, Asher et al., 2017). Recovery, as it has
62 been conceptualised in HIC settings, is described as an individual journey of transformation
63 and personal growth moving from the distress of the acute experience of the condition
64 towards finding meaning and purpose, a sense of belonging, forming or rebuilding
65 meaningful relationships (Frost et al., 2017), bringing hope, empowerment, goal orientation
66 and fulfilment (Warner, 2009, Whitley et al., 2015, Drake and Whitley, 2014). Recovery
67 encompasses concepts of prosperity (legal, political and economic dimensions); individual
68 recovery (dimensions of normalcy, knowledge, individuality, responsibility, and identity);
69 clinical recovery (treatment and diagnosis dimensions); and social recovery (externally and
70 internally derived notions of social awareness, being a part of society, functioning well within,
71 groups, treated as an equal) (Vera San Juan et al., 2021). Biomedically-oriented health
72 systems alone are inadequately configured to address the spectrum of these recovery needs
73 which extend across intersecting social, economic, cultural and political spheres, beyond the
74 health sector (Gamieldien et al., 2022). While many of the recovery concepts may be cross-
75 cutting among HIC and LMIC, some concepts, developed in Western sociocultural contexts,
76 may be limited in being rooted in economic environments and health and social welfare
77 systems able to provide for people's material needs (Gamieldien et al., 2021). In LMICs there
78 may be greater involvement of families in providing care and supportive environment, use of
79 non-Western healing approaches (Onken et al., 2007), and a more important role of
80 spirituality in recovery (Gamieldien et al., 2021).

81 Since its introduction into health policy discourse in the 1970s, "intersectoral action" has
82 become a staple in framing responses to public health challenges. The need for the health
83 sector to collaborate with a range of other sectors to improve health outcomes continues to

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

84 be highlighted (Sanni et al., 2019). More recent conceptualisations include "multisectoral
85 action for health" which refers to the deliberate or collateral inclusion of different actors and
86 sectors in health improvement, including initiatives such as "Whole of Government", Joined-
87 up Government" approaches, horizontal and integrated policymaking, and Health in All
88 Policies. Despite the conceptual promise of inter-and multisectorality, and evidence of its
89 implementation in HIC (Mondal et al., 2021, Jørgensen et al., 2021, Jørgensen et al., 2020,
90 Diminic et al., 2015) this has not consistently translated into policy or services. For instance,
91 neither the WHO's Innovative Care for Chronic Conditions Framework (Nuño et al., 2012), nor
92 its subsequent modification for LMICs or countries in health transition (Oni et al., 2014),
93 adequately considers the role of sectors outside of health. A well-documented example of
94 the costs of failure to approach community mental health from an intersectoral approach is
95 the US deinstitutionalisation movement. Following the policy shifts towards
96 deinstitutionalisation, financial costs and responsibilities were dispersed through various
97 stakeholders and agencies. This led to a fractured system, inadequate to address the complex
98 needs of people with SMI, leading to homelessness or incarceration when placed in
99 community settings (Grazier et al., 2005). In order to develop more people-centred, humane
100 and effective community mental health systems, recovery should be firmly couched in service
101 and strategic collaboration across sectors (Drake and Whitley, 2014). Several examples of
102 promising shifts towards intersectoral collaboration in community SMI services have
103 emerged in high-income settings. Intersectoral service networks in Belgium (Nicaise et al.,
104 2021) and Canada (Fleury et al., 2017) includes integrated, intersectoral collaboration in the
105 form of housing, educational and employment support, beyond medical and psychiatric care.
106 The Australian Partners in Recovery model is a good example of how care coordination can
107 aid recovery for people living with SMI (Isaacs, 2022). A review of interventions that focus on
108 system-level intersectoral linkages involving mental health services and non-clinical support
109 services yielded forty examples from high-income countries, with various different
110 collaboration modalities. Outcomes reported were largely positive, particularly regarding
111 improved interagency communication, mutual understanding and empathy, cost efficiency,
112 involvement of lay health workers, as well as various service user outcomes such as clinical
113 functioning, employment prospects, and accommodation stability (Whiteford et al., 2014).
114 This being noted, the connection between recovery and intersectoral care remains relatively
115 ill-defined and several gaps remain in this body of evidence (Jørgensen et al., 2021). However

116 the relevance and need for development of this approach to recovery services is highlighted
117 in the 2022 World Mental Health report (World Health Organization, 2022).

118 While there is much promise of inter- and multisectoral approaches to SMI recovery, there is
119 paucity of reviews on the subject – particularly in LMICs, and a lack of systematised evidence
120 on how to implement the approach. While the implementation of intersectoral collaborations
121 to enable recovery of people living with SMIs have been well-described in HICs, it remains
122 uncertain how intersectoral care is being pursued in contexts faced with a lack of resources
123 and infrastructure, mental health system investment-to-population ratio, substantial
124 geographical and cultural variation and underdeveloped welfare systems (Patel, 2016). The
125 aim of this scoping review was therefore to identify and describe multi and intersectoral
126 approaches underpinning community-based SMI recovery interventions in LMICs.

127 ## Methods

128 This scoping review was guided by the methodological steps outlined by Arksey and O'Malley
129 (Arksey and O'Malley, 2005) and the Johanna Briggs Institute (JBI, 2015), following the
130 following phases: 1) Objectives for the review were developed and refined among the
131 authors, based on a brief, initial literature review; 2) A systematic search of databases was
132 undertaken where relevant papers were identified; 3) Relevant papers were selected for
133 inclusion; 4) Data were extracted from these selected studies, and were charted according to
134 the Preferred Reporting Items for Systematic reviews and Meta-Analyses Extension for
135 Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018); and 5) Findings were thematically
136 analysed and reported.

137 The search was undertaken by the authors, with weekly discussions to compare results and
138 discuss inclusions and exclusions. We applied search terms as used in a recent scoping review
139 exploring recovery of people living with SMI in LMICs (Gamieldien et al., 2021), with updated
140 time parameters to reflect our search scope of 2012-2022. This resulted in an additional 12
141 papers added to their results (22 in total). We then conducted searches using key terms
142 related to recovery, SMI, community settings, LMICs (see Addendum 1 for a full description
143 of search terms), in EbscoHost (Academic Search Complete; APA PsycInfo; Health Source -
144 Consumer Edition; Health Source: Nursing/Academic Edition; MasterFILE Premier; MEDLINE
145 with Full Text), PubMed, and Google Scholar. In Google Scholar, the terms and related terms

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

146 "recovery", "SMI", "community settings", and "LMICs" were included and results were
147 screened until two sequential pages did not yield any further papers that adheres to the
148 inclusion criteria. During the screening and review process, it became apparent that the
149 interchangeable and ambiguous application of complex terms such as recovery, multi-and
150 intersectoral approaches, may limit the number of papers found in databases. Therefore, an
151 additional review of the results of 11 systematic reviews on psychosocial interventions with a
152 focus on severe mental illness was undertaken (Al-Sawafi et al., 2020, Alhadidi et al., 2020,
153 Bighelli et al., 2021, Brooke-Sumner et al., 2015, Davies et al., 2018, Frederick and
154 VanderWeele, 2019, Lutgens et al., 2017, Morillo et al., 2022, Rodolico et al., 2022, Sin and
155 Spain, 2017, Solmi et al., 2022), while peer reviewers helpfully pointed out additional
156 omissions in the results. This underlines the importance of including an additional
157 consultation phase in scoping reviews, framed as an optional step in existing guidelines
158 (Levac et al., 2010). Inclusion and exclusion criteria are summarized in Table 1.

159 Table 1: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
A primary focus on people living with SMI, as defined by the National Institute for Mental Health ("severe" and "serious" were used interchangeably), i.e. "…a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI." (National Institute of Mental Health, 2022). This includes specific ICD-10 diagnostic categories F20-29, F30-39, F30.2, F31.2, F31.5, F32.3, F33.3.	Primary focus not on people living with SMI
A description of a specific intervention, programme, or service	General overviews or descriptions of health systems or services, rather than a specific focus on an intervention aimed at recovery from SMI
A focus on community-based, outpatient settings	A focus on inpatient, institutionalised settings
A focus on the enabling of recovery as defined in the Introduction	No focus on dimensions of recovery
Adults (aged 18 years and above)	People under 18 years of age
Studies reported during the past decade (2012-2022)	Studies reported before 2012
Studies with a primary location in LMICs (World Bank, 2022)	Studies focusing on settings in HICs (World Bank, 2022)
Explicit description of intended linkages with sectors other than health	No apparent linkages of an intervention with sectors beyond health
Published in English	Full text not in English

160

161 # Findings

162 ### *Search results*

163 As shown in Figure 1, a total of 471 papers were initially identified through PubMed (n=336),
164 EbscoHost (n=64), Google Scholar (n=38), results of other reviews (n=24) and peer reviewers
165 (n=9). After duplicates were removed, 204 titles and abstracts were screened, where 100
166 records were excluded based on the exclusion criteria. Two papers were excluded due to
167 language, one was in Turkish, the other in Portuguese. Following a screening of 104 full text
168 papers, an additional 67 papers were excluded due to not having a primary focus on SMI, no
169 clear focus on recovery, and no apparent linkages with sectors other than health. This
170 resulted in 37 papers being included for qualitative synthesis (Table 2).

171

172 *FIGURE 1 HERE*

173 Figure 1: PRISMA illustration of search and selection process

174

175 ### *Included studies*

176 An overview of included studies is presented in Table 2. Studies from an array of countries
177 were included: Bosnia and Herzegovina (n=1); Egypt (n=1); Eswatini (n=1); Ethiopia (n=1);
178 Ghana (n=1); Indonesia (n=1); Kenya (n=1); Kyrgyz Republic (n=1); Liberia (n=1); Nepal (n=1);
179 Chile (n=1); Timor-Leste (n=1); Turkey (n=2); Brazil (n=3); China (n=4); South Africa (n=4); and
180 India (n=12). A variety of study designs and methodologies were reported, including various
181 qualitative studies, randomised control trials, desktop and secondary data reviews, quasi-
182 experimental studies, and case studies.

183

184

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

185 Table 2: Overview of included studies

Citation	Country	Primary intervention	Dimensions of involvement of different sectors in recovery	Study type	Data type
1. Acebal et al. (2021)	Brazil	Psychosocial rehabilitation	Community-based Residential Therapeutic Services (SRT) in conjunction with routine medical care.	Cross sectional survey	Quantitative
2. Anish (2013)	India	Psychosocial rehabilitation	Collaboration between healthcare and agriculture industries to promote recovery through vocational activities in diary and farming, and horticulture.	Programme evaluation	Quantitative
3. Arahanthabailu et al. (2022)	India	Assertive community treatment	Manipal Assertive Community Treatment (M-ACT) teams liaise with community resources to facilitate vocational rehabilitation and access to welfare benefits.	Quasi-experimental	Quantitative
4. Arias et al. (2016)	Ghana	Prayer camps	Collaboration between biomedical services and faith-based care delivered at prayer camps.	Exploratory qualitative study	Qualitative
5. Asher et al. (2015), Asher et al. (2022)	Ethiopia	Community-Based Rehabilitation Intervention for People with Schizophrenia	Using community-based rehabilitation workers as principal deliverers of the intervention allows networking and integration with NGOs and traditional health practitioners.	RCT	Quantitative and qualitative
6. Brooke-Sumner et al. (2016)	South Africa	Intersectoral psychosocial rehabilitation	Despite very little formal collaboration between government departments, singular examples emerged e.g. collaboration between social development and public works in placing people living with schizophrenia in an employment programme.	Exploratory qualitative study	Qualitative
7. Brooke-Sumner et al. (2018)	South Africa	Psychosocial rehabilitation (group based, psychoeducation)	Psychosocial rehabilitation programme delivered by auxiliary social workers via collaboration between the health and social development/welfare sectors.	Quasi-experimental	Mixed methods
8. Chatterjee et al. (2014)	India	Collaborative community-based care	Collaborative package of community-based care facilitated linkages between service users and a) user-led support structures, b) community support agencies to address social issues and improve social inclusion, and c) community agencies that provide legal and employment services.	RCT	Quantitative
9. Chen et al. (2020)	China	Psychosocial rehabilitation (clubhouse model)	The Clubhouse facilitates transitional employment and supported education programmes in collaboration with community partners.	RCT	Quantitative
10. de Menil et al. (2015)	Kenya	Mental Health and Development model	Collaboration between the Ministry of Health, NGOs, the Ministry of Gender, Children and Social Services, and Ministry of Agriculture, Livestock and Fisheries, to provide a continuum of services including self-help groups and training in and support for livelihood and farming capacities.	Cost-effectiveness analysis	Primary and secondary quantitative data
11. Gamieldien et al. (2022)	South Africa	Perceptions on recovery	NGOs provide multisectoral services to aid recovery efforts, including basic needs, transportation, life skills, vocational training, and leisure and sport activities.	Exploratory qualitative study	Qualitative

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

12. Hall et al. (2019)	Timor-Leste	Intersectoral mental health service collaboration	Referral linkages between government health facilities, police, local authorities, private clinics, social sector service providers, and customary healers, forming a network of services that include health care, disability support, victimisation support, and residential support.	Case study	Mixed methods
13. İncedere and Yildiz (2019)	Turkey	Case Management for Individuals with Severe Mental Illness	A case manager liaises with employment sector to identify suitable candidates to undertake an examination and be positioned for an appropriate job.	Quasi-experimental	Quantitative
14. Janse van Rensburg et al. (2018)	South Africa	Service referrals between state and non-state actors	Government clinics and hospitals refer service users to NGOs for residential support and welfare grant application assistance.	Case study	Mixed methods
15. Kallivayalil and Sudhakar (2018)	India	Low-cost community psychosocial rehabilitation model	NGO has a candle-making unit where people living with severe mental illness can sell candles at nearby churches during holy days, while clothes manufacturing initiative linked service users up with retail outlets to sell clothes.	Quasi-experimental	Survey
16. Kohrt et al. (2015)	Liberia	Crisis Intervention Team (CIT) Model of Police–Mental Health Collaboration	The Carter Center Mental Health Program (TCC-MHP) facilitated partnerships to advance mental health policy, legislation, and funding, which included engaging with the Liberia National Police to identify spaces for collaboration on crisis intervention.	Programme development description	Narrative description
17. Li and Ma (2021)	China	National comprehensive management pilot project for integrated care for people with severe mental disorders through strengthened cooperation among government organisations and between government and other relevant social organisations	A quasi-governmental organisation establishes and coordinates community service organisations for people living with severe mental illness, with formal links between the ministries of health and social affairs. Through training and cooperation across a range of organisations and sectors, an integrated package of services is provided to be more responsive to individual needs.	Case study	Qualitative interviews
18. MacDougall et al. (2022)	Kenya	Community REcovery Achieved Through Entrepreneurship (CREATE)	An initiative that integrates elements of psychosocial rehabilitation (PSR), community-based rehabilitation (CBR), and work integration social enterprise (WISE).	Programme development description	Qualitative
19. Mascayano et al. (2022), Mascayano et al. (2019a)	Brazil & Chile	Critical Time Intervention with Task-sharing (CTI-TS)	Teams made up of auxiliary and peer workers supported service users following discharge from acute psychiatric hospitalisation, to facilitate linkages with a range of community-based support systems that included basic and specialist medical care, psychosocial rehabilitation,	RCT	Quantitative

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

			leisure and art-based activities, and basic needs.		
20. Molchanova (2014)	Kyrgyz Republic	Indigenous model of family rehabilitation	The development of family-driven NGOs led to the provisioning of a range of psychosocial rehabilitation activities to people living with severe mental illness in community settings.	Desktop review	Government documents
21. Muhić et al. (2022)	Bosnia and Herzegovina	Brief, multifamily group intervention for patients with schizophrenia and related disorders	Multifamily groups mobilised mutual support for people living with severe mental illness in community settings.	RCT	Survey and qualitative interviews
22. Nxumalo Ngubane et al. (2019)	Eswatini	Psychiatric outpatient care	People living with severe mental illness' engagement in community-based projects such as community kitchens for orphaned and vulnerable children aided in recovery efforts.	Interpretive phenomenological analysis	Qualitative interviews
23. Padmakar et al. (2020)	India	The Banyan's supported housing model	The Banyan organisation developed a supported housing programme where people living with severe mental illness can live independently, with an emergency care and recovery unit located in close proximity.	Mixed methods	Qualitative interviews, logbook notes, survey
24. Pfizer and Kavitha (2018)	India	Interdisciplinary recovery model of psychosocial rehabilitation	People living with severe mental illness were enrolled into a sheltered workshop, where their functionality, occupational skills and readiness was improved and evaluated, after which appropriate service users could be promoted to peer mentorship at a trial worksite, with the ultimate goal of securing competitive employment. The programme also included generating financial support for the building of houses on private owners' properties, as well as linkages with Alcoholics Anonymous to address substance abuse challenges.	Desktop review	Narrative description
25. Raja et al. (2012)	Nepal	BasicNeeds model of Mental Health and Development	Livelihood support was provided to people living with severe mental illness and their families through cash grants or supporting the setting up of businesses, as well as support for the setting up of self-help groups.	Case study	Project data
26. Rao et al. (2022)	India	SCARF Telepsychiatry in Pudukkottai (STEP) program	A range of community-based psychosocial rehabilitation activities were provided in a rural area, including facilitating access to disability and welfare benefits, supporting job-seeking efforts and facilitating placement in partner businesses, and supporting the obtaining of loans from banks to help set up small businesses.	Desktop review	Project data
27. Rashed (2015)	Egypt	Qur'anic healing	A duality of recovery care that consisted of psychiatric services delivered by medical doctors, and Qur'anic healing providing spiritual care.	Ethnography	Participant observation
28. Saha et al. (2020)	India	Non-governmental psychosocial rehabilitation	NGO that provided support for livelihood activities, access to government grant schemes, as well as a range of psychosocial therapies with service users and their	Secondary data analysis	Patient case records

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

		centers	families.		
29. Soygür et al. (2017)	Turkey	Therapeutic community and supported-employment setting where people living with schizophrenia work	Blue Horse Café provides a protective space where people living with schizophrenia can work, build skills and develop independence from medical institutionalisation, while still accessing medical care.	Phenomenological	Qualitative interviews
30. Subandi (2015)	Indonesia	Psychiatric outpatient care	In addition to outpatient community-based medical care, people accessed "natural therapy" in the form of spiritual guidance from mosques alongside neighbours and friends, which also allowed for community integration, while others accessed services from both biomedical and traditional health practitioners.	Ethnography	Participant observations
31. Vijayan (2021)	India	Recovery Oriented Services (ROSeS)	Community-based psychiatric rehabilitation programme aids in recovery efforts by acting as intermediary between service users and organisations that facilitate work placements.	Case study	Qualitative
32. World Health Organization (2021)	Brazil	Centro de Atenção Psicosocial (CAPS)	Drives recovery efforts by facilitating active citizenship, which includes helping service users to navigate government bureaucracies to obtain formal documentation and access benefits, and liaising with a range of community resources to support housing, employment and social life improvement.	Case study	Narrative description
33. World Health Organization (2021)	China	Phoenix Clubhouse	Clubhouse collaborates with business partners to facilitate placement for paid employment in the local labour market for its members.	Case study	Narrative description
34. World Health Organization (2021)	India	Naya Daur Community Outreach	A community outreach programme that refer people to temporary shelters, where they can access basic services such as hygiene materials, food, water, and a place to sleep.	Case study	Narrative description
35. World Health Organization (2021)	India	Atmiyatab primary care community outreach service	Mental health champions are instituted as intermediaries for people living with severe mental illness and their families to access disability certification, to access government benefits such as pensions, grants and disability benefits, as well as work schemes.	Case study	Narrative description
36. World Health Organization (2021)	Georgia	Hand in Hand supported living	An organisation providing employment support by collaborating with community social enterprises and employers.	Case study	Narrative description
37. World Health Organization (2021)	India	Home Again housing and supportive services	The Banyan organisation's housing and supportive services initiative provides access to housing, establishing work placements, educational support, and linking with various community resources to promote recovery efforts.	Case study	Narrative description

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

187 *Overview of SMI recovery approaches*

188 Several different approaches to supporting recovery were highlighted. A common initiative
189 was the establishment of community-based psychosocial rehabilitation centres, which were
190 often run as a collaborative between family members, mental health professionals, and other
191 community resources, to provide psychosocial, job and basic needs support to people with
192 severe mental illness, described in India, Turkey and the Kyrgyz Republic (Soygür et al., 2017,
193 Saha et al., 2020, Pfizer and Kavitha, 2018, Kallivayalil and Sudhakar, 2018, Molchanova,
194 2014). Also, the clubhouse model for psychosocial rehabilitation was reported in China (Chen
195 et al., 2020), one case describing linkages with a supported employment programme in
196 surrounding communities (World Health Organization, 2021). Supported housing, especially
197 focusing on those experiencing poverty and homelessness, was described in India, (Anish,
198 2013, Padmakar et al., 2020, World Health Organization, 2021) and Brazil (Acebal et al.,
199 2021). In some instances, mental health teams performed various services, for instance
200 facilitating residential training and placement according to individual preferences and needs
201 – an example is a Recovery Oriented Services (ROSeS) team in India facilitating placement at a
202 rural development centre for an individual who was interested in agriculture and animal
203 husbandry (Vijayan, 2021). Some teams, for instance a mental health outreach team in India,
204 also facilitated service access through telepsychiatry (Rao et al., 2022), and others, like
205 Atmiyata, facilitated access to government-based social benefits including pensions, rural
206 employment grants, disability benefits and other financial assistance, through the
207 establishment of mental health champions (World Health Organization, 2021). Recovery
208 models that included task-sharing of services to non-specialist workers were reported in
209 South Africa (Brooke-Sumner et al., 2018) and India (Chatterjee et al., 2014). A Critical Time
210 Intervention with task-sharing (CTI-TS) was reported in Chile and Brazil, involving
211 psychosocial support during the transition from psychiatric hospital discharge to community
212 settings (Mascayano et al., 2022). A case describing a multifamily group intervention based
213 on trialogue, psychosis seminars, and co-learning was described in Bosnia and Herzegovina
214 (Muhić et al., 2022), with an NGO-delivered multicomponent intervention for people with
215 severe mental illness and caregivers that included biomedical treatment and supporting
216 economic independence in Nepal (Raja et al., 2012). The salience of integration with religious
217 practices was described in Java (Subandi, 2015) and Egypt (Rashed, 2015). In China, a national

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

218 pilot programme was described that involved psychosocial rehabilitation through
219 cooperation among government organisations and between government and other relevant
220 social organisations (Li and Ma, 2021). A study in Ethiopia seeking to develop a community-
221 based rehabilitation intervention for people with schizophrenia, focused on the development
222 of a specific cadre of worker that would facilitate better networking with other NGO services
223 and expand to other forms of disability as well (Asher et al., 2015, Asher et al., 2022).

224

225 *Dimensions of multi-and intersectoral collaboration in supporting recovery*

226 As suggested by the number of papers included in this synthesis, very few examples could be
227 found that explicitly highlight the involvement of sectors other than health in recovery
228 processes in community settings. Only one study described an intersectoral collaboration
229 between health and other sectors in supporting SMI recovery on a national, policy-level scale,
230 describing the formalising of governance and funding structures for better
231 interorganisational collaboration and funding in China (Li and Ma, 2021). In terms of
232 programmatic interventions, several dimensions of multi- and intersectoral collaboration
233 emerged, described below in terms of Health and Housing, Health and Community Support
234 Systems, Supportive Community Spaces for Recovery, and Bridging Biomedical and Social
235 Spheres of Care through Lay Health Workers.

236 *Health and housing*

237 There were instances of collaboration between the health sector and various actors involved
238 in providing supported housing to people living with SMIs. The Phoenix Clubhouse in Hong
239 Kong, China, put in place arrangements with housing partners, including public housing,
240 supported hostels, halfway houses, long-stay care homes and residential respite services,
241 which members can access (World Health Organization, 2021). An Indian study (Anish, 2013)
242 reported that the majority of residential facilities for people with SMI were provided by faith-
243 based organisations with funds from public donations. These faith-based organisations
244 tended to collaborate with other sectors during the period when service users are admitted
245 to the centre following referral by mental health professionals, family members, police, and
246 social services.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

247

248 An example of this kind of collaboration is the Banyan's supported housing model. The
249 Banyan started out as a crisis intervention and rehabilitation centre for homeless women
250 with mental illness in the city of Chennai, India, and has expanded its services to include
251 emergency, open shelter and street-based services, social care, and long-term and
252 alternative living. In support of living arrangements, the organisation entered into rental
253 agreements with private property owners in order to secure housing for people with SMI,
254 who were supported through stages of confrontation, adaptation, and stabilisation
255 (Padmakar et al., 2020). A Brazilian study (Acebal et al., 2021) investigated service users'
256 perspectives on the relationship between housing needs and mental health/illness. It
257 highlighted the importance of the links between 'residential therapeutic services' (supported
258 housing) and biomedical health facilities but details of the working relationships between
259 health facilities and residential facilities were lacking.

260 *Health and community support systems*

261 A key area for multi- and intersectoral collaboration is the setting up and strengthening of
262 community-based support resources beyond the health sector. In the aforementioned CTI-TS
263 model in South America, lay community mental health workers and peer support workers
264 formed CTI teams that provided structured, time-limited support to people discharged from
265 psychiatric hospitalisation. Working from community mental health centres, a key task in this
266 initiative was to support beneficiaries through linking them to informal and formal support
267 systems in communities (including local leisure clubs and community centres) after which a
268 gradual withdrawal period would take place thereby lessening dependence on the CTI
269 programme or institutional mental health services (Mascayano et al., 2022, Mascayano et al.,
270 2019b, Silva et al., 2017). The multifamily support group model in Bosnia and Herzegovina
271 served to mobilise mutual support in community settings (Muhić et al., 2022), Two studies
272 described mental health service networks across sectors, that included support for people
273 living with SMI. In Liberia, The Carter Center Mental Health Program (TCC-MHP) partnered
274 with the Liberian police sector to develop Crisis Intervention Teams (CIT) to create more
275 supportive services for people living with SMI (Kohrt et al., 2015). In Timor-Leste,
276 collaboration and referral between mental health and social service delivery platforms were
277 reported, that included referral from police, local authorities, private care and social services

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

278 to government health facilities for care, particularly those living with SMI. Government
279 services in turn referred people to support organisations, including housing support for
280 people living with SMI (Hall et al., 2019). In a similar study from South Africa, a range of NGO
281 activities were described, where people living with SMI were sometimes referred to
282 organisations for housing and basic needs support, as well as to a social services organisation
283 that provided home-based psychotherapy, group therapy, social support, community
284 awareness and education campaigns. There were also instances of collaborating with old-age
285 facilities to provide housing support to people with SMI (Janse van Rensburg et al., 2018).

286 *Supportive community spaces for recovery*

287 Given the history and prevalence of stigma, discrimination, and structural barriers to social
288 integration faced by people living with SMI, recovery processes require safe and supportive
289 spaces in communities. The Centro de Atenção Psicosocial (CAPS) in Brazil is a network of
290 community-based mental health centres, which promotes active citizenship through a range
291 of services, including supporting people through the various bureaucracies of obtaining
292 formal documentation and access social support, training and education, access to
293 supportive housing, and supportive work placement, with collaborations across the sectors of
294 health, education, justice, social assistance, and various non-governmental agencies (World
295 Health Organization, 2021). The well-known clubhouse model of psychosocial rehabilitation,
296 with its roots in the 1940s in New York, was applied in Chinese settings and involved non-
297 residential services that included employment and supported education programmes, linked
298 with private and education sectors (Chen et al., 2020, World Health Organization, 2021).
299 Another example is the Blue Horse Café in Turkey, a therapeutic community and supported-
300 employment setting where most services offered by the café are performed by people living
301 with SMI, including food preparation and serving, reservation management, cleaning,
302 management and organisation, and selling of second-hand goods. This provides a protective
303 environment within which people with SMI can participate in the labour sector, while also
304 receiving therapeutic support (Soygür et al., 2017). Another programme in Turkey assisted
305 service users through case management, where people were supported in preparing CVs and
306 job interviewing, interviews with labour agencies, and reviewing of vacancies. People were
307 also accompanied during job interviews, and during their first days of employment, and
308 relationships were established between case managers and line managers in work places

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

309 (İncedere and Yildiz, 2019). In India, the Rajah Rehabilitation Centre (RRC) collaborates with
310 employers to secure employment for people with SMI, following a period of supported work
311 and skills development. There is also collaboration with community-based Alcoholics
312 Anonymous and Al-Anon support groups to support participants and their families who have
313 to deal with challenges related to substance abuse, while legal services are made accessible
314 through a collaboration with a Legal Aid clinic (Pfizer and Kavitha, 2018). The development of
315 peer support networks in Kenya connected people living with SMI with skill-building in
316 livelihood activities, such as drought-resistant farming and making detergent (de Menil et al.,
317 2015). In Ghana, supportive spaces including housing was provided in prayer camps,
318 overseen by local prophets (Arias et al., 2016).

319 *Bridging biomedical and social spheres of care through lay health workers*

320 Instances emerged where lay health workers were trained and supervised by mental health
321 professionals to provide community-based services, thereby bridging the domain of
322 healthcare within facilities with the social dimensions of recovery in community settings. In
323 the community-based intervention for people with schizophrenia and their caregivers in India
324 (COPSI), the programme included the linkage of people with SMI with community agencies
325 and user-led self-help groups. This provided a support for seeking employment as well as to
326 access social and legal benefits (Chatterjee et al., 2014). A similar intervention was described
327 in South Africa, where a community-based psychosocial rehabilitation intervention was
328 delivered in partnership with PHC health clinics and a local NGO by auxiliary social workers.
329 Participants for the intervention were recruited through clinics and intervention conducted in
330 clinic premises by auxiliary social workers (Brooke-Sumner et al., 2018). A Nepalese study of
331 an NGO delivered multicomponent intervention for people with severe mental illness and
332 caregivers (access to biomedical treatment and enabling service users and caregivers to
333 develop a livelihood) recommended expanding scope of training of community health
334 workers to include skills in delivering support for sustainable livelihood interventions (Raja et
335 al., 2012).

336 ***Barriers to multi- and intersectoral collaboration***

337 Though difficult to assess comprehensively due to the ambiguity of descriptions of multi- and
338 intersectoral collaboration, limited barriers to such collaboration emerged. A key barrier

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

339 highlighted in the Chinese interorganisational collaboration case was differences in
340 commitment and professional authority between organisations, both government and non-
341 government. Specifically, there stronger institutional commitment of actors in the health
342 sector were reinforced by the greater degree of professional authority wielded by
343 psychiatrists (Li and Ma, 2021). The Blue Horse Café case in Turkey highlighted contrasts in
344 relationships with healthcare workers versus relationships in a community-based therapeutic
345 community, with descriptions of the former cold, indifferent, or lacking in sincerity, whereas
346 the humanistic aspects of the latter were detailed in terms of equal power relations and
347 mutual respect. The space was described as supportive of power sharing between health
348 workers and people living with SMI (Soygür et al., 2017). However, not all healthcare workers
349 might feel comfortable working outside the spheres of health facilities. In the reporting of the
350 Banyan supported housing model, healthcare workers experienced challenges adapting to
351 their roles in community settings and social rather than biomedical orientation. There was
352 also a cultural dimension, in that unmarried female healthcare workers felt pressure to justify
353 them living unmarried in the community where they worked (Padmakar et al., 2020). In the
354 Chinese case, a lack of role clarification for frontline workers attending to multiple vulnerable
355 populations and working across sectors resulted in them experiencing increased pressure to
356 deal with SMI. Also, the dominance of the Chinese government resulted in cooperation
357 between government and social organisations being driven by the willingness of government
358 organisations to work with social organisations (and not vice versa), thereby skewing the
359 power differential towards government departments rooted in psychiatric professional
360 expertise (Li and Ma, 2021). Nonetheless, intersectoral working was codified in formal
361 arrangements, which is not the case in many other settings. In South Africa, there is a
362 recognized need for input from social services, education, labour into recovery programmes
363 (Gamieldien et al., 2022). Further, recommendations were made that the Department of
364 Health, Department of Social Development and NGO sectors should improve communication
365 between sectors, promote leadership from all levels and formalise intersectoral relationships
366 through appropriate written agreements (Brooke-Sumner et al., 2016). The lack of formal
367 agreements and intersectoral policy was also highlighted in Timor-Leste, which often
368 translated into limited prioritising of mental healthcare (Hall et al., 2019). Finally, there are
369 persistent structural barriers faced by organisations and individuals alike when pursuing SMI
370 recovery in community settings. For instance, the Banyan model faced challenged from

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

371 private property owners when attempting to secure housing for their beneficiaries, which
372 included stigmatising attitudes towards people living with SMI and enacting a preference for
373 residents who are more functional and mobile (Padmakar et al., 2020).

374 Discussion

375 The aim of this scoping review was to identify and describe multi- and intersectoral
376 approaches to enable SMI recovery in LMICs. The principal finding of this scoping review is
377 that while such approaches have been widely supported in literature on developing
378 appropriate and responsive support systems for SMI, very few studies operationalise and
379 describe how multi-and intersectoral work is done in relation to recovery services in LMICs.
380 This is in contrast to the comparatively vast body of work on multisectoral interorganizational
381 collaboration and networks for community SMI care developed in HICs (Fleury and Mercier,
382 2002, Jørgensen et al., 2020, Lorant et al., 2017, Morrissey et al., 2002, Nicaise et al., 2021,
383 Rosenheck et al., 1998, Whiteford et al., 2014, Wiktorowicz et al., 2010). From its origins
384 from a WHO technical working group who realised that optimal sanitation requires a
385 coordination between traditional public health and infectious disease actors, and engineering
386 and water management specialists (de Leeuw, 2022), intersectoral action has gained traction
387 in global health discourse, though this has not been robustly translated to services supporting
388 SMI recovery. Our review highlights several areas where multi-and intersectoral collaboration
389 has been demonstrated in LMICs with respect to community support for people living with
390 SMI, particularly in the areas of housing support, the development and sustainment of
391 protective spaces where recovery can take place, and linkages between health facilities and
392 community resources.

393 The Integrated Recovery Model posits that each individual has subjective recovery needs,
394 centred around basic needs such as accommodation and employment, as well as less tangible
395 needs such as coping skills and hope. Three core components interact with these needs:
396 remediation of functioning (recovering mental and physical wellbeing), collaborative
397 restoration of skills and competencies (building hope through collaborative restoration of
398 agency, function, and participation), and active community reconnection (re-establishing a
399 place in the community with a range of skills and supports). Importantly, these processes
400 unfold in linear and overlapping fashion. During the critical period following deterioration of
401 wellbeing, remediation comes into play, where collaboration between various community

402 actors and sectors and acute mental health services are critical. During the restoration 403 period, psychosocial rehabilitation becomes central, which again necessitates the 404 mobilization of collaborations and resources in LMIC settings. Finally, moving towards an 405 achievement of a degree of recovery, various community-based actors including NGOs, faith-406 based actors and community members becomes key (Frost et al., 2017). Our findings here 407 suggest that, in most settings, elements of this model can be found, addressing the key 408 movements from psychiatric relapse to recovery and community integration – whether 409 through initial referral for specialist care, fulfilling basic needs, or sustaining safe spaces and 410 collaborations across sectors for people to recover.

411 Importantly, in many societies where tightly-knit families and high level of social cohesion are 412 prevalent, especially in African and sub-Indian continental communities, the family has (and 413 continues to be) a central locus of care beyond the boundaries of facility-based mental 414 healthcare (Alem et al., 2008, Chadda, 2012). Family caregivers in LMIC are key to creating an 415 environment that supports recovery but the burden of care is compounded by less 416 developed community systems of care, marked social stigma and certain cultural practices 417 (Karambelas et al., 2022). People with SMI and their caregivers face barriers to securing 418 formal income or employment, food, housing, transport, and education (Addo et al., 2018). 419 Holistic care for this vulnerable group is thus intricately linked with poverty alleviation, 420 development, and working towards social inclusion (Plagerson, 2015, Jenkins et al., 2011a, 421 Jenkins et al., 2011b, Jenkins et al., 2011c, Lund et al., 2011) all of which have been 422 hampered by the impact of COVID-19 (Kola et al., 2021).

423 Several studies indicate the leading coordinating role of non-governmental or charitable 424 organizations (e.g. BasicNeeds) in bringing together stakeholders from other sectors for 425 recovery-focused work. While this may be effective, NGOs are commonly reliant on donor 426 funding and programmes may not be sustained in the long-term and the corresponding 427 influence in coordinating intersectoral action may be eroded. While a whole of government 428 approach is indicated it is likely that one stakeholder or partner sector should take a leading 429 coordinating role in sustaining intersectoral work and this need not be the health sector. In 430 principle this involves moving away from a purely biomedical model of treatment and 431 recovery for severe mental illness in which sectors other than the health sector recognize the 432 role of the social environment in creating psychosocial disability associated with these

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

433 conditions (World Health Organization, 2019). The benefits of such a shift also include
434 sharing of the economic burden of SMI across sectors, a critical step away from health
435 facility-focused spending (OECD, 2021). Although the literature on operationalised
436 intersectoral and multisectoral work for recovery is limited, findings of this review suggest
437 overarching domains for action that may be pursued (in context-specific ways) to drive
438 intersectoral work in LMIC. These are: (i) building relationships between key actors including
439 people with lived experience and families (iii) prioritising supportive spaces for recovery that
440 help with fulfilling basic needs; (iii) building leadership capacity among actors to solidify and
441 formalise intersectoral work; and (iv) integrating resource allocation between actors to
442 upderpin these approaches. Country specific approaches to may also benefit from
443 leapfrogging, that is, harnessing strategies previously used in intersectoral initiatives of
444 disability movements and advocacy for treatment and care for HIV and TB in LMIC.

445 Limitations

446 The main limitation of this scoping review was the exclusion of non-English language papers,
447 and of grey literature. This approach was taken as a feasible first approach to scoping the
448 literature on this topic. A future review should consider inclusion of grey literature, given the
449 importance of the non-profit/non-government sector in provision of community-based
450 services for recovery. This review also did not include searches specifically looking at social
451 welfare payments and health insurance coverage for treatment costs (which are available in
452 some LMIC and may be considered a form of intersectoral work). A further scoping review is
453 in process that will cover this topic.
454

455 Conclusion

456 Multi- and intersectoral collaboration lies at the heart of recovery – "medical solutions to
457 social problems are expensive, ineffective, and inefficient", and integration between the
458 biomedical and the social is "humane, cost-effective, and truly recovery-oriented" (Drake and
459 Whitley, 2014). In this review, we have described limited, though promising, examples of
460 such action. This hopefully serves as a call for researchers, policymakers and service providers
461 to both work more deliberately with other sectors and to strive to be more strategic in doing
462 so, while keeping the recovery needs of the individual at the centre of actions.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

463

464 Considerations for the future

465 As the barriers outlined in the findings suggest, these are often piecemeal and relatively
466 uncoordinated ventures, and require more deliberate, strategically coordinated actions.
467 Multi- and intersectoral action for health and wellbeing involve strategies and action plans;
468 long-term multisectoral and intersectoral initiatives; permanent structures; projects;
469 legislative or parliamentary decisions; and tools (World Health Organization, 2018). The
470 following five recommendations have been suggested to facilitate intersectoral action for
471 mental health in LMICs (Skeen et al., 2010) which align with the four domains for action
472 described above:

473 1. Develop supportive legislation and policy alongside the other formalized structures
474 for intersectoral action

475 2. Develop leadership in the health sector and beyond, especially in cross-cutting
476 agencies

477 3. Employ targeted awareness-raising to engage all relevant sectors in order to specify
478 roles, responsibilities and strategies

479 4. Develop a formal, structured approach to intersectoral action for mental health to
480 address the lack of dedicated budgeting and unclear roles

481 5. Drive intersectoral work on a microlevel, in order to effectively address basic services
482 such as water, electricity and sanitation

483 The principles for recovery-related service delivery should further be couched in these
484 structures, including that services are person-centred, holistic and inclusive; enable agency
485 and self-management; integrated across the care continuum; seamless and complementary
486 across government departments, NGOs and other services; evidence-based; underlines
487 equity in choosing service options; and are aligned with national, national and local strategy
488 (Frost et al., 2017).

489 In terms of the findings reported here, generating universal recommendations or actions is
490 challenging given the wide array of health and social systems across countries and regions.
491 Nonetheless, there are thematic clusters that could provide direction to policymakers and

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

492 other stakeholders in strengthening recovery efforts in an inter and multisectoral way. A
493 common strategy that emerged relates to providing housing support, which ranged from
494 communal, semi-institutionalised recovery settings to independent living in supportive
495 housing arrangements. This requires the acquisition and appropriate management of physical
496 spaces and require partnerships between the health sector, public civil infrastructure sector
497 as well as private citizens and organisations, and formal arrangements through public-private
498 partnerships should be set in place. Regarding community support systems, many examples
499 here highlight linkages between people living with SMI and their caregivers, and various
500 community-based resources. This requires a community-based body, organisation, clinic or
501 government agency (depending on the health system configuration) that can set up
502 relationships with and curate a list of a range of resources that people can be referred to.
503 Especially in lower-resource settings, it is essential to tap into existing resources beyond the
504 health sector that often remain underutilised in supporting people living with SMI. Lessons
505 can be gleaned from many examples of multisectoral collaboration in addressing HIV, TB and
506 non-communicable diseases. In terms of supportive spaces for recovery, many NGOs provide
507 such environments with various types and degrees of support, much of which relates to
508 assistance in navigating the bureaucracies involved in accessing grant schemes as well as
509 supporting people to access the job market. This requires willing employers and a supportive
510 employment work environment, which, given perpetuating stigma, would require
511 educational investment as well as buy-in from appropriate employers. In terms of the
512 bureaucracies of accessing grant schemes, more can be done by government agencies to
513 remove administrative obstacles for people living with SMI, for example, making the medical
514 diagnostic screening process more accessible. Finally, it is crucial to develop an appropriate
515 health worker mix to deliver the complex range of activities within the ambit of recovery and
516 inter- and multisectoral approaches. Task-sharing and empowering lay health workers have
517 grown substantially as a viable option for constrained settings, and lay health workers can
518 potentially offer crucial linkages with sectors and resources outside of the health sector.
519 Nonetheless, these workers need appropriate training, regulation and a supportive career
520 pathway in order to sustain their role in recovery-oriented services.

521 Finally, a particular challenge that emerged during the search and screen phases of this
522 review was the imprecision evident in descriptions of multi-and intersectoral collaboration.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

523 Descriptions of the roles and remits of sectors were lacking, and are required to give context
524 to the application of multi or intersectoral work. Intersectoral collaboration has been
525 described as "an intricate web of interdependent organisations, individuals and behaviours,
526 implicitly or explicitly driven by beliefs or assumptions to pursue a set of interconnected
527 ideals, goals and objectives through the variously dispersed and joint control and allocation
528 of resources" (de Leeuw, 2022). Given this complexity, an approach to render descriptions of
529 multi- and intersectoral work more explicit could be for reviewers and journals involved in
530 publishing recovery-based studies and interventions to request details on the ways that
531 partnerships are formed and maintained (partnership working as a heading).

532 Author Contribution statement

533 AVR and CBS conceptualised the study, conducted the search, screening and analysis, and co-
534 wrote and endorsed the final draft.

535 Financial Support

536 AvR receives funding from the National Institute for Health Research (NIHR) (NIHR201816)
537 using UK aid from the UK Government to support global health research. The views
538 expressed in this publication are those of the author and not necessarily those of the NIHR or
539 the UK Department of Health and Social Care. Research reported in this publication is
540 supported by the National Institute of Mental Health (NIH) under award
541 number U19MH113191-01 and 1R34MH131233-01. The content is solely the responsibility of
542 the authors and does not necessarily represent the official views of the National Institutes of
543 Health. This work is based on the research supported in part by the National Research
544 Foundation of South Africa.

545 CBS is supported by grants from the South African Medical Research Council with funds
546 received from the South African National Department of Health and the UK Medical Research
547 Council, with funds received from the UK Government's Newton Fund.

548 Conflict of Interest statement

549 The authors declare no conflict of interest.

550 Ethics statement

551 Not applicable.

552 Data Availability statement

553 Data available on request from the corresponding author.

554

555 References

556 Acebal JS, Barbosa GC, Domingos TDS, Bocchi SCM and Paiva ATU (2021) Living in
557 psychosocial rehabilitation: analysis between Two Residential Therapeutic Services.
558 Saúde em Debate 44, 1120-1133.
559 Addo R, Agyemang SA, Tozan Y and Nonvignon J (2018) Economic burden of caregiving for
560 persons with severe mental illness in sub-Saharan Africa: A systematic review. PLOS
561 ONE 13, e0199830.
562 Al-Sawafi A, Lovell K, Renwick L and Husain N (2020) Psychosocial family interventions for
563 relatives of people living with psychotic disorders in the Arab world: systematic
564 review. BMC psychiatry 20, 1-14.
565 Alem A, Jacobsson L and Hanlon C (2008) Community-based mental health care in Africa:
566 mental health workers' views. World psychiatry : official journal of the World
567 Psychiatric Association (WPA) 7, 54-57.
568 Alhadidi MM, Lim Abdullah K, Yoong TL, Al Hadid L and Danaee M (2020) A systematic review
569 of randomized controlled trials of psychoeducation interventions for patients
570 diagnosed with schizophrenia. International Journal of Social Psychiatry 66, 542-552.
571 Ali S, Santomauro D, Ferrari AJ and Charlson F (2022) Excess mortality in severe mental
572 disorders: A systematic review and meta-regression. J Psychiatr Res 149, 97-105.
573 Anish K (2013) An evaluation of psychosocial rehabilitation facilities for homeless mentally ill
574 in India. Artha Journal of Social Sciences 12, 1-19.
575 Arahanthabailu P, Purohith AN, Kanakode R, Praharaj SK, Bhandary RP and Venkata
576 Narasimha Sharma PS (2022) Modified assertive community treatment program for
577 patients with schizophrenia: Effectiveness and perspectives of service consumers
578 from a South Indian setting. Asian Journal of Psychiatry 73, 103102.
579 Arias D, Taylor L, Ofori-Atta A and Bradley EH (2016) Prayer Camps and Biomedical Care in
580 Ghana: Is Collaboration in Mental Health Care Possible? PLOS ONE 11, e0162305.
581 Arksey H and O'malley L (2005) Scoping studies: towards a methodological framework.
582 International Journal of Social Research Methodology 8, 19-32.
583 Asher L, Birhane R, Weiss HA, Medhin G, Selamu M, Patel V, De Silva M, Hanlon C and Fekadu
584 A (2022) Community-based rehabilitation intervention for people with schizophrenia
585 in Ethiopia (RISE): results of a 12-month cluster-randomised controlled trial. The
586 Lancet Global Health 10, e530-e542.
587 Asher L, Fekadu A, Hanlon C, Mideksa G, Eaton J, Patel V and De Silva MJ (2015) Development
588 of a community-based rehabilitation intervention for people with schizophrenia in
589 Ethiopia. PLoS One 10, e0143572.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

590 Asher L, Fekadu A, Teferra S, De Silva M, Pathare S and Hanlon C (2017) "I cry every day and
591 night, I have my son tied in chains": physical restraint of people with schizophrenia in
592 community settings in Ethiopia. Global Health 13, 47.
593 Bighelli I, Rodolico A, García-Mieres H, Pitschel-Walz G, Hansen W-P, Schneider-Thoma J,
594 Siafis S, Wu H, Wang D and Salanti G (2021) Psychosocial and psychological
595 interventions for relapse prevention in schizophrenia: a systematic review and
596 network meta-analysis. The Lancet Psychiatry 8, 969-980.
597 Brooke-Sumner C, Lund C and Petersen I (2014) Perceptions of psychosocial disability
598 amongst psychiatric service users and caregivers in South Africa. Afr J Disabil 3, 146.
599 Brooke-Sumner C, Lund C and Petersen I (2016) Bridging the gap: investigating challenges
600 and way forward for intersectoral provision of psychosocial rehabilitation in South
601 Africa. Int J Ment Health Syst 10, 21.
602 Brooke-Sumner C, Petersen I, Asher L, Mall S, Egbe CO and Lund C (2015) Systematic review
603 of feasibility and acceptability of psychosocial interventions for schizophrenia in low
604 and middle income countries. BMC psychiatry 15, 1-12.
605 Brooke-Sumner C, Selohilwe O, Mazibuko MS and Petersen I (2018) Process evaluation of a
606 pilot intervention for psychosocial rehabilitation for service users with schizophrenia
607 in North West Province, South Africa. Community mental health journal 54, 1089-
608 1096.
609 Chadda RK (2012) Six decades of community psychiatry in India. International psychiatry :
610 bulletin of the Board of International Affairs of the Royal College of Psychiatrists 9, 45-
611 47.
612 Chatterjee S, Naik S, John S, Dabholkar H, Balaji M, Koschorke M, Varghese M, Thara R, Weiss
613 HA and Williams P (2014) Effectiveness of a community-based intervention for people
614 with schizophrenia and their caregivers in India (COPSI): a randomised controlled trial.
615 The Lancet 383, 1385-1394.
616 Chen Y, Yau E, Lam C, Deng H, Weng Y, Liu T and Mo X (2020) A 6-Month Randomized
617 Controlled Pilot Study on the Effects of the Clubhouse Model of Psychosocial
618 Rehabilitation with Chinese Individuals with Schizophrenia. Adm Policy Ment Health
619 47, 107-114.
620 Davies C, Radua J, Cipriani A, Stahl D, Provenzani U, Mcguire P and Fusar-Poli P (2018) Efficacy
621 and acceptability of interventions for attenuated positive psychotic symptoms in
622 individuals at clinical high risk of psychosis: a network meta-analysis. Frontiers in
623 Psychiatry 9, 187.
624 De Leeuw E (2022) Intersectorality and health: a glossary. J Epidemiol Community Health 76,
625 206-208.
626 De Menil V, Knapp M, Mcdaid D, Raja S, Kingori J, Waruguru M, Wood SK, Mannarath S and
627 Lund C (2015) Cost-effectiveness of the Mental Health and Development model for
628 schizophrenia-spectrum and bipolar disorders in rural Kenya. Psychological medicine
629 45, 2747-2756.
630 Diminic S, Carstensen G, Harris M, Reavley N, Pirkis J, Meurk C, Wong I, Bassilios B and
631 Whiteford H (2015) Intersectoral policy for severe and persistent mental illness:
632 review of approaches in a sample of high-income countries. Global Mental Health 2.
633 Drake RE and Whitley R (2014) Recovery and severe mental illness: description and analysis.
634 Can J Psychiatry 59, 236-42.
635 Fleury M-J, Grenier G, Vallée C, Aubé D and Farand L (2017) Implementation of integrated
636 service networks under the Quebec mental health reform: facilitators and barriers

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

637 associated with different territorial profiles. International Journal of Integrated Care
638 17.
639 Fleury M-J and Mercier C (2002) Integrated Local Networks as a Model for Organizing Mental
640 Health Services. Administration and Policy in Mental Health and Mental Health
641 Services Research 30, 55-73.
642 Frederick DE and Vanderweele TJ (2019) Supported employment: Meta-analysis and review
643 of randomized controlled trials of individual placement and support. PloS one 14,
644 e0212208.
645 Frost BG, Tirupati S, Johnston S, Turrell M, Lewin TJ, Sly KA and Conrad AM (2017) An
646 Integrated Recovery-oriented Model (IRM) for mental health services: evolution and
647 challenges. BMC Psychiatry 17, 22.
648 Gamieldien F, Galvaan R, Myers B and Sorsdahl K (2022) Service Providers Perspectives on
649 Personal Recovery from Severe Mental Illness in Cape Town, South Africa: A
650 Qualitative Study. Community Ment Health J 58, 955-966.
651 Gamieldien F, Galvaan R, Myers B, Syed Z and Sorsdahl K (2021) Exploration of recovery of
652 people living with severe mental illness (SMI) in low/middle-income countries (LMICs):
653 a scoping review. BMJ Open 11, e045005.
654 Grazier KL, Mowbray CT and Holter MC (2005) Rationing psychosocial treatments in the
655 United States. Int J Law Psychiatry 28, 545-60.
656 Hall T, Kakuma R, Palmer L, Minas H, Martins J and Armstrong G (2019) Intersectoral
657 collaboration for people-centred mental health care in Timor-Leste: a mixed-methods
658 study using qualitative and social network analysis. International Journal of Mental
659 Health Systems 13, 72.
660 İncedere A and Yildiz M (2019) Case Management for Individuals with Severe Mental Illness:
661 Outcomes of a 24-Month Practice. Turkish Journal of Psychiatry 30.
662 Isaacs AN (2022) Care coordination as a collaborative element of recovery oriented services
663 for persons with severe mental illness. Australasian Psychiatry 30, 110-112.
664 Janse Van Rensburg A, Petersen I, Wouters E, Engelbrecht M, Kigozi G, Fourie P, Van
665 Rensburg D and Bracke P (2018) State and non-state mental health service
666 collaboration in a South African district: a mixed methods study. Health Policy and
667 Planning 33, 516-527.
668 Jbi 2015. Joanna Briggs Institute Reviewers' Manual: Methodology for JBI Scoping Reviews.
669 Adelaide.
670 Jenkins R, Baingana F, Ahmad R, Mcdaid D and Atun R (2011a) International and national
671 policy challenges in mental health. Mental Health in Family Medicine 8, 101.
672 Jenkins R, Baingana F, Ahmad R, Mcdaid D and Atun R (2011b) Mental health and the global
673 agenda: core conceptual issues. Mental health in family medicine 8, 69-82.
674 Jenkins R, Baingana F, Ahmad R, Mcdaid D and Atun R (2011c) Social, economic, human rights
675 and political challenges to global mental health. Mental Health in Family Medicine 8,
676 87.
677 Jørgensen K, Rasmussen T, Hansen M and Andreasson K (2021) Recovery-oriented
678 intersectoral care between mental health hospitals and community mental health
679 services: An integrative review. International Journal of Social Psychiatry 67, 788-800.
680 Jørgensen K, Rasmussen T, Hansen M, Andreasson K and Karlsson B (2020) Recovery-oriented
681 intersectoral care in mental health: As perceived by healthcare professionals and
682 users. International Journal of Environmental Research and Public Health 17, 8777.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

683 Kallivayalil RA and Sudhakar S (2018) Effectiveness of a new low-cost psychosocial
684 rehabilitative model to reduce burden of disease among persons with severe mental
685 illness: An interventional follow-up study. Indian J Psychiatry 60, 65-70.
686 Karambelas GJ, Filia K, Byrne LK, Allott KA, Jayasinghe A and Cotton SM (2022) A systematic
687 review comparing caregiver burden and psychological functioning in caregivers of
688 individuals with schizophrenia spectrum disorders and bipolar disorders. BMC
689 Psychiatry 22, 422.
690 Kohrt BA, Blasingame E, Compton MT, Dakana SF, Dossen B, Lang F, Strode P and Cooper J
691 (2015) Adapting the Crisis Intervention Team (CIT) Model of Polic e–M ental Health
692 Collaboration in a Low-Income, Post-Conflict Country: Curriculum Development in
693 Liberia, West Africa. American journal of public health 105, e73-e80.
694 Kola L, Kohrt BA, Hanlon C, Naslund JA, Sikander S, Balaji M, Benjet C, Cheung EYL, Eaton J
695 and Gonsalves P (2021) COVID-19 mental health impact and responses in low-income
696 and middle-income countries: reimagining global mental health. The Lancet
697 Psychiatry 8, 535-550.
698 Lambert AM, Parretti HM, Pearce E, Price MJ, Riley M, Ryan R, Tyldesley-Marshall N, Avşar TS,
699 Matthewman G, Lee A, Ahmed K, Odland ML, Correll CU, Solmi M and Marshall T
700 (2022) Temporal trends in associations between severe mental illness and risk of
701 cardiovascular disease: A systematic review and meta-analysis. PLOS Medicine 19,
702 e1003960.
703 Levac D, Colquhoun H and O'brien KK (2010) Scoping studies: advancing the methodology.
704 Implementation Science 5, 69.
705 Li Y and Ma H (2021) Interorganisational cooperation and its effects on community
706 rehabilitation for people with severe mental disorders in Beijing, China: A case study.
707 Health Soc Care Community 29, 154-163.
708 Lorant V, Nazroo J and Nicaise P (2017) Optimal Network for Patients with Severe Mental
709 Illness: A Social Network Analysis. Adm Policy Ment Health 44, 877-887.
710 Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, Knapp M and Patel V (2011)
711 Poverty and mental disorders: breaking the cycle in low-income and middle-income
712 countries. The lancet 378, 1502-1514.
713 Lutgens D, Gariepy G and Malla A (2017) Psychological and psychosocial interventions for
714 negative symptoms in psychosis: systematic review and meta-analysis. The British
715 Journal of Psychiatry 210, 324-332.
716 Macdougall AG, Krupa T, Lysaght R, Mutiso V, Casey R, Le Ber MJ, Ruhara R, Price E, Kidd S
717 and Ndetei DM (2022) The CREATE strategy of rehabilitation and recovery for mental
718 illness in low resource settings: Development processes and evaluation from a proof
719 of concept study in Kenya. International Journal of Mental Health 51, 32-60.
720 Mascayano F, Alvarado R, Andrews HF, Baumgartner JN, Burrone MS, Cintra J, Conover S,
721 Dahl CM, Fader KM and Gorroochurn P (2022) A Recovery-Oriented Intervention for
722 People With Psychosis: A Pilot Randomized Controlled Trial. Psychiatric Services, appi.
723 ps. 202000843.
724 Mascayano F, Alvarado R, Andrews HF, Jorquera MJ, Lovisi GM, Souza FM, Pratt C, Rojas G,
725 Restrepo-Toro ME, Fader K, Gorroochurn P, Galea S, Dahl CM, Cintra J, Conover S,
726 Burrone MS, Baumgartner JN, Rosenheck R, Schilling S, Sarução KR, Stastny P, Tapia E,
727 Cavalcanti MT, Valencia E, Yang LH and Susser E (2019a) Implementing the protocol of
728 a pilot randomized controlled trial for the recovery-oriented intervention to people
729 with psychoses in two Latin American cities. Cad Saude Publica 35, e00108018.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

730 Mascayano F, Alvarado R, Andrews HF, Jorquera MJ, Lovisi GM, Souza FMD, Pratt C, Rojas G,
731 Restrepo-Toro ME and Fader K (2019b) Implementing the protocol of a pilot
732 randomized controlled trial for the recovery-oriented intervention to people with
733 psychoses in two Latin American cities. Cadernos de saude publica 35, e00108018.
734 Molchanova E (2014) Mental Health Rehabilitation in the Kyrgyz Republic: Official and
735 Indigenous Models. Journal of Psychosocial Rehabilitation and Mental Health 1, 23-
736 26.
737 Mondal S, Van Belle S and Maioni A (2021) Learning from intersectoral action beyond health:
738 a meta-narrative review. Health Policy and Planning 36, 552-571.
739 Morillo H, Lowry S and Henderson C (2022) Exploring the effectiveness of family-based
740 interventions for psychosis in low-and middle-income countries: a systematic review.
741 Social psychiatry and psychiatric epidemiology, 1-21.
742 Morrissey JP, Calloway MO, Thakur N, Cocozza J, Steadman HJ, Dennis D and Team ANE
743 (2002) Integration of service systems for homeless persons with serious mental illness
744 through the ACCESS program. Psychiatric Services 53, 949-957.
745 Muhić M, Janković S, Sikira H, Slatina Murga S, Mcgrath M, Fung C, Priebe S and Džubur
746 Kulenović A (2022) Multifamily groups for patients with schizophrenia: an exploratory
747 randomised controlled trial in Bosnia and Herzegovina. Soc Psychiatry Psychiatr
748 Epidemiol 57, 1357-1364.
749 National Institute of Mental Health. 2022. *Mental Illness* [Online].
750 https://www.nimh.nih.gov/health/statistics/mental-illness: National Institutes of
751 Health. [Accessed 14 November 2022].
752 Nicaise P, Grard A, Leys M, Van Audenhove C and Lorant V (2021) Key dimensions of
753 collaboration quality in mental health care service networks. Journal of
754 Interprofessional Care 35, 28-36.
755 Nuño R, Coleman K, Bengoa R and Sauto R (2012) Integrated care for chronic conditions: The
756 contribution of the ICCC Framework. Health Policy 105, 55-64.
757 Nxumalo Ngubane S, Mcandrew S and Collier E (2019) The experiences and meanings of
758 recovery for Swazi women living with "schizophrenia". J Psychiatr Ment Health Nurs
759 26, 153-162.
760 Oecd 2021. A New Benchmark for Mental Health Systems: Tackling the Social and Economic
761 Costs of Mental Ill-Health, OECD Health Policy Studies. OECD Publishing Paris, France.
762 Oni T, Mcgrath N, Belue R, Roderick P, Colagiuri S, May CR and Levitt NS (2014) Chronic
763 diseases and multi-morbidity - a conceptual modification to the WHO ICCC model for
764 countries in health transition. BMC Public Health 14, 575.
765 Onken SJ, Craig CM, Ridgway P, Ralph RO and Cook JA (2007) An analysis of the definitions
766 and elements of recovery: a review of the literature. Psychiatric rehabilitation journal
767 31, 9.
768 Padmakar A, De Wit EE, Mary S, Regeer E, Bunders-Aelen J and Regeer B (2020) Supported
769 Housing as a recovery option for long-stay patients with severe mental illness in a
770 psychiatric hospital in South India: Learning from an innovative de-hospitalization
771 process. PLoS One 15, e0230074.
772 Patel V (2015) Universal Health Coverage for Schizophrenia: A Global Mental Health Priority.
773 Schizophrenia Bulletin 42, 885-890.
774 Patel V (2016) Universal health coverage for schizophrenia: a global mental health priority.
775 Schizophrenia bulletin 42, 885-890.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

776 Pfizer N and Kavitha M (2018) Psychosocial rehabilitation: a model by Rajah Rehabilitation
777 Centre. Kerala Journal of Psychiatry 31.
778 Plagerson S (2015) Integrating mental health and social development in theory and practice.
779 Health policy and planning 30, 163-170.
780 Raja S, Underhill C, Shrestha P, Sunder U, Mannarath S, Wood SK and Patel V (2012)
781 Integrating mental health and development: a case study of the BasicNeeds Model in
782 Nepal. PLoS Med 9, e1001261.
783 Rao K, John S, Kulandesu A, Karthick S, Senthilkumar S, Gunaselvi T, Raghavan V and Thara R
784 (2022) Psychosocial Rehabilitation of Persons with Severe Mental Disorders in Rural
785 South India: Learnings from Step Project. Journal of Psychosocial Rehabilitation and
786 Mental Health.
787 Rashed M (2015) From Powerlessness to control: psychosis, spirit possession and recovery in
788 the Western desert of Egypt. Health, Culture and Society 8, 10-26.
789 Rodolico A, Bighelli I, Avanzato C, Concerto C, Cutrufelli P, Mineo L, Schneider-Thoma J, Siafis
790 S, Signorelli MS and Wu H (2022) Family interventions for relapse prevention in
791 schizophrenia: a systematic review and network meta-analysis. The Lancet Psychiatry.
792 Rosenheck R, Morrissey J, Lam J, Calloway M, Johnsen M, Goldman H, Randolph F, Blasinsky
793 M, Fontana A and Calsyn R (1998) Service system integration, access to services, and
794 housing outcomes in a program for homeless persons with severe mental illness.
795 American Journal of Public Health 88, 1610-1615.
796 Saha S, Chauhan A, Buch B, Makwana S, Vikar S, Kotwani P and Pandya A (2020) Psychosocial
797 rehabilitation of people living with mental illness: Lessons learned from community-
798 based psychiatric rehabilitation centres in Gujarat. J Family Med Prim Care 9, 892-897.
799 Sanni S, Wisdom JP, Ayo-Yusuf OA and Hongoro C (2019) Multi-sectoral approach to
800 noncommunicable disease prevention policy in Sub-Saharan Africa: a conceptual
801 framework for analysis. International Journal of Health Services 49, 371-392.
802 Silva P, Carvalho MCA, Cavalcanti MT, Echebarrena RC, Mello AS, Dahl CM, Lima DB and
803 Souza FM (2017) Deinstitutionalization of long stay patients in a psychiatric hospital in
804 Rio de Janeiro. Cien Saude Colet 22, 2341-2352.
805 Sin J and Spain D (2017) Psychological interventions for trauma in individuals who have
806 psychosis: a systematic review and meta-analysis. Psychosis 9, 67-81.
807 Skeen S, Kleintjes S, Lund C, Petersen I, Bhana A, Flisher AJ, Health TM and Consortium PRP
808 (2010) 'Mental health is everybody's business': roles for an intersectoral approach in
809 South Africa. International Review of Psychiatry 22, 611-623.
810 Solmi M, Croatto G, Piva G, Rosson S, Fusar-Poli P, Rubio JM, Carvalho AF, Vieta E, Arango C
811 and Detore NR (2022) Efficacy and acceptability of psychosocial interventions in
812 schizophrenia: systematic overview and quality appraisal of the meta-analytic
813 evidence. Molecular Psychiatry, 1-15.
814 Soygür H, Yüksel MM, Eraslan P and Attepe Özden S (2017) [Lessons Learned from
815 Experiencing Mavi At Café (Blue Horse Café) during Six Years: A Qualitative Analysis of
816 Factors Contributing to Recovery from the Perspective of Schizophrenia Patients].
817 Turk Psikiyatri Derg 28, 75-80.
818 Subandi M (2015) Bangkit: the processes of recovery from first episode psychosis in Java.
819 Culture, Medicine, and Psychiatry 39, 597-613.
820 Tirfessa K, Lund C, Medhin G, Hailemichael Y, Fekadu A and Hanlon C (2019) Food insecurity
821 among people with severe mental disorder in a rural Ethiopian setting: a comparative,
822 population-based study. Epidemiology and psychiatric sciences 28, 397-407.

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press

823 Tricco AC, Lillie E, Zarin W, O'brien KK, Colquhoun H, Levac D, Moher D, Peters MDJ, Horsley
824 T, Weeks L, Hempel S, Akl EA, Chang C, Mcgowan J, Stewart L, Hartling L, Aldcroft A,
825 Wilson MG, Garritty C, Lewin S, Godfrey CM, Macdonald MT, Langlois EV, Soares-
826 Weiser K, Moriarty J, Clifford T, Tuncalp O and Straus SE (2018) PRISMA Extension for
827 Scoping Reviews (PRISMA-ScR): Checklist and Explanation. Ann Intern Med 169, 467-
828 473.
829 Vera San Juan N, Gronholm PC, Heslin M, Lawrence V, Bain M, Okuma A and Evans-Lacko S
830 (2021) Recovery From Severe Mental Health Problems: A Systematic Review of
831 Service User and Informal Caregiver Perspectives. Frontiers in Psychiatry 12.
832 Vijayan T (2021) Psychiatric rehabilitation: A few recovery narratives. ASEAN Journal of
833 Psychiatry 22.
834 Warner R (2009) Recovery from schizophrenia and the recovery model. Current Opinion in
835 Psychiatry 22, 374-380.
836 Whiteford H, Mckeon G, Harris M, Diminic S, Siskind D and Scheurer R (2014) System-level
837 intersectoral linkages between the mental health and non-clinical support sectors: a
838 qualitative systematic review. Australian & New Zealand Journal of Psychiatry 48, 895-
839 906.
840 Whitley R, Palmer V and Gunn J (2015) Recovery from severe mental illness. Cmaj 187, 951-
841 952.
842 Wiktorowicz ME, Fleury M-J, Adair CE, Lesage A, Goldner E and Peters S (2010) Mental health
843 network governance: comparative analysis across Canadian regions. International
844 Journal of Integrated Care 10.
845 World Bank. 2022. *Low & Middle Income* [Online]. https://data.worldbank.org/country/XO:
846 World Bank. [Accessed 14 November 2022].
847 World Health Organization 2018. Multisectoral and intersectoral action for improved health
848 and well-being for all: mapping of the WHO European Region. Governance for a
849 sustainable future: improving health and well-being for all. World Health
850 Organization. Regional Office for Europe.
851 World Health Organization 2019. WHO Thematic Brief on Mental Health: Multisectoral Action
852 for Mental health. Geneva: WHO.
853 World Health Organization 2021. *Guidance on community mental health services: Promoting*
854 *person-centred and rights-based approaches,* Geneva, World Health Organization.
855 World Health Organization 2022. World mental health report: Transforming mental health
856 for all. Geneva: WHO.

857

858

https://doi.org/10.1017/gmh.2023.10 Published online by Cambridge University Press