tries[7]. In all cases, task-sharing relies on mental health specialists leveraging their experience and expertise and supervising, training and mentoring general health workers and community providers to deliver evidence-based care, including psychological interventions and psychosocial supports.

As well as improving care environments, mental health specialists can and should help advocate for action in other environments like homes, schools and workplaces. They can do this by, for example, sharing evidence on the most detrimental determinants of mental health (such as bullying and gender-based violence) and supporting the design and delivery of multisectoral initiatives to address these.

The last time the WHO published a world report on mental health, in 2001, it captured the attention of political and health care leaders around the world and provided the momentum for national and international mental health initiatives to advance. It is our hope that the new World Mental Health Report will similarly inspire and inform all stakeholders to reprioritize mental health and to redou-ble their efforts to transform mental health. Making change happen is everybody's business. But mental health specialists have a central role to play.

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Psychiatric diagnosis and treatment in the 21st century: paradigm shifts or power shifts?

The paper by Stein et al in this issue of the journal[1] makes a timely and important contribution to our field. In particular, I strongly support the wise counsel to improve diagnostic and treatment systems based upon the foundation of the gradual, careful extension of scientific knowledge. I will focus my remarks upon two specific issues: a) the relationship between deinstitutionalization and the development of community-based services; and b) the involvement of patients/service users in developing and using psychiatric diagnostic systems, and what this tells us in particular about doctor-patient power relationships.

For too long there has been an over-heated debate on a false dichotomy between hospital *or* community care. I have developed with M. Tansella the *balanced care model*, which is an evidence-based model describing the need for *both* services in hospital and the community[2]. It is true, as Stein et al point out, that in many countries which have developed a system of psychiatric hospitals or other large institutions, progress in reducing their size or fully closing them has been slow or haphazard. It is also the case that rushed attempts to shut such hospitals and to transfer patients to poor quality community care have sometimes had terrible consequences, such as the Life Esidimeni case in South Africa[1]. But it is also true that there has been a gradual trend, especially in many middle- and high-income countries, to change the profile of mental health service expenditure from hospital to community-based services and staff, as documented over time in the series of World Health Organization (WHO)'s Mental Health Atlases. Indeed, there are some remarkable national level examples of scaled up community-based care in low- and middle-income countries, such as the 686 Program in China[3].

If I were to bring together my experience of being involved in such policy and practice discussions in many countries around the world with my understanding of all the most relevant evidence, then the following key points strike me as important[4,5]. Almost all the evidence on psychiatric hospital closure is from high-income countries, and there is very little evidence on this question from low- and middle-income countries, some of which have never developed such institutions. We therefore need to be careful not to naively export findings and policy lessons across countries. From the evidence we do have, it is clear that most long-term patients in psychiatric hospitals can be reasonably transferred to community care settings, *if* community care is provided, and *if* the total costs of service investment before and after are about the same. In other words, if hospital "downsizing" or closure is not used as an occasion or excuse for service disinvestment.

Data from high-income countries show that, after substantially reducing long-term psychiatric beds, a mental health system continues to need acute bed provision for admission of severely unwell patients, even in the presence of high levels of intensive community support such as crisis resolution / home treatment teams. There also needs to be hospital provision for discharged long-term patients to be supported from time to time during acute periods of relapse. Overall, evidence is lacking on whether acute psychiatric bed provision is better provided in psychiatric hospitals or in general hospitals. It is likely that this is not so important as long as the services and care provided are accessible to patients and carers, have a decent quality of care and respect for human rights. An asset not used often enough is the value of land of large psychiatric hospitals which are closed or downsized; the resale proceeds of the land sale should be reinvested in mental health services, largely community-based services.

So, in my view, it is right not to choose between hospitals *or* community services, but rather to tailor for each setting the *balance* of hospital and community care that is required. More widely, it is a mistake to confuse specialized mental health services with the wider array of supports and services that are needed for all people with mental health conditions. In most countries, the number of specialist mental health staff is very limited, while the number of primary and community care staff are far greater. The likelihood of being able to substantially reduce the gap between need and treatment for people with mental health conditions worldwide, therefore, rests to a large extent upon training primary and community care staff to be able to recognize, treat and refer patients appropriately, for example using the WHO mhGAP Intervention Guide[6].

I now turn to an issue less well researched: namely, the involvement of patients/service users in developing and using psychiatric diagnostic systems, and what this tells us in particular about doctor-patient power relationships. The advocacy motif of "Nothing about us without us" is a helpful guideline here. Diagnoses are not neutral and can have powerful, indeed life-changing consequences for patients. On the positive side, an accurate diagnosis helps clinicians to know which treatments are most likely to confer benefits to patients. But we also need to keep in mind that diagnoses can also bring harm to patients.

"People's perception of you suddenly shifts as soon as you receive a diagnosis. They are scared to talk to you because they don't know how to approach it or what to say. This makes it even more isolating and a very lonely place". This quotation, from a global survey of people with lived experience of mental health conditions co-ordinated by C. Sunkel of the Global Mental Health Peer Network, suggests that receiving a psychiatric diagnosis can have a profoundly negative impact on people, and can in fact increase stigma and discrimination, both as expressed by others and internalized as self-stigma[7].

In my view, there needs to be much stronger involvement of people with lived experience of mental health conditions in the revision of diagnostic systems in the future, including the naming of conditions, which if poorly phrased may cause misunderstanding or offence[8,9]. I would therefore argue that there is a need for a very specific paradigm shift in psychiatry and mental health: to change the balance of power between patients and psychiatrists and other mental health staff, so as to fully include people with experience of mental health conditions in all the processes, including diagnostic and treatment systems, that are designed to support their intended beneficiaries.

I would like to close my editorial with a quotation from a person with lived experience of a mental health condition who lives in Georgia: "*Even educated people consider schizophrenia a death sentence for the person, like your mind is gone forever, and you have to say goodbye to the person you used to know and care about. In worse cases there are expectations of violence, abuse and some accidents from the person with schizophrenia, there is profound lack of trust and what the person says or does is viewed through the lens of the diagnosis. Friends in many cases just stop understanding and communicating at all*". We should reflect on these words very carefully.

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