THE ROLE OF COMMUNITY INTEGRATION AND EMPOWERMENT FOR THE TRANSFORMATIVE CHANGE IN COMMUNITY MENTAL HEALTH

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The present article first presents a critique about the current status of the community mental health (CMH) field. Second, based on theoretical and empirical literature, it presents a perspective inspired by the inception of community psychology, namely the empowerment and community integration principles to offer a challenging framework to inspire reforms in the CMH field. The article also discusses two promising CMH practices, supported employment and independent housing with support, determinant for the transformation of life conditions for people experiencing mental illness while promoting people's empowerment and integration in the community. The authors argue that CMH programs and practices focused on integration together with self-representation movements, organisations, or networks aligned with the community psychology acting principles have the potential to inform a renovated partnership within CMH stakeholders and bring about sustainable change focused on the active citizenship for people who experience mental illness.

***Keywords**: community mental health, empowerment, recovery, community integration*

1. Introduction

The present article provides a discussion that expands the frame of current community mental health (CMH) serving-system interventions in Europe and proposes the empowerment and community integration processes as core features for transformative change within CMH systems.

Despite the progress observed in recent decades of practice and systems renovation, the continuous separation of people who experienced mental illness in CMH services still remain captive to a medically-oriented system of support (Nelson, 2010). Likewise, they are facing

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situations of prevailing poverty including homelessness, lower quality of housing, poor nutrition, and poor health patterns with impacts on their longevity (Scheewe et al., 2013; Ströhle, 2009; Swarbrick, Murphy, Zechner, Spagnolo & Gill, 2011), long-term unemployment, economic dependency on family members, and social isolation (Nelson, Kloos & Ornelas, 2014b). Thus, analysis of current CMH services through a community psychology transformative approach to research and practice is presented here (Maton, 2000; Nelson, Kloos & Ornelas, 2014a; Trickett, 2009), reflecting on the prospective effects of the emergent high-impact programs and approaches (e.g., intervention-first approaches such as the supported employment and housing first programs).

In this article, we review the CMH transformative theoretical framework with a focus on community psychology principles. From the scope of CMH and community psychology, we analyse published accounts of recovery-oriented care and community integration; we also review empowerment or community integration and supported employment or housing-first literature, including our own empowerment and community integration research conducted with participants from those intervention-first community-oriented programs. We then discuss the development and transformation of the CMH system that is a core interest for community psychology. From our review, we intend to understand how CMH conditions have contributed toward the prevailing disparities in community living conditions of those who had experienced mental illness, about people's access to integrated contexts of employment, school, housing, and health care, and how community psychology research and practice might play a significant role in transforming CMH while promoting individuals' agency and sustainable social change efforts. We acknowledge that the field of CMH still assumes diverse meanings for different professional backgrounds, and even within psychology, there is not a consensual core practice. Therefore, we consider it crucial to provide a critical reflection on what a core practice for community psychology in CMH might become.

2. The Transformation in CMH: From Separation to Inclusion in Natural Contexts

In the post-deinstitutionalisation era, the community support system conceptualisation that emerged in the 1970s was defined as a team-based approach for teaching skills to people in the community and for crisis management (Baronet & Gerber, 1998; Stroul, 1989), having substantive arguments favouring the most humane or appropriate community contexts of practice, and the less expensive practice to deliver mental health services in comparison to hospital-based psychiatric practice (Blanch, Carling & Ridgway, 1988; Mosher & Burti, 1989). During the following decades, several model programs emerged aiming at treatment and rehabilitation of people with mental illness in the community environments.

From the outset stage of CMH, a new era of long-term rehabilitative services had emerged, which expanded worldwide as the countries adopted deinstitutionalisation and community integration in mental health policies in the second half of the 20th century (Shen & Snowden, 2014). Day centres or day treatment programs were then considered core structures of mental health systems. These were composed of a series of formal mental health support in the community, where professional interventions aimed at treatment issues, medication or illness management focused on reducing hospitalisation rates, and the provision of daily occupational or

psychosocial rehabilitation (Evans et al., 2012; Nelson, 2010; Parker & Knoll, 1990). The services were delivered in a community environment, but the core services were mainly service-oriented and occupational where people spend time playing cards and games, have access to some artistic or physical activities, socialise with their peers, or train their performance on daily life skills known as "meeting place-oriented." When programs of vocational-rehabilitation were adopted, day-care centres or clubhouses eventually created manufacturing, retail, or catering programs (i.e., sheltered/social firms; Eklund, Hansson & Ahlqvist, 2004; Eklund & Sandlund, 2012).

Frequently, the observation that people are physically located in the community but that they are not an effective part of it still persists, as it was simplistically presumed that their presence in the community was enough to facilitate community involvement and automatic integration (Nelson, Kloos & Ornelas, 2017). That happens because continuously the new mental health programs tend to reproduce many of the characteristics of the institutions they aimed to replace (Nelson et al., 2014b) such as the continuing tendency for separation and the maintenance of "protected" environments and the "chronicity" labels keep the focus on the individual limitations. This time, it is not centred on illness criteria but the functionality within the community, never questioning the influence of the programs or service models on the attained individual outcomes. Also, programs designed according to different degrees of limitation implicate people's assignments according to an evaluation performed by mental health experts. The argument for protected environments is the transitional approach or the so called "stair case" model based on the assumption of the preparation and graduation within a competence training curriculum for the last stage of transition to a natural community environment (Becker et al., 2001; Blanch, et al., 1988; Ornelas, Duarte & Jorge-Monteiro, 2014). Fisher and Ahern (2000), emphasised that the vision resulting from a rehabilitation paradigm is that the people with mental illnesses can improve social functioning with the support of professionals, but that process is limited; the transition to new environments implies new adjustments always requiring professional intervention. Conversely, research has demonstrated that capacities acquired in artificial environments are not generalisable in natural contexts (Becker et al., 2001; Corrigan & McCracken, 2005; Evans et al., 2012).

The move to the community by itself did not contribute to the expanding or strengthening of the natural support networks of people who experienced mental illness without additional support (Deegan, 1988; Salzer & Baron, 2014b; Yanos, Stefancic & Tsemberis, 2012). Thus, community-based mental health services that were devised to facilitate people's community involvement lost its ability over time and strongly contributed to a way of community existence in which people who experience mental health problems are just physically present in the community but access a very limited number of community resources and do not effectively participate in community life (Ornelas, Duarte et al., 2014; Salzer & Baron, 2014b).

Nelson and colleagues (2017) argue for a transformative model in mental health with the core values of recovery, empowerment, community integration, user involvement in service organisation, and access to opportunities to meaningfully contribute and participate in the community.

The conceptualisation of recovery in mental illness initially advanced by narratives of mental health service users (Davidson, Sells, Songster & O'Connell, 2005; Davidson et al., 2007; Deegan, 2005) provided a vision that the experience of mental illness is not a return to a prior condition but rather a regaining of one's life and identity that is congruent with the proposed community psychology transformative framework. According to the evidence produced,

recovery as a personal process is only possible if people are involved in natural community contexts and have concrete opportunities for participation (Davidson, Ridgway, Wieland & O'Connell, 2009; Ornelas, Duarte, et al., 2014; Ware, Hopper, Tugenberg, Dickey & Fisher, 2007). Fisher and Ahern's Empowerment Model of Recovery (2000) states that mental illness is not a permanent condition, and recovery is attained through a combination of support, particularly peer support, helping people to regain control over important decisions affecting their lives, regain valued social roles, and participate in all dimensions of community life. The programmatic framework of the recovery perspective brought significant changes to the mental health systems (Anthony, 1993, 2000; Davidson et al., 2007). However, there are critical reflections stating that the effective impact of this perspective has produced fewer results than expected (Davidson et al., 2009; Salzer & Baron, 2014b). It is crucial to emphasise that recovery in mental health is associated with re-establishing life within the community (community integration) and personal power or mastery (empowerment) – that is, the improvement of one's capabilities toward full citizenship (Davidson, O'Connell, Tondora, Styron & Kangas, 2006; Pelletier, Davidson, Roelandt & Daumerie, 2009; Sacchetto et al., 2016).

Authors of this article have conducted research with participants involved in an empowering community-centred model of intervention to examine whether personal empowerment, recovery, and community integration were associated with the individual's participation in the program. Participants' outcomes were compared with a matched group of individuals from standard interventions of four equivalent organisations. The results demonstrated that taking advantage of the empowering community-centred intervention is associated with higher levels of recovery dimensions of personal goals and hope, of empowerment dimensions such as self-esteem and efficacy or activism and autonomy, and of effective community integration (Jorge-Monteiro & Ornelas, 2016). Their analysis also revealed that the empowering community-centred intervention promotes the organisational capability to increase the number of people involved in supported employment or independent housing programs than the standard interventions in the study.

3. Fostering Community Integration and Empowerment through Housing and Employment

Supported employment and housing-first models are well described in the literature. Supported employment (SE) is built around several defining features including competitive employment, rapid job-search and placement, attention to people's job preferences, a zero-exclusion approach, individualised and long-term support (Drake, Bond & Becker, 2012). There is substantial evidence that supported employment results in better employment outcomes for people with mental illness than other vocational programs, particularly in job acquisition, hours worked, money earned, and job satisfaction (Bond, 2004; Corrigan, Barr, Driscoll & Boyle, 2008; Drake et al., 2012).

Supported employment models also emphasise the role of community natural support rather than relying exclusively on professional and service supports. Consistent with an ecological approach, classmates, teachers, neighbours, landlords, employers, co-workers, and other community members are viewed as potential resources with an important role to play in supporting users' community integration. Research, for instance, revealed that social support and

mentoring provided by co-workers are important to job satisfaction, job performance, and overall job adjustment (Mank, 2000; Rollins, Bond, Jones, Kukla & Collins, 2011). There is evidence supporting the relation of vocational outcomes and non-vocational outcomes such as quality of life, social functioning, or community integration (Bond & Drake, 2014; Bond, Drake & Becker, 2008; Marino & Dixon, 2014).

Studies also highlighted the interconnection of employment with recovery (Eklund et al., 2004; Lloyd, King & Moore, 2010), but there are few larger studies evaluating the association between the work status of people who experience mental illness and empowerment or recovery outcomes. Despite this, the results indicated higher scores of individual empowerment in those who were working compared with those who were not working. Our study of 186 people with mental illness about the effects of an empowerment-community integration model on individuals' outcomes revealed that those who were engaged in SE programs reported higher levels of empowerment, personal recovery, or community integration, which paralleled concurrent research (Jorge-Monteiro & Ornelas, 2016; Lloyd et al., 2010). Sá-Fernandes, Jorge-Monteiro, and Ornelas (2018) compared SE workers with unemployed persons with mental illness and found that the empowerment dimension of power-based interpersonal relationships was significantly associated with being at work.

Moreover, the integration of education and employment support is considered a promising practice due to the adjustment of "education-employment" over time (Unger, 2014; Unger, Pardee & Shafer, 2000; Waghorn, Saha & McGrath, 2014). Higher levels of education, particularly post-secondary education, expand employment opportunities and individuals' chances of obtaining higher skilled, better paying, and more satisfying jobs, which will encourage job tenure and career advancement (Gao, Gill, Schmidt & Pratt, 2010; Murphy, Mullen & Spagnolo, 2005).

In relation to housing interventions, there is sound empirical evidence that supports the effectiveness of the supported housing approach in the field of mental health as an alternative response to institutional residential programs such as transitional halfway houses, group-homes, or congregate residential settings (Blanch et al., 1988; Carling, 1990; Kloos & Shah, 2009; Ridgway, Simpson, Wittman & Wheeler, 1994; Ridgway & Zipple, 1990). The housing-first (HF) approach, a form of supported housing, combines the access to independent and permanent housing in regular community settings with the provision of personalised and flexible support services that are consumer-driven and provided by an off-site team. Research shows that the independent scattered housing, compared with congregate residential programs, provides better outcomes in terms of housing tenure over time, housing satisfaction, reduction of hospitalisation, and quality of life (Cheng, Lin, Kasprow & Rosenheck, 2007; Goering et al., 2014; Nelson, Aubry & Lafrance, 2007; Tsemberis, Gulcur & Nakae, 2004). Again, HF is also rated by people with mental illness as the preferred form of living arrangement. Several studies have demonstrated that people who experience mental illness prefer to have their own independent apartments and to live in safe neighbourhoods and near public transportation (Davidson et al., 2006; Nelson, 2010; O'Connell, Rosenheck, Kasprow & Frisman, 2006; Tsai, Bond, Salyers, Godfrey & Davis, 2010).

Living in independent housing increases people's perceived choice and enhances their sense of mastery (Gulcur, Tsemberis, Stefancic & Greenwood, 2007; Yanos, Felton, Tsemberis & Frye, 2007). Several studies corroborate that having choice and control over housing and support increases housing stability, housing satisfaction, recovery, and perceived quality of life (Gilmer, Stefanic, Ettner, Manning & Tsemberis, 2010; Greenwood, Schaefer-McDaniel, Winkel &

Tsemberis, 2005; Martins, Ornelas & Silva, 2016; Newman, 2001; O'Connell et al., 2006; Tsemberis, Moran, Shinn, Asmussen & Shern, 2003). Few studies have directly examined the association between independent housing and subjective dimensions of empowerment or recovery evaluated by standardised measures for these constructs. However, some qualitative literature and preliminary studies suggest that independent housing has a beneficial effect on empowerment and recovery. In a qualitative study participants reported that having a home of their own affords a sense of protection, privacy, order, comfort, and identity that are crucial elements of the recovery process (Borg et al., 2005). Comparing empowerment and recovery outcomes associated with the housing situation of participants enrolled in CMH programs, Jorge-Monteiro and Ornelas (2016) found that those who live in independent housing performed better compared with those who live in group homes or in their parents' home.

Independent housing is also associated with better community integration indicators, as research shows that independent housing is predictive of psychological and social integration (Gulcur et al., 2007). Other studies found that living independently is associated with engagement in community activities, social connectedness, and a sense of community belonging (Jorge-Monteiro & Ornelas, 2016; Kloos & Townley, 2011; Ornelas, Martins, Zilhão & Duarte, 2014; Yanos et al., 2007). People who live in congregate settings tend to find their most meaningful activities and social interactions in-doors. Conversely, people who live in independent apartments are more likely to find meaningful activities in the neighbourhood or in employment and to report greater social interaction with other community members (Jorge-Monteiro & Ornelas, 2016; Yanos et al., 2007).

Several studies have examined the impact of housing environments' effects on housing stability, recovery, and community integration. The findings from these studies support a fundamental premise of independent housing that scattered-site apartments throughout mainstream residential neighbourhoods is associated with more positive outcomes. High standards of housing, good quality of neighbourhoods, and perceptions of a neighbourhood's social cohesion are associated with housing stability, psychological well-being, and community integration (Evans, Wells, Chan & Saltzman, 2000; Kloos & Shah, 2009; Parkinson, Nelson & Horgan, 1999; Yanos et al., 2007; Wright & Kloos, 2007).

The quality of housing environment also increases people's perceived choice over housing, treatment, and support services that, in turn, predict recovery outcomes (Martins et al., 2016) as opposed to living in deprived, socially isolated, and unsafe neighbourhoods where social housing tends to be concentrated, and the range of opportunities for community integration is restricted (Barnes, 2012; Brodsky, O´Campo & Aronson, 1999; Yanos et al., 2012). These findings are relevant to reinforce that supported housing programs should not focus on deprived geographical areas, but they should take advantage of the rental private market, which offers more housing choices, higher housing quality, and better opportunities for recovery and community integration (Martins et al., 2016; Ornelas, Martins et al., 2014).

On the other hand, the study of the factors influencing social interactions confirmed that long-standing housing stability was associated with better results in community integration and that symptomatology was not associated with better social integration; therefore, housing support programs for people with mental illness should develop strategies that support the adaptation to new environments (Yanos et al., 2012). The role of housing support teams should be focused on social support, specifically on the bridging strategies related to the elimination of barriers in establishing connections and strengthening the use of spaces available for the general population and those resources specific to people with mental illness experience (Kloos & Townley, 2011;

Townley, Kloos & Wright, 2009; Wong, Matejkowski & Lee, 2011). The reengagement of CHM through independent housing is therefore considered a relevant factor to transform lives because it provides the opportunities to live independently, thereby enhancing people's possibilities to evolve in their citizenship (Davidson et al., 2009; Gulcur et al., 2007; O'Connell et al., 2006; Ornelas, Martins, et al., 2014; Pelletier et al., 2015; Ware et al., 2007).

4. Discussion

With this scope review of CMH, we intended to provide a broad perspective on the advancements, achievements, reforms, and future challenges within the field that inspired the inception of community psychology. With the ground-breaking publication by Rappaport (1987), CMH was described as an approach to community problems that rejects the notion of deficit and defends the principles of person-environment fit and cultural relativeness and diversity, transforming social intervention in the provision of material, educational, and psychological support resources to individuals and groups to live in the community (Rappaport, 1987). This broad and general account prevails as a central premise for the present and future discussion about the challenges within CMH. A particularly relevant notion for the understanding of the complexities of CMH was brought by Kelly (1986), transposing to psychology the need to observe individuals in their natural contexts, creating a research challenge related to the impossibility of separating problem definition from research methods, and that social intervention is focused in the continuous flux of the community life. As a result of these two visions, community psychology research became more clearly focused on the resource exchanges among people, contexts, and events with the purpose of developing products useful and beneficial for the communities as a whole (Trickett, Kelly & Vincent, 1985). Revisiting the basics inspires us to look into the future and reminds us that social change requires long-standing commitments, and strategic research and action in CMH is still a pertinent and promising field for community psychologists.

The lives of people with mental illness are determinately affected by the theories and models proposed by theorists, researchers, practitioners, and policy-makers worldwide. Therefore, it is our responsibility to make sure that the advancements we propose and the collaborative efforts that we entail are aligned with the human rights propositions and provide opportunities for social integration and access to a full community life. Over the past five decades, despite these visions and subsequent social movements, systematised evidence, and policy formation, large-scale traditional psychiatric hospitals subsist, traditional group-housing solutions, day-care hospitals and drop-in centres, sheltered vocational programs, and social firms are still being advocated for, and rehabilitation-focused services are mainstreamed policies. Since the deinstitutionalisation movement and the conceptualisation of the Community Support System, hospital populations were effectively reduced, and a myriad of science-based accounts emerged advocating for social integration (Blanch et al., 1988; Mosher & Burti 1989). However, these practices resulted in new forms of segregation, attaining a presence in the community but not the effective integration and citizenship. Values, political reform documents, community theories, and models have evolved and produced impacts in the CMH services, but efforts are still needed to develop effective interventions more capable of producing results in terms of community participation and

citizenship of people experiencing mental illness (Bond, Salyers, Rollins, Rapp & Zipple, 2004; Carling, 1995; Nelson et al., 2014a; Pelletier et al., 2009).

It is already acknowledged that community integration should be the overall aim to be attained within the CMH programs because integration generates recovery, and this was achieved with contributions from community psychology associated with the relevance of promoting interdependence or connectedness amongst community members for the performance of normative, substantive, empowered, and meaningful social roles (Lloyd, Tse & Deane, 2006; Pelletier et al., 2015; Salzer & Baron, 2014a). Transformative CMH systems are therefore those that maximize individuals' agency with meaningful opportunities that enable people's capabilities to control their own lives (Ornelas, Duarte et al., 2014; Shinn, 2014a; Swarbrick & Drake, 2013). The opportunities to participate in community contexts are essential to achieve more lasting and significant purpose in terms of personal empowerment and community integration. The incorporation of the recovery perspective in mental health, particularly the narratives of people with self-experiences, and user-led research are crucial ingredients for the acknowledgement that change is not transformational if these stakeholders are not clearly included in the reflection, debate, policy and program design, implementation, and evaluation (Jones, Harrison, Aguiar & Munro, 2014; Ochocka, Janzen & Nelson, 2002). We have probed to demonstrate that housing and employment are crucial programmatic features of a transformative CMH system due to their relevance for concrete integration and the potential for the promotion of empowerment, recovery, and effective exercise of citizenship (Wong, Matejkowski & Lee, 2011), potentiating the use of spaces and community resources (Kloos & Townley, 2011; Nelson, Lord & Ochocka, 2001; Townley, Kloos & Wright, 2009). The additional combination of forms of peer support with CMH services also produces results in individuals' empowerment and recovery outcomes (Resnick & Rosenheck, 2008; Segal, Silverman & Temkin, 2010, 2013).

Effective community integration is performed by being exposed to concrete participation opportunities that are to be provided by the mental health services going beyond treatment. Opportunities for social integration can contribute to proximity bridging and bonding with other people outside the mental health systems (Ornelas, Duarte et al., 2014; Ware et al., 2007). The recent community science literature suggests the relevance of objective indicators for the integration of people with mental illness related to employment, housing, and the size and interactions of social support.

A contemporary trend toward the reform of day-care centres is therefore focused on its conversion to supported employment programs or to community-integrated recovery centres influenced by the evidence that rehabilitative programs do not help users to obtain jobs in the community (Becker et al., 2001; Drake et al., 1994; Whitley, Strickler & Drake, 2012; Evans et al., 2012). Assuming that the systems and models designed to provide community responses to people with mental illness have clearly evolved over the last five decades, rethinking these systems continues an endeavour constantly facing setbacks and barriers. Among community psychology scholars and practitioners, there is a renovated interest to influence socio-political movements and policy reform documents to proceed with the seminal endeavour of the pioneers who advocated for a community life for people with mental illness. Arguments for supported education students and supported employment workers report a greater level of satisfaction with their living situation, daily activities, social relations, and personal contacts than those who are not going to school or unemployed (Mowbray, Collins & Bybee, 1999; Murphy et al., 2005; Revell, Kregel, Wehman & Bond, 2000; Rollins et al., 2011; Unger et al., 2000). For the argument of favoring independent housing as a strategy generating transformative change in

CMH, it is crucial that community psychology makes efforts to theorise and empirically corroborate the concrete impacts of housing programs that go beyond the household including the community life, social support, community participation, empowerment, and collaborative support of professional teams implementing service systems focused on community integration. To become effectively transformative, independent housing needs to be absolutely clear about the premise underlying the model concerning the separation of housing and treatment. The use of extensive professional teams associated with treatment (i.e., assertive community treatment, ACT) providing services to the residents with mental illness collides with the stated premise (Blanch et al., 1988; Carling, 1995; Ridgway & Zipple, 1990; Tsemberis, 1999). The implementation of a mental health treatment service keeps the people apart, recreating the separate service-delivery environments already described. Transposing treatment to the household or creating a specific team for service-users in their own homes could hinder the transformative potential of independent housing. Establishing the connections and bonds of people with mental illness in all levels of the health system also contributes to the transformational potential of CMH (Ornelas, Duarte et al., 2014).

Arguments advocating for the relevance of connecting empowerment and CMH are long standing and emerged from the social and civil rights movements, assuming empowerment as a transformative in their own lives (Chamberlin, 1978; Chamberlin & Rogers, 1990; Fisher & Chamberlin, 2005; Ridgway, 2001). The incorporation of these contributions in systems thinking are the result of the expansion of rights-based perspectives with the socio-political debates within social justice that influenced changes in policies and practices intended to achieve social inclusion and equal opportunities for every citizen (Janzen, Nelson, Hausfather & Ochocka, 2007). The claim for the right to full exercise of citizenship was consistently integrated and reproduced in mental health policy such as the United Nations' ENABLE – Convention on the Rights of Persons With Disabilities, legislative pieces, or reform plans that were implemented in many countries worldwide (Salzer & Baron, 2014b; Shen & Snowden, 2014). Other sources of evidence for transformative CMH was systematised in studies about consumer-run organisations empowering people who experienced mental illness (Brown, 2012; Corrigan, 2006; Nelson, Janzen, Ochocka & Trainor, 2010; Resnick & Rosenheck, 2008; Rogers et al., 2007; Segal et al., 2010).

For community psychology, empowerment is an essential ingredient (Aber, Maton & Seidman, 2011; Rappaport, 1987; Seidman & Tseng, 2011). It is not power over an issue but the power to achieve, attain, or reach aims or interests (Cattaneo & Goodman, 2015; Zimmerman, 1995). The increased relational power is a determinant for transformational change in CMH because a) it potentiates the sense of personal recovery, and b) it directs the focus on the community integration and its sustainability. Empowerment has assumed an enhanced programmatic expression with the contributions made by Nelson, Lord, and Ochocka (2001), who proposed a service system grounded in an "empowerment-community integration" (EMP-COM) paradigm. The model is aimed at the integration in natural community contexts instead of separation, an essential shift from the initial contemporary CMH interventions. The current focus on community integration is also a crucial guiding principle for the design of programs and services, which requires it to be multidimensionally conceptualised involving a physical presence in the community, sustainable relational strategies with other community members, and the sense of effectiveness and belonging (Wong & Solomon, 2002).

As community integration gained increasing prominence as a core value and guiding framework for community-based mental health services, the focus on broadening opportunities

for people who experience mental illness to fully participate in community life, access meaningful resources, activities, and settings available for all citizens – including employment, education, or housing – became a fundamental focus, particularly to improve peoples' living conditions, facilitate social engagement in community-based relationships, and strengthen the sense of community belonging (Bond et al., 2004; Brown & Rogers, 2014; Ornelas, Duarte et al., 2014; Ware, Hopper, Tugenberg, Dickey & Fisher, 2008). Community integration depends not only on individual abilities, but also on environmental conditions that could either hinder or foster the range of opportunities for choice, mastery, and social participation. People with mental illness often confined to segregated contexts face discrimination and stigmatising attitudes and are excluded from many rights and benefits of full citizenship. As suggested by the capability theory, enhancing people's capabilities for community integration requires efforts to address the literal and figurative barriers that lead to social exclusion, change practices, programs, and policies to expand the set of opportunities for social participation, and advocate for inclusive and diverse communities (Sacchetto et al., 2016; Shinn, 2014b).

The socio-political conditions in Europe for the development of sustainable community-based mental health programs focused on integration, empowerment, and recovery premises require the effective generalised implementation of core high-impact programs and practices following the recommendations of the European Union Joint Action for Mental Health and Well-being (Caldas Almeida, Mateus & Tomé, 2017), which is also consistent with the Chapter I "Equal opportunities and access to the labour market" and III "Social protection and inclusion" of the European Pillar of Social Rights (2017). Given this socio-political environment combined with the evidence advocating for supported employment, education, and access to scattered and independent housing in the community, we consider that there is a European-based knowledge and experience that enables a consistent and profound reform of CMH systems directly aimed at reducing prevailing disparities in community living conditions of people with mental illness (Pickett & Wilkinson, 2010). Prospective CMH implies a collaborative alliance and partnership of people with mental illness (and their self-representation organisations with their different perspectives, aims, or interests in a global perspective) with community psychologists to ensure that the future directions for policy and program formation are directed to accomplish the purpose of community integration and diversity within concrete ecological contexts, inspiring a global vision for sustainable change.

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