Review

The Role of Community-Based Mental Health Services in Strengthening Social ResilienceA Critical Interdisciplinary Review of Evidence, Theory, and Policy Implications

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The Role of Community-Based Mental Health Services in Strengthening Social Resilience

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Abstract: This review explores how community-based mental health services (CBMHS) contribute to the development of social resilience. Drawing on interdisciplinary literature, it synthesizes theoretical foundations, empirical evidence, and implementation challenges. The analysis highlights that CBMHS foster resilience through psychosocial, structural, and cultural mechanisms—yet face persistent barriers in funding, equity, and systemic integration. Strategic policy recommendations are provided to support the institutionalization of CBMHS as key infrastructures of collective adaptation and wellbeing.

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1. Introduction

In recent decades, there has been a growing recognition that mental health is not only an individual concern but a profoundly social and structural issue. Global crises such as the COVID-19 pandemic, forced displacement, economic insecurity, and the rising frequency of climate-induced disasters have laid bare the vulnerabilities embedded in our societal fabrics. These complex stressors do not affect individuals in isolation but reverberate through families, communities, and systems, often exacerbating pre-existing inequalities and psychological distress. Against this backdrop, the notion of *social resilience*—defined as the capacity of communities to withstand, adapt to, and recover from adversity—has gained significant traction across disciplines, including public health, sociology, psychology, and disaster studies (Norris et al., 2008; Berkes & Ross, 2013; Panter-Brick & Leckman, 2013).

Within this emerging discourse, *community-based mental health services* (CBMHS) are increasingly positioned as pivotal infrastructures for fostering resilience at both individual and collective levels. Unlike hospital-centric psychiatric systems, CBMHS emphasize decentralized, participatory, and contextually grounded forms of mental health care, rooted in the everyday lifeworlds of people and communities (WHO, 2021; Patel et al., 2018). These services often involve task-sharing models, peer support networks, mobile outreach teams, and integrated psychosocial interventions that operate within schools, religious institutions, workplaces, and neighborhoods (Lund et al., 2010; Barry et al., 2019). The intersection of community mental health and social resilience is, however, still under-theorized and under-researched. While both concepts are frequently invoked in global development and humanitarian rhetoric, there remains a lack of conceptual clarity and empirical synthesis regarding how precisely CBMHS contribute to social resilience, under what conditions, and for whom (Tol et al., 2011; Wind & Komproe, 2012). This review article aims to address this gap by offering a comprehensive, interdisciplinary synthesis of the current state of knowledge at the nexus of these two critical domains. As the World Health Organization (2022) notes, "There is no health without mental health, and no resilient society without equitable, community-rooted mental health systems." In this light, community-based mental health care must be reimagined not as a residual or supplementary service but as a strategic pillar of both public health and societal resilience.

2. Conceptual and Theoretical Framework

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To understand how community-based mental health services (CBMHS) contribute to social resilience, it is necessary to engage with the foundational concepts and theories that shape both domains. The relationship between mental health systems and resilience is neither linear nor self-evident—it is mediated by contextual, structural, cultural, and psychological processes. Accordingly, any serious scholarly inquiry into this relationship must begin by clarifying what is meant by *social resilience*, how *community-based mental health* is conceptualized, and which theoretical frameworks offer interpretive power in connecting the two.

Resilience, in its classical psychological form, was long considered an individual trait—an internal strength allowing people to recover from trauma. Early research emphasized attributes such as hardiness, self-efficacy, and cognitive flexibility (Masten, 2001; Luthar, Cicchetti, & Becker, 2000). Yet, this individual-centered paradigm has been increasingly critiqued for its limited attention to social determinants and for its implicit tendency to locate responsibility for coping within the individual. In response, the concept of *social resilience* has emerged as a corrective. Rather than being a mere sum of resilient individuals, social resilience refers to the collective capacity of communities to endure, adapt to, and transform in the face of adversity while retaining or reinventing their core functions, identities, and values (Norris et al., 2008; Obrist et al., 2010; Berkes & Ross, 2013). It encompasses dimensions such as mutual trust, collective efficacy, participatory structures, social capital, and equitable access to resources.

In parallel, CBMHS represent a fundamental shift from institution-centered, often coercive psychiatric models toward decentralized, integrative, and community-rooted approaches. These services are not uniform but take varied forms—ranging from mobile outreach and peer-led programs to culturally adapted psychosocial interventions within schools, neighborhoods, and religious spaces. Their core logic is not just accessibility, but embeddedness: mental health care that is intertwined with everyday life, tailored to local meaning systems, and co-produced with community actors (Patel et al., 2018; WHO, 2021). By prioritizing lived experience, empowerment, and non-clinical forms of support, CBMHS create conditions in which individuals and groups can reclaim agency, build networks of solidarity, and reframe suffering in ways that promote resilience. To elucidate the theoretical basis of this interconnection, several frameworks must be considered. First, the *salutogenic model* developed by Antonovsky (1996) posits that health is sustained not by the elimination of risk but by the presence of a robust *sense of coherence*—a cognitive-emotional orientation in which life is perceived as comprehensible, manageable, and meaningful. CBMHS strengthen this orientation by offering predictability (e.g., regular contact), manageability (e.g., accessible and flexible services), and meaning-making (e.g., group-based narrative reconstruction), particularly in contexts marked by loss or dislocation.

Second, *Bronfenbrenner's ecological systems theory* (1979) conceptualizes the individual as nested within a series of social systems—family, school, community, policy environment—each influencing development and resilience. CBMHS operate across these levels, engaging not just the individual but also the relational and structural environments that shape vulnerability and recovery. This systemic lens highlights that interventions which neglect context will inevitably fail to foster lasting resilience.

Third, the *capabilities approach* as developed by Sen (1999) and Nussbaum (2011) provides a normative framework for evaluating the real freedoms people have to lead lives they have reason to value. From this perspective, CBMHS do more than restore psychological functioning; they expand human capabilities by enabling participation, decision-making, and relational autonomy—conditions essential for resilient lives in the face of adversity. Resilience, here, is not merely adaptation, but the preservation and enhancement of human agency under duress.

Fourth, *social capital theory* emphasizes the role of trust, networks, and reciprocity in enabling communities to mobilize resources and respond collectively to challenges (Putnam, 2000; Kawachi & Berkman, 2000). CBMHS play a crucial role in cultivating both bonding capital (e.g., among marginalized peer groups) and bridging capital (e.g., between professional and lay actors), thereby reinforcing communal trust and participatory structures that are vital for resilience in times of crisis.

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Finally, a *complex systems perspective* understands both mental health and resilience as emergent properties of dynamic, non-linear, and interdependent systems (Folke et al., 2010; Blanchet et al., 2017). CBMHS, by virtue of their decentralization, adaptability, and embeddedness, are structurally aligned with such systems. They can quickly respond to local needs, integrate feedback from multiple actors, and experiment with context-specific models of care—capacities that are vital in fluid and uncertain environments.

To clarify these interrelations and provide a synthetic overview, the following table contrasts the core assumptions, strengths, and limitations of each framework:

Table 1. Core Theoretical Frameworks Linking CBMHS and Social Resilience.

Theory	Key Insight	CBMHS Contribution to Resilience
Salutogenesis	Health arises from coherence and meaning	Supports structure, coping, and existential orientation
Ecological Systems	Individuals are embedded in multi-level environments	Connects micro (individual) to macro (institutional) systems
Capabilities Approach	Resilience as freedom to act and be in valued ways	Enhances agency, participation, and social inclusion
Social Capital Theory	Trust and networks enable communal adaptation	Builds solidarity, collective efficacy, and local trust
Systems Theory	Resilience is emergent in adaptive, decentralized systems	Enables responsive, contextualized, and flexible care

3. Empirical Evidence Linking CBMHS and Social Resilience

While theoretical linkages between community-based mental health services (CBMHS) and social resilience are conceptually compelling, it is the empirical evidence that determines their practical validity and policy relevance. A growing body of interdisciplinary research—spanning public health, psychiatry, community psychology, and humanitarian studies—demonstrates that CBMHS can substantially contribute to resilience-building processes, particularly in contexts of chronic adversity, crisis, and systemic marginalization.

One of the most consistent findings across studies is the preventive and buffering role of CBMHS in reducing psychological distress and mitigating the escalation of mental health problems. In low-resource settings, task-shifting models in which non-specialist community health workers deliver basic mental health care have been shown to be both effective and cost-efficient. For example, Patel et al. (2010) found that lay health counselors providing behavioral interventions in primary care settings in India significantly reduced depressive symptoms, while Chibanda et al. (2016) demonstrated similar outcomes in Zimbabwe's Friendship Bench project. These services function not only as clinical interventions but also as early warning systems—detecting distress, preventing social withdrawal, and re-engaging individuals in meaningful roles, all of which are core to resilience.

Beyond individual-level outcomes, CBMHS foster community empowerment and collective efficacy, two critical dimensions of social resilience. In post-conflict and disaster-affected regions, community psychosocial programs have helped rebuild disrupted social networks and strengthen local agency. For instance, Jordans et al. (2012) reported that group-based interventions for war-

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affected youth in Nepal led not only to improved mental health but also to increased school attendance, civic participation, and perceived social support. Similarly, studies in Sierra Leone and South Sudan have shown that integrating mental health support with local storytelling, traditional healing, and group dialogue fosters a sense of cultural continuity and shared purpose, which enhances the community's collective capacity to recover (Wessells, 2009; Tol et al., 2013). During acute crises such as pandemics or natural disasters, CBMHS have also played a critical role in sustaining psychological and social functioning. Data from the COVID-19 pandemic offer compelling illustrations. In Italy, community psychologists mobilized neighborhood-based phone counseling networks for the elderly, mitigating loneliness and restoring a sense of intergenerational connection (Castellini et al., 2020). In Bangladesh, Rohingya refugee camps deployed lay counselors supported by NGOs to provide stress management and trauma-informed care to displaced populations, with evidence suggesting reduced emotional distress and improved coping strategies (Tracy et al., 2021). These interventions highlight that resilience in times of systemic disruption is not merely an individual capacity, but an ecological phenomenon supported by community infrastructure.

The equity-enhancing potential of CBMHS is another empirically documented mechanism through which social resilience is strengthened. Marginalized groups—whether due to poverty, migration status, ethnicity, or gender—often face systemic barriers to accessing mental health care. CBMHS reduce these barriers by offering services in non-stigmatizing environments, using culturally adapted models, and embedding support in familiar community spaces. For example, peer-led support groups for LGBTQ+ youth in urban North America have demonstrated not only reductions in depressive symptoms but also increased political agency, community organizing, and resilience to discrimination (Craig et al., 2015). In rural Uganda, programs integrating maternal mental health with community-based education and nutrition services have improved both psychological outcomes and collective wellbeing, particularly among women facing compounded vulnerability (Atif et al., 2015; Singla et al., 2015).

It is important to underscore that many of these positive outcomes are contingent on the relational quality of the interventions and the degree of community ownership. Studies have shown that top-down, externally imposed programs with limited cultural congruence often fail to achieve sustainable impact (Summerfield, 1999). In contrast, interventions that involve co-design with local stakeholders, include indigenous knowledge systems, and are delivered by trusted community members tend to be more successful in fostering long-term resilience (Kohrt & Mendenhall, 2015; Kirmayer et al., 2012). The presence of trust, reciprocity, and horizontal accountability within the CBMHS ecosystem appears to be a central determinant of their resilience-enhancing effects.

At the meso- and macro-levels, CBMHS have been shown to catalyze system-wide improvements in mental health literacy, stigma reduction, and intersectoral collaboration. For instance, community mental health networks in Chile and Brazil have demonstrated how localized services can influence national policy by generating scalable models of integrated care that include education, employment, and housing supports (Minoletti et al., 2012). These systemic transformations not only improve service coverage but also normalize help-seeking, reduce fear and marginalization, and embed mental health into broader social development agendas. Despite these encouraging findings, the empirical landscape is not without limitations. Methodological challenges persist, including a lack of longitudinal studies, limited cross-cultural validation of outcome measures, and insufficient attention to structural power asymmetries in program design. Moreover, much of the available evidence is drawn from pilot projects or short-term evaluations, raising concerns about sustainability and scalability (Lund et al., 2011). Nonetheless, the cumulative weight of the evidence strongly suggests that CBMHS—when culturally embedded, community-owned, and structurally supported—are effective levers for cultivating social resilience in diverse global contexts.

4. Mechanisms of Impact

Understanding *how* community-based mental health services (CBMHS) foster social resilience requires a departure from simplistic input–output models of intervention logic. Instead, it

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necessitates a nuanced investigation into the underlying mechanisms through which these services interact with psychological, social, and institutional systems. These mechanisms are not merely technical functions; they are dynamic, relational, and often deeply cultural processes that mediate the translation of mental health support into adaptive capacity. In what follows, we explore these mechanisms along three interrelated dimensions: psychosocial pathways, structural and institutional dynamics, and cultural-symbolic resonance.

At the core of the psychosocial impact of CBMHS lies the capacity to generate stabilizing and coherence-enhancing experiences in individuals and groups. Psychological resilience, as theorized by Masten (2001), is the product of "ordinary magic"—that is, the availability of predictable, supportive relationships and environments. CBMHS often function as precisely this kind of stabilizing infrastructure. By offering consistent contact, safe spaces for disclosure, and non-pathologizing narratives of distress, they enhance individuals' perceived control and connectedness. This buffering effect is particularly salient in chronically adverse settings where stressors are not episodic but structural and cumulative. Empirical research supports this function: interventions such as lay-counseling in Zimbabwe (Chibanda et al., 2016) or community healing groups in post-genocide Rwanda (Ng et al., 2015) have shown significant effects not only on depression scores but also on reestablishing social trust, rebuilding fragmented identities, and fostering pro-social behavior. Crucially, these psychosocial benefits extend beyond the individual through what Hobfoll et al. (2007) term "resource caravans." Mental health support, when delivered in relational formats—such as peer groups, family-centered outreach, or communal rituals—generates cascading effects across social networks. These processes enhance bonding capital, reinforce shared norms, and generate affective economies of mutual care. In this sense, CBMHS are not merely therapeutic spaces; they are generative of what Kirmayer et al. (2011) describe as "resilience ecologies"—interdependent configurations of psychological and relational resources that allow communities to reassemble after fragmentation.

In addition to psychosocial pathways, CBMHS operate through structural and institutional mechanisms that recalibrate access, accountability, and agency in the mental health system. By relocating services into community contexts, they reduce traditional barriers to care such as geographical distance, financial cost, and stigma associated with formal institutions (WHO, 2021). However, the impact is not limited to improved uptake. Decentralized care delivery reconfigures the locus of authority and expertise. Instead of clinical hierarchies, CBMHS often rely on horizontal collaboration between professionals, lay workers, and community leaders, thereby democratizing mental health governance (Funk & Ivbijaro, 2008). This shift fosters what Bourdieu (1991) might call symbolic legitimacy: when care is embedded in trusted social relationships, it acquires moral authority and cultural resonance that institutional psychiatry often lacks. Moreover, CBMHS frequently act as intermediaries between sectors, linking health, education, housing, and justice systems. Such integrative functions create what Blanchet et al. (2017) describe as "resilient health systems"—networks characterized by redundancy, flexibility, and the capacity to learn and adapt in the face of stress. For example, community mental health programs in post-earthquake Haiti collaborated with microfinance and housing agencies to address the material drivers of psychological distress, thus reinforcing the systemic embeddedness of mental health as a social rather than merely medical concern (Raviola et al., 2012). These cross-sectoral linkages are not auxiliary; they are constitutive of the mechanism by which resilience is fostered at the population level.

Finally, the symbolic and cultural mechanisms of CBMHS must not be underestimated. Mental health, unlike many other domains of health, is deeply embedded in local cosmologies, moral frameworks, and language. CBMHS that resonate with indigenous worldviews, religious interpretations, and local idioms of distress do more than treat symptoms—they restore moral coherence and ontological security. As Kohrt and Hruschka (2010) show in their work in Nepal, the success of mental health interventions often hinges not on biomedical accuracy but on narrative congruence with local belief systems. When CBMHS employ community elders, integrate traditional healing practices, or facilitate communal storytelling, they operate not only as health services but as

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meaning-making institutions. Such symbolic labor is essential for resilience because it reestablishes the collective imaginaries through which suffering can be comprehended, shared, and ultimately transcended.

5. Challenges and Limitations

Despite the considerable promise of community-based mental health services (CBMHS) in strengthening social resilience, their implementation and evaluation remain fraught with significant conceptual, operational, and structural challenges. These limitations are not merely technical inconveniences; they point to deeper tensions within the global mental health movement, particularly in its engagement with questions of power, sustainability, epistemology, and justice. Understanding these fault lines is essential not only to temper optimistic claims but also to refine the future trajectory of research, policy, and practice.

One of the most persistent limitations is the chronic underfunding of community mental health infrastructures. Globally, mental health receives less than 2% of national health budgets, and only a fraction of this is allocated to community-based care (WHO, 2022). In low- and middle-income countries, the disparity is even more pronounced, with most funding still directed toward psychiatric hospitals or vertical NGO-led projects. This structural marginalization creates a paradox: while CBMHS are often championed for their accessibility and cost-effectiveness, they are simultaneously denied the financial and political resources needed for long-term institutionalization (Patel et al., 2018; Saxena et al., 2007). As a result, many programs exist in a liminal state—innovative, promising, but perpetually pilot-level and vulnerable to policy shifts or donor withdrawal. Closely related is the issue of sustainability. While numerous evaluations report short-term gains in symptom reduction, social connectedness, or community empowerment, few studies track whether these effects endure beyond the funding cycle. The lack of longitudinal research in this domain is a serious methodological blind spot (Tol et al., 2011). Moreover, sustainability is not only a matter of duration but of institutional embeddedness. Programs that remain externally governed, overly reliant on NGO infrastructure, or disconnected from national health systems risk becoming ephemeral, culturally dislocated, or even counterproductive. Indeed, as Summerfield (1999) has argued, when psychosocial interventions are transplanted without deep contextual adaptation, they may impose alien frameworks of suffering, inadvertently pathologize normative reactions, or erode existing coping traditions.

A further set of challenges concerns the tension between standardization and contextualization. The global mental health movement has rightly emphasized the need for evidence-based interventions and scalable models, but this ambition often clashes with the inherently situated nature of mental health and resilience. Interventions such as WHO's mhGAP program offer valuable training tools but can risk epistemic reductionism when local idioms, explanatory models, and healing practices are sidelined in favor of diagnostic universality (Kohrt & Mendenhall, 2015; Nichter, 2008). This raises profound ethical and epistemological questions: Whose knowledge counts in the design of community mental health? How can standardization be pursued without erasing local nuance? And who gets to define what constitutes "resilience" in a given cultural or political context? Moreover, CBMHS can inadvertently reproduce the very inequalities they aim to address. Without careful attention to intra-community hierarchies—such as gender, caste, ethnicity, or age—interventions may disproportionately benefit dominant subgroups while marginalizing others. For example, peer-support programs may exclude individuals with less social capital, or community health workers may lack training in intersectional sensitivity, thus replicating patterns of exclusion under the guise of "community participation" (Campbell & Burgess, 2012). Additionally, the reliance on volunteer or low-paid labor in many CBMHS models raises questions of fairness, burnout, and the feminization of care. As critics have noted, community-based care is often sustained by the unpaid emotional labor of women, especially in contexts where state support is minimal (George, 2007). Such arrangements, while cost-saving, may entrench gendered labor inequities and undermine the emancipatory potential of community resilience. Another limitation lies in the fragility of

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horizontal governance structures. While decentralization and community ownership are central tenets of CBMHS, in practice, these ideals often confront bureaucratic inertia, fragmented service landscapes, and competing institutional logics. Coordination across sectors—education, justice, housing, health—remains uneven, and accountability mechanisms are frequently weak or absent. This fragmentation not only reduces efficacy but also risks confusing service users and overburdening frontline providers. Without robust coordination platforms and governance frameworks, the promise of integrated community care risks degenerating into a patchwork of disconnected initiatives (Blanchet et al., 2017).

Finally, there remains a fundamental ambiguity in the concept of resilience itself. While resilience is often valorized as a positive attribute, it can also serve as a rhetorical tool that shifts responsibility for systemic failure onto individuals and communities. Critics have warned that the resilience discourse, if uncritically adopted, may normalize precarity, obscure structural violence, or justify neoliberal rollbacks of state services under the guise of promoting "self-reliance" (Joseph, 2013; MacKinnon & Derickson, 2012). In this view, CBMHS risk becoming instruments of adaptation to injustice rather than vehicles of transformation. The ethical imperative, therefore, is not merely to build resilient subjects but to ensure that resilience does not become a substitute for equity, rights, or systemic reform.

6. Policy and Practice Implications

If community-based mental health services (CBMHS) are to realize their potential as engines of social resilience, their institutionalization cannot rely on rhetorical support or isolated pilot programs. Instead, what is required is a systemic reorientation—both strategic and ethical—of mental health governance, financing, professional training, and multisectoral collaboration. Translating the conceptual and empirical insights of this review into actionable policy and practice demands a multilayered approach that spans national policy frameworks, community infrastructure, professional paradigms, and global funding mechanisms.

At the national policy level, governments must explicitly recognize CBMHS as foundational components of both public health and social infrastructure. This entails embedding them into mental health legislation, national health plans, and emergency preparedness frameworks—not as supplementary add-ons, but as core systems of care delivery. Such a shift requires more than administrative integration; it demands a normative revaluation of care that prioritizes equity, participation, and locality. Strategic investments must be reallocated accordingly. Public spending should decisively move away from institutional overreliance on psychiatric hospitals and toward scalable CBMHS models that are culturally embedded, community-governed, and outcome-oriented (WHO, 2021; Patel et al., 2018). In practical terms, this means establishing decentralized funding streams that allow for long-term community ownership and adaptive service delivery. Conditional grants, community-based budgeting mechanisms, and co-financing models involving civil society actors could enhance sustainability and local responsiveness. International donors, too, must shift from short-term, project-based funding cycles toward longer-term capacity-building and infrastructure investment. The WHO's Special Initiative for Mental Health (2020–2030) provides a partial blueprint, but its implementation must be widened and adapted to local political economies.

Equally critical is the development of a trained, diverse, and resilient community mental health workforce. This includes not only psychiatrists and psychologists but also social workers, peer-support workers, community health workers, and traditional healers—each of whom brings specific competencies and relational capital to the mental health ecosystem. Training programs must adopt interdisciplinary, rights-based curricula that emphasize trauma-informed care, cultural humility, and participatory methods. Regulatory frameworks must also be adapted to formally recognize and remunerate non-traditional care providers, whose labor has too often been undervalued or rendered invisible (George, 2007; Funk & Ivbijaro, 2008). Without such integration, CBMHS risk becoming marginal appendages rather than transformative nodes within health systems. To institutionalize resilience, intersectoral coordination must be elevated from aspiration to operational reality. Mental

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health cannot be siloed from housing, education, employment, justice, and environmental planning. Policies must mandate cross-sectoral planning boards, shared data infrastructures, and integrated service hubs that address the full spectrum of vulnerability. For instance, urban mental health strategies could combine psychosocial support with safe housing, green space development, and income-generating programs. In rural areas, agricultural extension services could be cross-trained to recognize and respond to mental health concerns, as seen in the "farmer mental health" programs in Australia and India (Berry et al., 2011). Such hybrid strategies not only reduce institutional fragmentation but also enhance the ecological validity of resilience-building efforts.

At the level of community practice, participatory governance must be central. This involves co-designing services with local stakeholders, including service users, families, religious leaders, and marginalized groups. Community advisory boards, deliberative forums, and digital participatory platforms can democratize service planning and ensure that interventions are aligned with local priorities and values. Moreover, monitoring and evaluation systems must go beyond clinical indicators to include qualitative, culturally grounded metrics of empowerment, trust, collective efficacy, and meaning-making. This requires investing in mixed-methods research, participatory action research, and knowledge translation processes that make data legible and useful to communities themselves (Jordans & Tol, 2013; Blanchet et al., 2017). Global mental health actors—such as the WHO, UNICEF, and multilateral donors—must also refine their frameworks to better reflect the relational, political, and cultural dimensions of community resilience. The current dominance of technical-rational models risks flattening the complexity of social suffering and over-valorizing standardization. Instead, global guidance must become more pluralistic, reflexive, and context-sensitive. This may include issuing flexible toolkits rather than prescriptive manuals, funding South–South learning exchanges, and prioritizing ethical reflexivity in evaluation.

7. Conclusion

Community-based mental health services (CBMHS) are far more than a decentralized mode of care—they are relational, cultural, and institutional infrastructures through which communities cultivate resilience. By fostering psychosocial stability, expanding local agency, and reweaving fragmented social fabrics, CBMHS enable individuals and collectives not only to endure adversity but to reimagine futures with dignity and coherence. However, this potential is contingent. Without adequate funding, structural integration, cultural legitimacy, and ethical reflexivity, CBMHS risk being reduced to under-resourced stopgaps or instruments of adaptation to unjust conditions. Strengthening social resilience thus requires not only the expansion of CBMHS, but a fundamental transformation of how we value, organize, and politicize mental health in society. The challenge ahead is clear: to move from isolated promise to systemic change—where community mental health is not the exception, but the foundation of a resilient and humane society.

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