Social Work & Social Sciences Review 25(2) 15-29 Festschrift for Peter Huxley. DOI: swssr20252532

Aftermath to Lattermath and the Iconomy of Psychiatry: Shifting from hospital-centric towards community-centric mental health-care ecosystems

Alan Rosen, AO*

Abstract: Drawing on Professor Emeritus Terry Smith's work on Aftermath Architecture, we reflect on how the world's purportedly 'eternal' architectural icons can be transformed in the public consciousness, by terrorism and political intrigue, into impermanent 'soft targets'. In parallel we explore the grandiose 'Iconomy' of Psychiatry, and the decay of its grandiose institutional icons into stigmatizing stereotypes of dysfunctional mental health services. Professor Smith also invoked a related concept: the 'Lattermath', a late 15th century term for the new shoots of grass growing after harvest, to make the case that a renewal of hope is possible for architecture, prioritizing domestic and communal living. To achieve an enduring 'Lattermath' in psychiatry requires us to shift the centre of gravity of mental health services from being so hospital-centric towards community living. It also entails rebuilding mental health-care eco-systems which integrate clinical, lived experience, and carer expertise, while optimizing mental health and wellbeing outcomes., It also entails heeding First Nations caring for nature and community, their climate change activism and their resilience, and operationalizing human rights and an 'invisible village' or a co-designed local community of ongoing mental health care and support for individuals and families while ever they need it.

Keywords: aftermath; lattermath; iconomy; deinstitutionalization; shifting centre of gravity; hospital-centric; community-centric; mental healthcare ecosystems

***Correspondence**: alan.rosen@sydney.edu.au

Date accepted: 17th October 2025
Date of first (online) publication: 29th September 2025

Professor Alan Rosen, AO, is Honorary Professor and Professorial Fellow, Graduate School of Medicine and formerly Australian Health Services Research Institute, University

of Wollongong, and Clinical Associate Professor, Brain and Mind Centre, University of Sydney, Australia; Senior Consultant and Academic Psychiatrist, Far West NSW Mental Health Services 1985-present, specialising in Community, Urban, Remote, and Aboriginal Mental Health Services; Officer of Order of Australia, conferred 2014; Ian Simpson Award, Royal Australian & New Zealand (ANZ) College of Psychiatrists, 1994; formerly Psychiatrist/ Director/Clinical Director of Royal North Shore Hospital and Community Mental Health Services 1979-2009; and inaugural Deputy Commissioner of the Mental Health Commission of NSW 2012-2015, Member Mental Health Working Group, National Independent Hospital Pricing Authority 2013- and NSW Mental Health Review Tribunal 2020-; International consultant in MHS system redesign; Visiting Professor, University of Wisconsin 1990; Senior Fellow, Medical Anthropology and Social Psychiatry, Harvard University, 2006; Member, Section of Leadership & Management 2021-, Aboriginal and Torres Strait Islander Committee, 2014-2024, Royal ANZ College of Psychiatrists. Presidential Invited Speaker at American Psychiatric Association Annual Meeting, San Francisco and at World Psychiatric Association Congress, Berlin 2017 & Lisbon, 2019. Author/co-author-editor of 170 academic articles and chapters, several published books/manuals/ reports and many public media articles. ORCID: https://orcid.org/0000-0001-5478-702X

Developed further from: Alan Rosen, Sydney Australia, Invited Opening Plenary Lecture, National Assertive Community Treatment [ACT=TAC] Conference, Aviles, Asturias, Spain, June 2021; Invited address, Royal Australian & New Zealand College of Psychiatry Annual Congress, Hobart, Australia, May 2021.[1]

[[1] Sources: Terry Smith, *The Architecture of Aftermath* (University: Terry Smith, University of Pittsburgh, University of Chicago Press, 2006) and Terry Smith, *Iconomy: Towards a Political Economy of Images* (London: Anthem Press, 2023); , Duke University Press, 2018,

Note: The earliest version was presented in a Symposium by A Rosen, K Thompson, G Witte & D Pollack: Aftermath Architecture and Psychiatry, Institute on Psychiatric Services, New Orleans. October 2007. An earlier summary version publication of this work is referenced (Rosen 2022).

Dedications

In appreciation of and drawing on the inspiring and challenging work of Terry Smith, Andrew W. Mellon Professor Emeritus of Contemporary Art History and Theory in the Department of the History of Art and Architecture at the University of Pittsburgh; former Power Professor of Contemporary Art and Director, Power Institute, Foundation for Art and Visual Culture, University of Sydney; and Australia Council Visual Arts Laureate, 2011.

In tribute to Professor Peter Huxley, on his retirement as Professor of Mental Health Research & Social Psychiatry at Bangor University, Wales, UK, and in appreciation of our interactions over many years, initially via our friendship forged through mutual close connections to Douglas Bennett and to Richard Warner, both of whom visited with our services in Sydney. Peter and I then came together and collaborated from time to time over many years, initially when he was inaugural Professor of Social Work at the Institute of Psychiatry, London, continuing when he came to Bangor University. These included, sometimes with Dr Jim Mandiberg, memorial communications, and events in memory of Dr. Richard Warner (deceased, psychiatrist and anthropologist, expert in community psychiatry, recovery from severe and complex mental health disorders and in challenging stigma. With Richard and Peter, our common interests and purpose have been in the development and research of interdisciplinary community mental health care teams, community mental health rehabilitation services, and routine service evaluation methods. Peter's friendship and active nurturing of an inclusive mental health community and dissemination of knowledge about Mental Health Service systems that work, was embodied over many years for us through Peter's warm friendship and participation, from time to time. in The Mental Health Services [TheMHS] Conference & Learning Network of Australia & New Zealand (www.themhs.org) combining mental health service users, families, professional, support and peer providers, indigenous and transcultural stakeholders, held regularly over the last 33 years. My partner and spouse Vivienne Miller, Inaugural Executive Director of TheMHS over all of that span, and we wish Peter a very happy and fulfilling next chapter of life.

Introduction: Architecture as icons

What has the evolution of community psychiatry and mental health services got to do with the evolution of architecture?

Earlier and late modernist architecture has increasingly symbolized global icons: for example, buildings projecting international brands vying for national prominence, or global commercial dominance such as Coca-Cola, Exxon/Mobil/ Esso, and Trump Tower.

The arguments advanced by Terry Smith (2006) about 'Aftermath Architecture', suggest that:

1. worldwide, there is not only an **econ**-omy but also an **icon**-omy, denoting 'the far-reaching significance of the realm of visual culture' which 'describes more than the dense image manipulation that prevails in cultures predicated on conspicuous and incessant consumption' (Smith, 2006). Multinational corporations have, for decades, used the 'iconomy' to disseminate their products, their logos and their style'....seeking dominance and 'hegemonic control' over the means of communication, forms of dissemination and the regulatory frameworks. They include 'a plethora' of international standard-setting agencies such as the World Bank, the International Monetary Fund, and the United Nations. Some of these companies have moved to control all reproducible images (e.g. Getty) while others have sought to monopolize all sports and entertainment imagery, (Smith, 2006), often by controlling all access, media, venues, performers and events.
2. Global Multinational corporations, (including public institutions, organisations, commercial enterprises and cults) have used the' Iconomy' to disseminate their products, their logos, their 'style', their messages conveying their simplistic rosy world-view and ...
3. global architecture has been reeling since the wanton destruction of global icons such as the World Trade Centre (WTC) in New York on 9/11/2001. There should be a growing discomfort among entrepreneurs, developers and architects that their constructing of iconic buildings to promote or perpetuate national or global brands, symbols or empires have been transformed in the public mind into building impermanent 'soft targets', vulnerable to terrorism.

Smith argues that architecture has lost its way from its roots in creating homes and communities for all (Smith,2006;2019). No longer are they almost magnetically attracting Icons but merely a challenge to disruptive and sometimes violent political miscreants, with the capacity of these structures to provide winning prestigious attractor images (so central to their prominence in the ''iconomy') turned, instantly, into a repellant and gigantic liability.

Similarly, psychiatry may also have lost its way in the face of the market, and since the loss of its iconic massive institutions, while retreating from engaging with whole communities to improve their wellbeing and mental health, and by

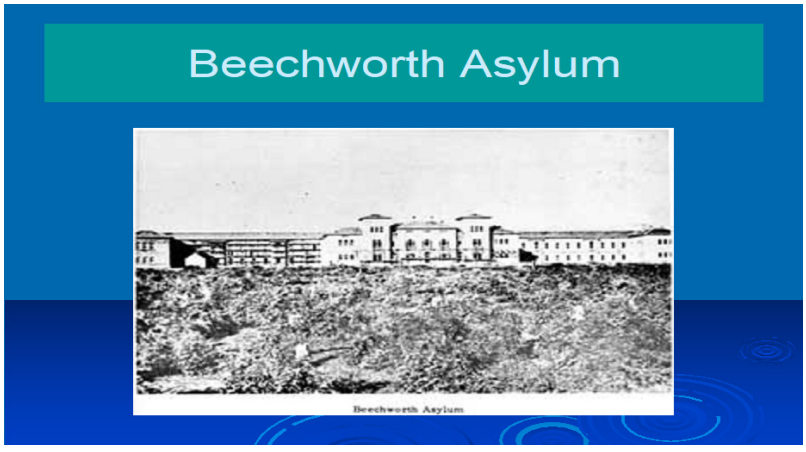
neglecting to promote full membership of the community and full human rights while dealing with mental disability. Instead, psychiatry has continued to build clinical edifices, fortress hospitals and academic empires, arguably with overreliance on medications, ever-longer acting injections, Electro-Convulsive-Therapy (ECT), involuntary incarceration, control, alienation, and neglect, which have become its dysfunctional public icons or signifiers.

Example 1: Beechworth Asylum, Victoria, Australia.

A working psychiatric Institution from 1867-1995, with up to 1200 in-patients, and 700 staff. Originally built with pride as a prominent edifice and testament to the benefits and era of moral therapy and the serenity of living in cloistered gardens, such asylums deteriorated to become sites of slave labour and human warehousing. They were increasingly both feared and ridiculed in their localities as 'loony bins', where parents would often threaten to consign their children if they misbehaved.

Negative stereotypes of deranged and violent psychiatric patients were transformed even after their closure into equivalents of carnival 'Ghost Trains' or 'Houses of Horror', and their 'resident ghosts' are still played up and sold there as entertainment. For example, the following is a recent advertisement. '*Beechworth Asylum*: Everything we know about the history of one of Australia's spookiest sites, including recent ghost sightings.' (and)

> '**Beechworth Asylum Ghost Tours** offers ghost & paranormal investigations...When all is quiet and the dead things open their eyes, find out who or what really does haunt this foreboding asylum.' (6 April 2019).



Beechworth Asylum, 1867-1995, Victoria , Australia, [Alchetron.com, Open Access Free Social History Encyclopedia].

Example 2: ECT: Electro-Convulsive Therapy

In One Flew Over the Cuckoo's Nest, which is the 1975 Milos Forman psychological drama film based on the 1962 novel by Ken Kesey, starring Jack Nicholson, shows stereotypic depictions and images of ECT delivered while awake in the Pre-Anesthetics Era.

These days, ECT is more often provided sparingly and humanely, and can be life-saving in conditions such as catatonic states and treatment recalcitrant or intractable psychotic depressions. However, when sometimes previously delivered as tacit or unofficial punishment, could ECT, be alternatively characterized as 'Electro- Counter-Transference' Therapy?

Box 1: Implications of acknowledging the Iconomy (Smith 2006, 2023)

We have not only an Economy, but an Iconomy

The Global Iconomy is as important as the Global Economy.

The ICONOMY is the pervasive trafficking (in the currency of prestigious icons or images) and the dense manipulation of images that prevails in cultures built on conspicuous consumption (...a commerce of goods, symbols, ideas and power).

There is a relationship of the Iconomy of Psychiatry to the impact of the loss of prestige or loss of these iconic images with the particular symbols represented, (as related to Stigma and Discrimination Research-see below) (Rosen et al.,2012).

Box 2: How do we deal with our own Aftermath Icons and Imagery of psychiatric services?

Decay and/or Dying and Abandonment of Institutions.

Depletion and dismantling by neglect of public psychiatry, in parallel with proliferation of urban-bound corporate imagery of private psychiatry.

Dominant Imagery of narrowing of professional tasks to pathologizing, clinicalizing, risk preoccupied, law-and-order compulsory hospitalizations and actual or quasi-commercial commodifying of human distress and healing, unbridled 'whatever-the-market-will-bear' money-making, while abandoning of most vulnerable people with the most complex needs.

Our purported psychiatric 'icons' did not work or endure as prestigious images representing our endeavours: they are no longer valued, nor enduring over time, nor uplifting, and they are much more fear- and repulsion-instilling than hope-instilling.

There has been no positive replacement for these repellent, decaying or moribund former icons, despite much more effective evidence-based interventions and service systems now emerging.

Aftermath to Lattermath

Additionally, Terry Smith has invoked a related concept: the '*Lattermath*', (Smith,2019) a late 15th century term for the new shoots of grass growing after harvest, to make the case that a renewal of hope is possible for architecture (Smith, 2006; 2018). Lattermath is an English Dialect noun, defined as 'a second mowing or crop of grass from land that has already been harvested in the same year' (Collins English Dictionary). Equally, such a Lattermath may also be imaginable and possible for psychiatry, especially if mental health services integrate clinical, lived experience, and family expertise, shifting their balance towards honouring and facilitating human rights and a community-based centre of gravity (Mezzina et al 2019) (Rosen et al.,2020).

So where does this leave architecture?

Should it remain 'Numb in the aftermath of its ravishment'? (Smith, 2006), or distrusted or abandoned in the ruins of its grandiose edifices, glossy marketing, conceit and greed? Rather, is it a time to revive what architecture can uniquely do, to return to its valued roots? For example:

1. in designing of peoples' homes within familiar terrain and cultural values, while sometimes gently challenging them.
2. In the construction, consolidation and continuity of communities and the creative, collective, cultural and ritual celebration of them.

Arguably, we may continue to need some community-binding, uplifting awe inspiring and culturally connecting architectures, which may amplify communally binding rituals, but can we ever prevent them being hijacked for personal celebrity or elite greed or demagogic aggrandizing?

This is the imagery and embodiment of welcoming, respectful, inclusive, comfortable and comforting, of ordinary human scale, not the attempted immortalizing of our professions with grand and shiny edifices.

This is a *celebration* of returning to a human scale, to the roots of the architecture of wellbeing, in the housing of people and in the construction and evolution of communities. Some ambiguities and dilemmas still remain to be resolved regarding the extent and limits of the latter.

Ambiguities will probably persist. Is Gaudi's Sagrada Familia Cathedral in Barcelona an inspirational spiritual meeting place or tourist icon or both? Is the Guggenheim Art Museum in Bilbao, Spain a communal temple of art, cultural bank or brand icon, or all of these and more?

Implications for psychiatry

So let us not rebuild large institutions, either stand-alone or on general hospital sites, where they are often placed behind the laundry and the boiler house, to dramatize their stigmatized low ranking in the clinical pecking order. Nor in prisons, nor grandiose imposing vertical edifices or institutes. Nor relocate community mental health centres from being based conveniently near their communal hubs to more regional hospital sites as purported 'economies of scale'. Rather, build more locally accessible, horizontal, home-like welcoming centres for inclusive, integrative, evidence-translational, up-to-date, practical interdisciplinary teamwork (Harding, 2024).

We now can describe the progression from de-institutionalization to 'Aftermath' psychiatry of Clinical Edifices, Hospital-centric fortresses , and Institute Empires with only occasional outreach, to a more hopeful '*Lattermath*' of new shoots of growth for a more hopeful, Community-centric and Rights-based mental health service with 'in-reach' to hospitals as necessary.

Our mental health professions do not have to be left perpetually trapped in the rubble and debris of our old practices and approaches (Thompson K, pers.comm., 2019). Instead, it can be demonstrated that, if examined closely, there is 'lattermath' growth occurring in psychiatry leading to new life, new growth and new hope for service users, their families, and the profession (Smith, 2006; Rosen,2006; Rosen et al.,2006) eg 'the early intervention of nearly everything' (Byrne & Rosen,2016).

The public, local communities and families have usually welcomed most phases of development of community psychiatry, once seen as working effectively, from pastoral home-visits, to *in-context* crisis intervention to integrated service delivery systems of evidence-based community mental health complex-care teamwork like mobile Assertive Community Treatment. Affected families and communities have protested when such services have been withdrawn due to back-lash from professionals, administrators or governments intent on re-institutionalization and/or privatization (Rosen et al, 2022): for example, the successful resisting by the family movement of attempts by ultra-conservative Italian Governments to undo the well-established community mental health reforms.

Can psychiatry revive itself with a new growth of practice innovation and evidence-based community mental health services for all with lived experience of complex and severe mental illnesses? Can such services be situated in the complexities and contexts of their own lives, and 'on their own turf and terms', often in their own homes and on their own streets? Can Community Psychiatry encompass both the necessary technical interventions and service delivery systems, while also facilitating human rights, humane relationships and purposeful fostering of healing, recovery and communal wellbeing?

If we do not learn, our future in psychiatry will continue to be like trying to tie together architectural gestures and fragments into top-heavy buildings with structural defects and unstable foundations by incompetent or fraudulent builders.

Setting / Characteristic	Inpatient	Community centre	Home
Respect	Compromised Devalued	Variable	Honouring
Intrusion on Identity	Loss of Privacy	Dependency	Hospitality
Positive Potency	Weak Demoralising	Variable Negotiable	Strong
Whose Turf & Terms?	Ours Institutional	Ours Clinical	Theirs

From Inpatient to Home Care Matrix: Rosen A, Invited lecture, National TAC Conference, Avîles, Spain, June 2017.

Media exposés and analyses of these complicit developers in Australia with their 'iconic' but flawed and uninhabitable residential towers, resonated for me with an earlier experience. I witnessed examples on an architectural tour by a professor of architecture moonlighting in Havana, Cuba, where, due to a severe shortage of trained builders, unskilled couples and families desperate for a home join a subsidized collective to try to learn how to build a medium-rise building of apartments from an assigned supervisor. By the time they reach the top floor, they could do a fairly good job, but they may worry about the structural integrity of those apartments they built earlier underneath, and the complete lack of a budget for repairs (AR, Study Tour, Cuba 2009).

Courtenay Harding's persistence in conducting a large-scale, long-term follow-up rigorous study of mental health outcomes for individuals deinstitutionalized from the Vermont State Institution demonstrated that most improved significantly clinically and in life quality, whether they received ongoing clinical and support services in the community or not, though those who accessed such services did better. She concluded that just living in the community was inherently healing, in ways that institutional living is not (Harding, 2024).

This suggested to Harding that the best served were provided with intensive wrap-around comprehensive community-based rehabilitation programs which changed the institutional vertical organization into a communally horizontal one. Unfortunately, she subsequently observed that too many contemporary community mental health centres in the USA and elsewhere have reverted, perhaps under bureaucratic pressure, to operating more on a vertical hospital-centric model, prioritizing stabilization, maintenance, and medication compliance, with a gestural 'pinch of rehab' (Harding, 2024).

How stigma and discrimination relate to site and type of mental health service delivery.

Psychiatric institutions, despite their sometimes earlier honourable intentions and lofty ambitions, have become emotionally polluted sites and negatively connoted symbols of indelible stigma, shame, and horror in their local communities (see Beechworth Asylum example, above). While community mental health services may be much less 'stained' in this way, all of psychiatry is stigmatized to some extent.

Our combined Lower North Shore of Sydney Community Mental Health Service and University of Sydney Community Pharmacists research of stigma perceived by service-users, their families and professionals involved with Assertive Community Treatment and Care teams may be relevant here (Ye et al.,2016; O'Reilly et al.,2019).

Service-users often report that the experience of the stigma of having a mental illness is often worse than living with the illness itself. Stigma and Discrimination experienced 'on the ground', can be disparaging of individuals and families with complex, severe and persistent mental illness. These are often expressed as internalized self-stigmatizing by service-users, and everyday professional pejorative attitudes and language usages, both based on discriminatory societal and media stereotypes.

Cumulative experiences of being stigmatized, shunned, and discriminated against, can often be perpetrated, sometimes inadvertently or due to ignorance, by extended families, friends, neighbours, workmates, and society. This can cause extreme isolation of the individual with a complex mental illness and their immediate family. Problem-solving methods applied together in community Multiple Family Groups can help diminish household stresses, conflicts, and subsequent relapses, but also provide an ongoing developing of community between such families (McFarlane, 2002; Rosen et al, 2020).

Stigma by some health and mental health professionals, and the trauma of insensitive and involuntary treatments, unwelcoming and unfriendly treatment environments, may also contribute substantially to the genesis of trauma disorders, in combination with frightening acute psychotic experiences. However, we also found evidence that indicates that Assertive Community Teams are often perceived by service-users and families as discriminating positively in favour of their clientele, possibly by earning their trust, advocating for, and believing in them, which may contribute considerably towards their recovery (Ye et al.,2016; O'Reilly et al.,2019).

Communal recovery and urban renewal

This entails learning from Indigenous communities about how to develop proxies for the culturally universal collective tasks of healing stress or trauma, or mental illness, and re-establishing wellbeing. We must draw on two key cultural tools:

(a) in the present time dimension: the person's extended kinship system, together with peers and social networks, in their own familiar environment; and (b) in the flow of time dimension from past to future: enabling people to complete their rites of passage, rather than getting stuck in a timeless psychiatric limbo (Rosen,2006).

Chris Beels (Rosen,2020) conceptualised 'the invisible village', which describes the need to proactively form an unobtrusive supportive community that can readily 'accommodate madness', and which can vastly improve the quality of life of people with severe mental illnesses while living in the community. It was based on the then emerging evidence from WHO studies that functional and social recovery from schizophrenia was shown to be much better in agricultural village societies of low-income countries than in Western industrial societies, even though the incidence was probably similar (Rosen A, 2006). Richard Warner (Warner, 2004) insisted that we needed to develop and retain 'Communities of Identity' (drop-in centres providing network support in crisis, or in ongoing rehabilitation via clubhouses, work cooperatives, living skills and day centres).

Urban Renewal was opportunistically blended with public health, mental health and well-being in Trieste, Italy, forming 'micro-areas', with decaying tenement precincts being redesigned according to Basaglian community mental health principles (Mezzina, 2014): social inclusivity, and generational reciprocity (e.g., young residents were employed to assist elderly with mobility),. Communal collaboration, with university architecture faculties has entailed consulting each precinct community to uniquely co-design its own housing, common spaces and facilities, funded and developed in partnership with the city Commune, and local social and health services (Rosen et al, 2020, Table 3, Macro section).

Intentional supportive communities of families which grew out of multiple family groups for severe mental illnesses, the effectiveness of which were rigorously demonstrated by Bill McFarlane's teams (McFarlane, 2002), with strong support from both Margaret and Chris Beels (Rosen, 2020).

The Beels' advocacy and support for research into Peer Assisted Open Dialogue followed, the Parachute study (Hopper K et al., 2020), in the real world at last, of tough inner urban New York, in already hard-working evidence-based community crisis or assertive teams. The funding for this study was prematurely and bureaucratically withdrawn (Rosen, 2020; Hopper et al.,2020), which is particularly concerning as Finnish Open Dialogue training, its highly theoretical and ambiguous fidelity criteria (Waters et.,2021) and related research appear to underemphasize and have too little focus on the crucial importance of working consistently with families during routine home visits and the neighbourhood resource network, rather than ultimately mainly with individuals in an office setting. These latter two specified components may well be key and among the most reproduceable practical variables which may correlate with positive outcomes. Yet they are only operative when implementing the full model of Open Dialogue, rather than the more theoretical components which can be more easily adapted to mainly 1-to-1 more sedentary office practices (Rosen, 2020).

Conclusion

We must consider whether community psychiatry can be revitalized and sustained:

1. with a new growth of practice innovation and evidence-based community mental health services for all who need them, encompassing both the necessary technical interventions and service delivery systems, as well as facilitating human rights, family and communal support and wellbeing.
2. while developing practitioner skills, including the clinicians, support and peer workforce, with supervision of evidence-based home delivery service systems, as well as pastoral support, to enable and sustain consistent compassion, confidence, and competence and to prevent burnout.
3. while providing training and supervision to work with both Micro-skills (Rosen, 2006; Rosen et al.2020) encompassing both individualized, 'bespoke' therapeutic relationships and care plans, offered to individual service-users and their families, and Macro-skills to address the mental health and wellbeing needs of an entire catchment population. The latter entail facilitating community networking meetings, social movements, and educational multiple family groups dealing with communal stressors and traumas, stigma and discrimination, plus access and service equity for whole local catchment, regional or national populations. Architecturally, these require welcoming, inspiring and convenient local venues.

Deploying these components should culminate in service delivery based on sound evidence, and inclusive co-planning with and co-leadership of service users, their families and providers of integrated Mental Health Care Ecosystems for each region (Rosen et al.,2020; Rosen & Salvador-Carulla,2022; Rosen & Holmes,2022).

Informed social science appraisals and critiques of asylums such as Erving Goffman's (Goffman, 1961) have provided inspiration for the global deinstitutionalization movement and international developments based on the Italian reforms. As described by Mezzina et al.,(2014), these have been built on the pioneering clinical, political and policy foundational works of Franco and Franca Basaglia, and have demonstrated the practical benefits and potentials of such reforms for over 5 decades (Mezzina et al.,2014; Rosen et al., 2022).

So like 'Aftermath Architecture' (Smith 2006, 2019) , the profession and edifices of psychiatry have suffered the fate of other icons which have shifted from positive (or at least more neutral) to negative connotation over time and with change of societal values. their prevailing dominant imagery doggedly remains as signifying stigma, loss of freedom, of human rights and of hope, as well as the taint of parallel commercialized empire building, serving only those who can afford them.

Whether we can enable psychiatry to move into a more hopeful 'Lattermath' phase is up to us, depending on whether we can be mindful of the significance of such

iconography, and then act on transforming it. To achieve an enduring 'Lattermath' in psychiatry requires us to shift the centre of gravity of mental health services towards community-centricity. It also entails rebuilding mental health-care eco-systems which integrate clinical, lived experience, and carer expertise, while optimizing mental health and wellbeing outcomes, heeding First Nations caring for nature and community as integral to their climate change activism and resilience (Rosen et al, 2024) and operationalizing human rights for individuals, families and whole local communities (Mezzina et al 2019) (Rosen et al.,2018, 2020, 2022).

Acknowledgements

To: Terry Smith (especially), Vivienne Miller, Ken Thompson, George Witte (dec'd), & David Pollack for input re Aftermath and Lattermath content, to Claire O'Reilly and Gary Walter re stigma and ACT teams, and Juanjo Jambrina, Helen Killaspy, Roberto Mezzina, Peppe Dell' Acqua, Ron Diamond, John Hoult, Roger Gurr, Luis Salvador-Carulla, Courtenay Harding, Margaret & Chris Beels, Michael Dudley, Carolyn Quadrio, Douglas Holmes, David Shiers, Jo Smith, Peter Byrne, Katherine Boydell, Louise Nash, Maree Teesson, Peter Huxley, Geoff Shepherd, and Lise van Susteren, Pat McGorry, David Shiers, Jo Smith, Peter Byrne, Pat Dudgeon, Neeraj Gill, Max Bennett and Jackie Curtis, for input re home visiting, continuity of care, community housing & work cooperatives, peer work, and recovery components, addressing clinical reductionism, facilitating healing via culture and nature, human rights, mental healthcare ecosystems, and early intervention strategies, and Rob Poole and Hans Pols for editorial advice. In memory of Franco & Franca Basaglia, Len & Karen Stein, George Witte, Richard & Lucy Warner, Ian Falloon, Anne Deveson, Lorraine Rose, Paul Polak, Wendy Weir, Gregor Henderson, Peter McGeorge and Chris Beels.

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