Community mental health: Theory, practices and perspectives

Operations Division
May 2018
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# Community mental health: Theory, practices and perspectives

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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>4</td>
</tr>
<tr>
<td>Executive summary</td>
<td>4</td>
</tr>
<tr>
<td>Why produce this document and who is it for?</td>
<td>6</td>
</tr>
<tr>
<td>Objectives of this document</td>
<td>7</td>
</tr>
<tr>
<td><strong>Part 1: community mental health theory</strong></td>
<td>8</td>
</tr>
<tr>
<td>1. Community mental health, a brief literature review</td>
<td>8</td>
</tr>
<tr>
<td>2. Community mental health and HI</td>
<td>11</td>
</tr>
<tr>
<td><strong>Part 2: community mental health practices</strong></td>
<td>14</td>
</tr>
<tr>
<td>1. The specificities of HI’s position</td>
<td>14</td>
</tr>
<tr>
<td>2. The Projects</td>
<td>20</td>
</tr>
<tr>
<td>3. Cross-cutting characteristics</td>
<td>22</td>
</tr>
<tr>
<td>4. Types of intervention</td>
<td>23</td>
</tr>
<tr>
<td>5. Nourishing our practice: new theoretical input?</td>
<td>28</td>
</tr>
<tr>
<td><strong>Part 3: challenges, stakes and perspectives</strong></td>
<td>36</td>
</tr>
<tr>
<td>1. Challenges</td>
<td>36</td>
</tr>
<tr>
<td>2. Stakes and perspectives</td>
<td>37</td>
</tr>
<tr>
<td><strong>Appendices</strong></td>
<td>40</td>
</tr>
<tr>
<td>1. Seminar Terms of Reference and Programme</td>
<td>40</td>
</tr>
<tr>
<td>2. Bibliography</td>
<td>43</td>
</tr>
</tbody>
</table>
Foreword

Executive summary

Mental health problems are commonplace and affect more than one in four people worldwide. They are responsible for a quarter of all disabilities. Humanity & Inclusion (HI) has been working in this area since 1990, deploying actions to prevent mental health disorders, provide care and support for social inclusion, fight the stigma around mental health and disabling situations, and promote positive mental health (see definition page 16).

A seminar was held in Kigali, Rwanda on 7 - 9 December 2017. It brought together 45 participants from 12 countries (see the appended Terms of Reference and programme) to think about and discuss community mental health concepts and practices.

Indeed, the mental health and psychosocial support (MHPSS) sector wants to rethink its intervention methods to best meet the needs of the populations we support.

The objectives of this document are two-fold:

- Set out analysis by an external expert, with a focus on community mental health at HI, in light of the literature and concepts and practices within the sector.
- Undertake preliminary work to identify new concepts for implementation, based on the aspects covered in the seminar, as part of ongoing in-depth work in this area, including the updating of the 2011 mental health framework document.

The first part of this document sets out a brief review of the scientific literature on community mental health, going back to its origins in the 1950s rooted in the deinstitutionalisation movement, focused on the importance of decentralising community services and involving «secular» or non-specialist actors, in particular in low and middle-income countries. At HI, community mental health mainly refers to three intervention methods: specialist mental health services (but locally-based and open to society), the inclusion of community mental health in primary health care, and inclusion of community mental health in community-based rehabilitation (CBR).

The second part of this document details the specificities of HI’s positioning in relation to the mental health and psychosocial support sector, based on:

- A wholly social vision of mental health disorders requiring not just attention to be paid to the symptoms of mental health disorders or stress reactions, but also to the person’s capacity to enjoy life and meet the challenges they face.
- The importance of social participation, which aims to give the most vulnerable, suffering people a place in society.
- A particular focus on the role of the person who is suffering, to ensure they are placed at the centre of the care process. This involvement leads practitioners to abandon the idea that they know what is best for people, and requires the sharing of knowledge and power.

HI runs a variety of projects. These include:

- On the one hand, projects with a mental health component integrated into other sectors (the majority of projects), such as physical rehabilitation (Iraq, Afghanistan etc.), gender-based violence (Rwanda, Burundi) or migration (Turkey, Bangladesh).
- On the other hand, stand-alone mental health projects (Rwanda, Togo, Madagascar, Lebanon, South Sudan etc.).

The majority of projects have a shared identity and cross-cutting characteristics:

- Community consultation, through a socio-anthropological study which aims to understand perceptions of mental health issues, the actors in place and the power balance between them;
- Work with non-specialists, including for the purpose of managing diagnosed psychiatric pathologies;
• **Support groups**, which for a number of years have been a particular focus for HI.

The interventions take the form of:
• **Community prevention and awareness-raising**, of mental health issues and existing resources;
• **Support and development of care systems**, such as referrals to specialist centres, capacity-building of services through training and supervision (specialists), the strengthening of psycho-social support workers (non-specialists), and finally the implementation of emergency psychosocial interventions during crises;
• **Support and development of social support systems**, such as job assistance or income-generating activities;
• **Support and development of collective support systems**, such as discussion groups and self-help groups;
• **Advocacy** to influence decision-makers, governments and actors to develop fair and inclusive policies.

New theoretical input, presented by guest experts, which might give us new ideas for HI’s activities: **resilience and recovery**. Resilience can be defined as a dynamic form of learning which allows people to bounce back in the face of adversity. Recovery can be defined as a unique and personal journey back to a full, meaningful life, despite the diagnosis of a psychiatric illness or mental health disorder.

The third section sets out the different problems raised in the discussions between participants: either resulting from the contexts in which the projects are developed (lack of specialist resources, lack of services, stigmatisation), or due to the ownership of our framework document on mental health by the people responsible for the projects.

The main challenges and perspectives for the future are also discussed in this final section, and are summarised under the following recommendations:
• **Disability and mental health disorders**: there is a lack of information on the mental health problems faced by people with disabilities and it would be interesting to develop and onboard tools to compensate for this gap.
• **A transverse psycho-social dimension** is likely to be developed in many, if not most, of our projects.
• **Involving users in their care pathway** by providing practitioners with tools (notably those relating to Carl Rogers’ person-centered approach) could be reinforced.
• **Mental health projects based on community-based rehabilitation**, built on the expertise developed through personalised social support, could also be developed.
• **Interventions in emergency settings** could be re-thought as part of the emergency / development continuum, through the prism of our experience in community mental health.
• **Advocacy for robust mental health policies** based on the updating of our strategy, could be stepped up.
• **An update of our mental health policy (framework document)** could potentially include the following components:
  • HI’s vision of mental health and psychosocial support projects, which, based on the components set out in the second part of this document is: A resolutely social vision of psychological disorders and/or distress, requiring the involvement of beneficiaries in their care pathway with the clear goal of ensuring people’s social participation.
  • A reaffirmation of what community mental health is from HI’s perspective, bearing in mind that this is largely contained in the 2011 framework document.
• **Choices in terms of the priority populations**: people suffering from disorders and/or distress typically associated with other physical (disability) or social (detention, gender-based violence etc.) issues, people with moderate to severe mental disorders (pre-existing and/or exacerbated by the context in which HI is operating), people suffering distress relating to the context (war, internal conflicts, natural disasters, vulnerability) etc.
• The intervention method, stand-alone project or integrated mental-health component.
The tools to use (or not) depending on the contexts and issues identified: peer support groups, individual or group psychotherapy, psychoeducation, psychological first aid etc.

A minimum level of competence for mental health and psychosocial support workers (knowledge, soft and hard skills).

Priorities in terms of advocacy.

Why produce this document and who is it for?

Mental health problems are commonplace and affect more than one in four people worldwide. This represents 10% of the global burden of disease. These problems are responsible for a quarter of disabilities and result from a complex range of personal, social and environmental situations. These figures are even higher in emergency situations.

Humanity & Inclusion has been working in the mental health sector since the 1990s. Our actions aim to prevent mental health disorders, provide care and support for social inclusion, fight the stigma around mental health and disabling situations, and promote positive mental health. All these actions are implemented using multi-disciplinary, participative, community approaches which take care to coordinate between the different actors involved.

Our interventions have always targeted vulnerable and isolated populations such as the victims of war or genocide, orphans, female victims of violence, people with mental, sensory, or intellectual disabilities, and people living with disabling diseases. Today, with more than 30 years’ experience in the field working in constantly changing socio-political contexts, the mental health and psychosocial support sector wants to rethink its intervention methods in order to best meet the needs of the populations it supports.

This document is in no way an exhaustive representation of mental health and psychosocial support (MHPSS) at Humanity & Inclusion (HI). It is based on observations made during the community mental health seminar which took place in Rwanda from 7 - 9 December 2017, which brought together 45 participants from 12 countries (Burkina Faso, Mali, Burundi, Rwanda, Cuba, Haiti, Nicaragua, Colombia, Bolivia, Cambodia, Iraq and Nepal). It is also based on a literature review of existing HI documents and scientific articles (see appended references), and from informal and formal discussions with seminar participants. The mental health technical advisers and the knowledge capitalisation methodology technical adviser also contributed to this thinking. This document is part of a more general process to reconsider the focus of HI’s future mental health strategy. It will therefore be used to update the current framework document as part of more general thinking around the emergency response-development nexus. It is intended to develop comprehensive thinking about mental health and psychosocial support at HI in emergency response and development settings. Given the wide variety of contexts in which HI operates, and the diversity of profiles (specialists and non-specialists) working in this sector, this document aims to explore the need for a shared foundation of knowledge, hard and soft skills to guarantee the quality of our interventions, regardless of their diversity.

This document is intended for HI and partner staff members who work in the mental health and psychosocial support sector. It is also intended for HI staff working on mental health strategy. It can also be used to feed into the work of field staff developing, implementing and assessing mental health and psychosocial support programmes.
Objectives of this document

These are two-fold:
• Set out analysis by an external expert with a focus on community mental health at HI, in light of the literature and concepts and practices within the sector;
• Undertake preliminary work to identify new concepts for implementation, based on the aspects covered in the seminar, as part of the ongoing in-depth work in this sector (MHPSS) at HI: updating of the mental health framework document with a view to integrating the emergency response-development nexus and the strategy to implement to multiply and reinforce our prevention and management actions in mental health and psychosocial support.
Part 1: community mental health theory

1. Community mental health, a brief literature review

The term «community mental health» refers to a number of different practices. It refers not only to a movement to transform mental health care, but also a type of care setting. The use of the term «community» can indicate the direct involvement of local community actors, but also expresses its difference in relation to care provided through hospitalisation in a psychiatric unit. In low and middle-income countries, community mental health projects incorporate a multitude of different practices, there is no standard model with a proven track record. It is therefore important that these different meanings are properly contextualised.

The origin: de-institutionalisation

In the western world, the community mental health movement began in the 1950s in response to the institutionalisation of psychiatric patients which was found to have truly disastrous consequences. Patients who spend too long in psychiatric hospitals experience a loss of social skills, the weakening fo social relationships, and difficulties in relation to social inclusion and stigmatisation.

Numerous community services were developed to address these problems: consultation services, rehabilitation services, job assistance and sheltered housing (Thara, John and Chatterjee 2014). This became known as the de-institutionalisation movement. Dedicated teams were set up to support the most vulnerable people proactively, in their homes, through assertive outreach, without waiting until they were in crisis and needed to be hospitalised. These methods achieved very positive results in relation to the limitation of psychiatric hospitalisation and in relation to housing stability (Bond and Campbell 2008; Burns et al. 2001; Marshall and Lockwood 2011; Wiley-Exley 2007). The hospitals themselves have been transformed, offering shorter, more intensive care, investing in outpatient care and developing day hospitals.

This community strategy is supported by three movements which have had a lasting influence and are still relevant today: (1) attention to the human rights of people with mental health disorders, including the right to live a fulfilling life in the community (2) constant organisational efforts to integrate the methods used in primary health care and community health care into mental health care care (3) scientific research which has proven that community-based mental health services provide better care at a lower cost (Wiley-Exley 2007).

These community mental health models are currently considered to be the best way of organising health care for people with mental disorders in western countries. They ensure continuity of care and address people’s needs in a holistic manner, encompassing social and economic issues. They also provide early detection and contribute to reducing stigma. Community care has better outcomes both in terms of symptoms and quality of life for people with severe mental health disorders. They are also more cost-effective and uphold people’s human rights (Jacob 2001; Jacob et al. 2007; Wiley-Exley 2007; Killaspy 2006; Thornicroft and Tansella 2004; Mueser et al. 1998).
They offer consultation, monitoring, psychoeducation, home support services, rehabilitation and job assistance, group activities etc.

Although the number of psychiatric hospital beds is decreasing in favour of these types of services, they are still extremely marginal in low and middle-income countries. However, unlike in western countries, where the financial resources allocated to mental health are broadly sufficient but need to be reallocated to community-based care, in low and middle-income countries merely prioritising community mental health is not enough, and alternative resources need to be found.

Alternative resources: «secular» actors

Low and middle-income countries face one challenge that is entirely different to western countries: the lack of resources. Reforms to decentralise services, although necessary, are not enough to provide patients with the right levels of care and support. It is therefore necessary to deploy other strategies. These strategies come under two main categories: integrating mental health care into mainstream services on the one hand, and mobilising non-specialist actors in health, on the other.

Inclusion in mainstream services

There is an increasingly widespread international consens to support the integration of mental health care into general care provision (Petersen 2000; Mooren et al. 2003; Henderson et al. 2005; Qureshi et al. 2006; WHO 2001; Chatterjee et al. 2003; Chisholm and Thornicroft 2007; Lund et al. 2012; Kakuma et al. 2011; Jenkins et al. 2010). This integrated healthcare offers numerous advantages. It increases the accessibility of mental health care and provides holistic care, which takes into account all the patient’s needs, and reduces stigma by not differentiating between people with mental disorders and other patients. This type of model involves
raising the awareness of, and involving health workers in front line services, as well as providing supervision and delivering decentralised training sessions for these workers. The aim is to provide these actors with tools to facilitate the identification of disorders: targeted therapeutic interventions (including short forms of psychotherapy and managing medication), as well as procedures to facilitate referral to specialist services.

Rather than being included in primary health care, mental health care can also be integrated into community-based rehabilitation (CBR) programmes. CBR is a form of care widely implemented in the field of physical disability in low-income countries (Lagerkvist 1992; Evans et al. 2001). It is a more effective way of helping people with disabilities and their families overcome the economic, cultural and geographic barriers to inclusion. This type of care and support is based on accessibility, active participation, and is sensitive to social and cultural specificities. These types of strategies can also be used to meet the complex needs of people with mental health disorders in areas with no psycho-medical resources. They have a proven track record for improving symptoms, treatment compliance, and social function (Chatterjee et al. 2003; Dias et al. 2008; Rathod et al. 2017; O’toole 1988; Lundgren-Lindquist and Nordholm 1996).

Community health workers

After inclusion in mainstream services, the second most common community mental health strategy is to make use of community health workers (Kakuma et al. 2011; Chisholm and Thornicroft 2007; Saraceno et al. 2007). These are members of the community they work in. They are volunteers (sometimes with personal experience of mental health issues) or social workers, but do not have an official qualification in mental health or even in health care. They are usually trained up over a period of several weeks and work for a primary healthcare centre or social services at a location close the population in question. Their role is to identify people who are suffering, to advise and refer them, and to deliver psychoeducation (for patients and their families) and medical and social follow-up. They also provide practical and material support - this type of support is often crucial, including for assisting people with mental health issues. These activities are implemented either via home visits or group sessions. These community workers often achieve outstanding results, such as convincing families to free people with mental disorders from their chains and start to receive psychiatric care (Thara, John, and Chatterjee 2014). These community health workers are also well placed to work on empowerment by mobilising and supporting vulnerable people to organise themselves as a group (Ventevogel 2014; de Menil and Underhill 2010; Wright et al. 2014). They have received specific training, making them very well placed to assist with developing telepsychiatry services and systems to allow local practitioners to conduct clinical consultations with remote diagnosis and prescription support from specialists. These services would appear to be a promising tool for making mental health care available in isolated areas far from medical centres (Parekh 2015; Rebello et al. 2014).

Several studies have provided evidence that using community health workers is not only feasible, but does actually improve the situation of people with mental health disorders. This type of set-up makes it easier to look for assistance from primary healthcare centres (Chatterjee et al. 2011; Ventevogel 2014; Eaton and Agomoh 2008). The work with families is one of the foundations for this type of intervention. Several studies have shown that working with families helps reduce the rate of relapse and improves the quality of life of
people living with a severe disorder (Li and Arthur 2005; Chien, Chan, and Thompson 2006; Ran et al. 2003). Family and friends can help with detecting disorders, referrals, finding assistance and day-to-day support. They must be recognised as a vital resource in the community mental health system. It is therefore particularly important that family education programmes are developed and families are helped to build the skills and knowledge required to support a family member with a mental disorder (Kakuma et al. 2011).

It is interesting to note that the interventions of community health workers are beneficial for patients, even though they do not use medical language or representations of mental health disorders. The terms depression or post-traumatic stress disorder are not used and are not needed to be beneficial for patients. This is important, because more often than not, people with common mental health disorders (depression, anxiety, substance abuse) do not express their difficulties using medical terms, but using their own cultural representations or in relation to their life experience (Patel 2014, 1995; Aggarwal et al. 2014; Ventevogel 2014; Ventevogel et al. 2013).

One tool commonly used by community health workers is the support group. Community health workers can set up and support these groups, with different purposes: peer-discussion and support, information, psychoeducation, income-generating activities and any activity to facilitate people’s inclusion in the community. These groups can be powerful tools for supporting people with mental health disorders and their families to become genuine care partners and decrease dependency on the healthcare services (Petersen et al. 2011). The few examples which have been assessed to date have been shown to have a positive impact on the symptoms of mental health disorders (Richters, Dekker, and Scholte 2008; Scholte et al. 2011; Tripathy et al. 2010).

Generally speaking, supporting people with mental health disorders using social work methods is often a good alternative to medical/psychological care where this is unavailable. It makes it possible to help people improve their daily life skills, with social relationships and with mobilising community resources, to help them cope with stressful events such as conflict, violence and poverty (Kermode et al. 2007; van Mierlo 2012).

We also found mentions in the scientific literature of several integrated community strategies, which make use of some of the components of the aforementioned interventions. None of them is conclusive enough to constitute a gold standard. The collaborative community-based care (CCBC) intervention, for example (Chatterjee et al. 2011), is a complete package incorporating psychoeducation and self-management support, strategies to improve treatment compliance, programmes focused on physical health, rehabilitation and job assistance strategies, links with self-help groups and other peer support initiatives and links with other services managing social issues and access to replacement income. Another example, is the Prime programme (Lund et al. 2012) which also develops service packages which are adapted to different local contexts by including change management processes to help organise mental health care.

2. Community mental health and HI

Some NGOs - including HI - have drawn on the different aspects found in the scientific literature to define a community mental health intervention strategy (HI 2011b, CBM 2008a, CBM 2008b).

These texts (HI 2011b, CBM 2008a, CBM 2008b) describe community mental health as a set of decentralised actions to provide accessible, affordable, acceptable, quality mental health care in the community, for people living with a mental health disorder. The main aim of these community mental health services is to improve the quality of life of people living with a mental health
Part 1: community mental health theory

disorder through the early detection of disorders, access to affordable treatment, improving social inclusion and securing livelihoods.

These texts also incorporate some community mental health values and operating principles:

- Community mental health involves the holistic management of the person, identifying all their resources and needs, including their social, occupational and psychological needs. Consequently, the care management provided is multidisciplinary, combining legal, social, economic (income-generating activities to meet people's basic needs) and psychological aspects (discussion groups, individual therapy, income-generating activities used as mediation).

- Community mental health services working with community resources (teachers, community workers, elected officials, parents) to put into place support and management mechanisms for vulnerable people and/or to refer them to the appropriate places for care.

- The active participation of people with mental health disorders, as well as their family members, is another key value. This involves giving them a voice and respecting their right to make decisions for themselves. It is also about empowering these people and facilitating their social participation.

- Finally, these texts consider community mental health as an approach which is sensitive to culture and traditions.

These principles and values are associated with the different conceptions of community mental health in the scientific literature, although not systematically. Working with community resources, for example, is closely linked to the process for developing care in the community, a process which began in the 1960s in western countries. These movements developed partly from the realisation of the positive impact social relationships and community support can have. A comprehensive vision of care management and active participation is a more recent dynamic in community mental health. It is more than likely that the links HI and other NGOs have with social work methods and community-based rehabilitation are partly responsible for the primacy of these approaches.

In terms of operationalisation, the HI text of reference (HI 2011b) refers to three community mental health service models: specialist mental health services, but provided locally and open to the community; inclusion of community mental health in primary healthcare services; and inclusion of community mental health in community-based rehabilitation (CBR). These three methods correspond to the findings in the scientific literature. The first corresponds to the type of services which should be developed, but which generally consume excessive amounts of human and financial resources. The other two correspond to strategies for inclusion in the mainstream systems, as set out above. Inclusion in community-based rehabilitation services, either by adding a psychosocial component to an existing project, or by developing stand-alone mental health disorder projects using this methodology, appears to be an interesting option for HI, which already has experience in this area.

The HI text of reference (HI 2011b) highlights the benefits of community mental health services in terms of accessibility and reducing stigma, which corresponds to the findings in the literature. In this sense, they differentiate between formal services, intended for people with severe mental illness, involving specialists (for example, community mental health centres, outreach visits to villages, monitoring the inclusive employment of users etc.) and informal services provided by unqualified people (for example, day-to-day care provided by neighbours).
It is important to mention here that the community health workers, extensively described in the literature, fall between these two categories, sometimes veering towards a more formal approach (working with frontline health services) and sometimes towards the informal (volunteers with their own experience of mental health disorders). Furthermore, although these types of workers are very often used when integrating projects into primary healthcare services or CBR services, they are also likely to be used in other contexts. Backed up with tools such as support groups or personalised social support, community health workers could constitute a 4th intervention model, along with specialist services and inclusion in mainstream services (primary healthcare and CBR).
Positive mental health
Refering back to article 2-8 of the Lyon declaration (The 39 collective, 2011), HI defines good mental health as follows: “The capacity to live with oneself and others, with enjoyment, happiness, and a meaningful life, in a given, but not unmoveable, environment which can be transformed by the activity of people and groups of people, without destruction but not without upheaval, i.e. the capacity to say “no” to what runs counter to people's needs and respect for individual and collective life, which allows the "yes", which implies a capacity to suffer whilst remaining alive, connected with themselves and with others”1 (HI 2013). The notion of positive mental health, also used in HI documents, refers more or less to the same idea. “It refers to a state of well-being, a feeling of happiness and/or self-fulfillment, aspects of people's personalities (resilience, optimism, capacity to cope with difficulties, impression of control over one's life, self-esteem). It is a positive state, in balance and harmony between the individual's structures and those in the environment to which people have to adapt.”2 (HI 2011). When discussing mental health or positive mental health, the key thing to remember is that we are not only talking about the symptoms of mental health disorders we can manage or treat. We are also attentive to the person's ability to enjoy life and meet the challenges facing them (Gilmour 2014). From this point of view, mental health is a question of positive feelings about life and social functioning (Keyes 2002).

Mental health disorders
Mental health disorders and psychological distress refer to a range of highly diverse conditions and syndromes, with very different causes, which cause problems in people's lives, psychological suffering,
cognitive disorders, behavioural and adaptation difficulties. There are numerous theories on the causes and progression of mental health disorders, as well as multiple nosographies (the systematic description and classification of diseases). The most frequently used of these are the WHO (ICD-10) and the American Association of Psychiatry (DSM-V) classifications. The most common disorders are mood disorders (depression, bipolar), psychosis, substance abuse disorders, and anxiety or stress-related disorders. They present in very different ways, both in terms of symptoms and the duration of the illness. Some people experience very brief episodes, whereas others find themselves suffering from long-term impairments due to their disorders. The latter are usually described as a set of symptoms which often develop conjointly. They are associated with psychological, medical and social interventions, which are usually able to help people. However, it is very rare to know exactly why a person has developed a given disorder and why they get better.

Psychological distress

In development and humanitarian contexts, we typically make a distinction between psychological distress and mental health disorders. Psychological distress is a concept which is not very precisely defined (Ridner 2004; Drapeau, Marchand, and Beaulieu-Prévost 2012). It is usually defined as a state of emotional suffering characterised by symptoms of depression (loss of interest, sadness, despair) and anxiety (agitation, tension). HI defines it as «a state of disquiet which is not necessarily symptomatic of a pathology or mental disorder. It signals the presence of, non-severe or temporary, symptoms of anxiety and depression which do not meet the criteria for diagnosing mental disorders and which may be a reaction to stressful situations (migration, exile, natural disaster which can induce symptoms of psychological trauma) or to existential difficulties.» (HI 2011).

Psychological distress is not actually part of the nosography of mental health disorders. However, this is a point of debate. For some it should form a distinct category in the nosography, close to «acute reaction to stress» (ICD-10) or «acute stress» (WHO 2015). Psychological distress develops following exposure to severe stress factors which threaten a person’s physical and mental health. The person is no longer able to adapt and develops emotional disorders. These disorders are usually temporary and related to a specific event (Horwitz 2007; Ridner 2004). Others consider psychological distress as one of a number of criteria for diagnosing other disorders (OCD or PTSD) or as an indicator of the severity of the symptoms of depression or anxiety (Drapeau, Marchand, and Beaulieu-Prévost 2012). Furthermore, some use the notion of psychological distress as an indicator of the mental health of a population in epidemiological studies or an outcome from intervention evaluation studies. In this case, psychological distress is used more as a general measure of psychological suffering, with no precise distinction between the various disorders likely to cause this suffering. Others even use the notion of psychological distress instead of mental health disorders. They consider that the term «mental health disorder» expresses a medical understanding of a phenomenon, and thus prefer to use «psychological distress» which they believe refers to a psycho-social paradigm. These authors are usually focused on the social construction of disorders and how people live with them and interact with others (Coppock and Dunn 2009).

HI prefers to use the first interpretation of psychological distress, i.e. a relatively indistinct set of symptoms of depression and anxiety which develop in contexts of acute stress. Regardless of the definition used, care must be taken to not create a false dichotomy between psychological distress and mental health disorders. There is often a very fine line between undefined disorders which develop in reaction to a situation and diagnosed mental health disorders. There is not necessarily a substantial difference between the two but they form different stages along a continuum of severity. Losing sight of this can impede both management
and treatment. For example, some authors concluded that psychological distress should first be managed with empathy, social support and understanding, as opposed to mental health disorders which require a medical intervention. In the ensuing debate, other authors raised the point that all mental health disorders need to be managed with empathy, social support and understanding (not just psychological distress) and that all mental health disorders are in part due to reactions to stressful social situations (Goldberg 2000).

**Two continuums**

Suffering from a mental health disorder does not necessarily mean having poor mental health, and poor mental health does not necessarily mean having a mental health disorder. The key is to distinguish between mental health and mental health disorders and to specify that these two dimensions are correlated, but not synonymous. This is the interpretation proposed in the two-continuum model (Keyes 2002; Keyes and Simoes 2012; Keyes 2007; Keyes, Dhingra, and Simoes 2010) which HI uses in a number of its documents (HI 2011b, 2013). From this perspective, mental health and mental health disorders constitute two distinct, but correlated, axes, one representing mental health (presence or absence) and the other mental health disorders (presence or absence). The two continuums are distinct because a person can be in good mental health even with a mental health disorder. However, studies have shown a correlation between the two. Good mental health protects against mortality, regardless of cause. Suicidal behaviours and an improvement in mental health were also associated with a lower risk of a mental health disease (Keyes and Simoes 2012; Grant et al. 2012; Keyes, Dhingra, and Simoes 2010; Keyes 2007).

**THE TWO CONTINUUMS OF MENTAL HEALTH**

For example: a person with schizophrenia who, over the course of a personal recovery process has established new life goals and socially-valued roles

**Good mental health**

Severe mental

For example: a person with post-traumatic stress disorder who struggles to manage their illness and cannot commit in the long-term to a job or other social activity.

**Poor mental health**

No mental illness

For example: a person who has not received a psychiatric diagnosis but is struggling to find meaning in their life and accomplish everyday tasks.

For example: a person who is able to bounce back when faced with difficulties in their life and if they do experience symptoms these are not so overwhelming that they constitute a psychiatric pathology.
The disability creation process

The disability creation process (DCP), cited in several HI documents (HI 2011b), attempts to find the middle ground between:

• social models which consider disability as a disadvantage resulting from social exclusion, and which solely focus on structural environmental barriers to social participation, and
• bio-medical models, focused on supporting people and developing skills to cope with the disadvantages associated with their impairment.

The DCP aims to document and explain the causes and consequences of illness, trauma and other damage to a person’s integrity or development. The model applies to everyone regardless of the cause, nature or severity of their impairment. It considers that the quality of each person’s social participation is the result of interaction between characteristics relating to organic, functional and identity aspects, and the characteristics of their life context.

In order to assess the quality of social participation, the DCP model focuses on describing «life habits» which are defined as daily activities or social roles valued by the person themselves and their socio-cultural context, depending on their characteristics (age, gender, socio-cultural identity, etc.). These include everyday activities (going to bed or getting up, eating etc.) and other activities which take place at varying frequencies (shopping, budget planning, raising children etc.) (Fougeyrollas et al. 1998; Noreau and Fougeyrollas 1999). The DCP considers full social participation to be reached when all life habits can be done. In this way, measuring the accomplishment of life habits is a way of producing a quality indicator for social participation: it is assessed on a continuum or scale ranging from optimal social participation to a fully disabling situation.

The DCP shows that accomplishing life habits can be influenced by capacity-building or compensating for disabilities through rehabilitation and technical aids, as well as by removing barriers in the environment. These barriers include prejudice, a lack of...
Part 2: community mental health practices

Community-Based Rehabilitation

Another key component of Hi’s projects to further people’s social participation is community-based rehabilitation (CBR). This is a community development strategy targeting rehabilitation, equal opportunities and social participation for all people with disabilities. Implementing CBR requires a conjoint effort from the people with disabilities themselves, their families, and their communities, as well as the social, health, education and training services (ILO, Unesco, and WHO 1994; WHO 2011).

Risk factors

Cause

Personal factors

Environmental factors

Interaction

Life habits

Aid or resources, poor accessibility at home or school, difficulties procuring adapted printed information or a lack of accessible signage hindering people's movements. The DCP proposes practical tools to assess and support people’s social participation, but also reminds us that we cannot infer the possibilities for social participation from a diagnosis or functional profile. Nor can we disregard the context, activities and social roles which are important to the person themselves (Hi 2011).

The term disability is not commonly used in the mental health field where it is generally associated with an intellectual disability (i.e. what used to be known as mental retardation). However, the social exclusion experienced by these people with mental impairments certainly contributes to the social and cultural construction of disability, which is no longer defined as a characteristic of a person with a disease, but as the interaction between the person (impairments, disabilities, identity) and their environment (barriers) leading to social exclusion (disabling situations) in certain areas of their lives (Hi, 2011).
The objectives of CBR are to:

- Ensure people with disabilities and vulnerable people can maximise their physical and mental capabilities, access the services and opportunities available to the general population, and actively contribute to the life of their community and society as a whole.
- Mobilise communities to promote and protect the human rights of people with disabilities through consistent reforms, for example to remove barriers to social participation.

As a component of social policy, CBR promotes the rights of people with disabilities to live within their community, enjoy good health and well-being, and fully participate in educational, social, cultural, religious, economic and political activities.

In practice, CBR involves working with all relevant actors to ensure the full participation of people with disabilities in the social lives of their families and communities. CBR programmes can provide aid and assistance to people with disabilities to allow them to access social opportunities and fight against stigma and discrimination, in order to effect positive social change. Social work can take different forms within a CBR approach.

Firstly, in a context where there are resources available, but these are not accessible, it is possible to put into place services people can come to and obtain the information their require. When populations are isolated and experience difficulties identifying their needs, a personalised social support system can be introduced. Finally, in cases where there are no services, or these are very underdeveloped, the social facilitator may sometimes be trained in basic rehabilitation, employment inclusion, education and other skills in order to provide a minimum response to facilitate the implementation of personalised projects (WHO 2011; HI 2009). In this type of community practice, the role of the social facilitator is to create links and mediate between the populations and the different actors which make up the person’s network of relationships (family, friends, employers, representatives of institutions, non-profit partners, other professionals, etc.), and the services made available (WHO 2011; HI 2009).

Its ability to mobilise the concepts of disability and social participation, as well as tools such as community-based rehabilitation, is what sets HI apart in its implementation of mental health projects. The aim is to support vulnerable people to give them a place in society, provide them with the tools they need to play this role, and transform society to give them this place. It should also be highlighted that CBR guidelines apply to all people with disabilities, including people with mental health issues (Khasnabis et al. 2010; Chatterjee et al. 2003). Many of the problems affecting people with mental health issues are similar to those which affect other groups of people with disabilities. It should be noted that supporting giving this place to people with mental health disorders does not mean neglecting the medical aspects. Access to appropriate care, including medication, remains a necessity, but the objective is much broader: social participation.

User involvement

Involving users in their care and support is a third vital feature of HI’s projects. This is the logical follow-on from the points made above. The first step towards giving people with mental health disorders a place in the community, is to ensure they are involved in their care. The active participation of the people supported is required at all stages: from diagnosis via the drafting and setting up of a personalised project, through to exiting the system. Their participation is also beneficial in terms of the organisation of care more generally (HI 2009).

It is important to distinguish between beneficiary involvement and social participation, as discussed in the previous point, which aims at the inclusion of people in their community, developing activities which are meaningful for them, and which allow them to connect with others. The disability creation process and community-based rehabilitation focus on developing the person’s capacity for action and their social participation. However, they also involve supporting beneficiaries to allow them to
Part 2: community mental health practices

make their own choices and develop their own projects, and this is what we will now turn our attention to.

This brings us close to the concept of empowerment which aims at making people autonomous actors in their own lives. It is a process for taking back control of their own situations. In practice, interventions in this area should allow people to analyse the constraints inherent to their own situation and to free themselves of these (Center for Global Health, Trinity College Dublin, Ireland, Ahfad University for Women, Sudan, and HI, France 2014; HI 2013).

This also comes close to the concepts of resilience and recovery developed below. These two concepts help us to understand that each person goes through a rebuilding process which is individual. Each person can call on a range of resources throughout this process, but ultimately it is the person themselves who will do the work needed to get better, and no-one else. This justifies giving people a say in their own care pathway.

Involving people in their own care pathway requires the professionals and caregivers involved to position themselves in a very specific way. They need to be capable of addressing the most vulnerable, and of developing appropriate methods throughout the process to reinforce the impact these people have on the organisation of their own care (HI 2009). They also need to abandon the idea that they know better than the person themselves what is best for them. They need to support people in their choices, using their strengths as leverage. Obtaining user acceptance of the intervention is not easy for professionals: it requires acknowledging the value of knowledge, experience and shared decision-making. It can lead to a certain amount of confusion around roles and uncertainty in how organisations operate (HI 2017).

This support position is mentioned throughout HI’s documents. It is said to require listening skills, empathy and an ability to value people. The practitioners who adopt this approach develop a specific capacity to explore people’s wants, objectives, resources and strengths. It is about having a positive attitude focused on «what we can do» rather then «what we can’t/can no longer do». (HI 2009). However, it is important to note that this specific attitude is mostly detailed in the documents describing social work such as community-based rehabilitation or personalised social support. It is not yet at the forefront of mental health projects.

Whilst it is important to support people’s involvement in their care as an individual, this also needs to happen collectively. Involving beneficiaries in the definition of the project objectives, for example, can be a way of ensuring success. It helps to improve the relevance, impact, flexibility, adaptation to the local environment, and sustainability of projects. Participation gives the population the opportunity to keep or take back control of the decisions that concern them, and to feel like a stakeholder in the interventions.

Supporting vulnerable populations to take part in the planning, development, implementation and evaluation of health policies is also beneficial. HI thereby supports the development of networks of people with disabilities, their families, communities and mental health professionals, in order to develop joint advocacy for the inclusion of these people in developing the public policies which affect them (health, social, education, justice).

2. The Projects

Out of the 12 countries which participated in the community mental health seminar in Rwanda from December 7 - 9, 2017,
peacebuilding missions (Syria, Gaza, Uganda, South Sudan, Somaliland, Bangladesh, etc.).
• Migration & MHPSS (Turkey, Bangladesh, Middle-East, Ethiopia, Mali, etc.).

Stand-alone mental health projects are specifically focused on mental health issues. In many projects, these mental health issues are naturally associated with traumatic events or particularly stressful contexts, but the primary objective is to manage people’s psychological suffering. Events such as the genocide of the Tutsis in Rwanda, along with a deep-rooted feeling of insecurity resulting from repeat cycles of violence, have fragilised entire populations. In refugee camps, many people find it difficult to adapt to the upheaval they experience and the harsh living conditions. Prison also generates or exacerbates a range of mental health issues. However, to the best of our knowledge there are no specific mental health projects focusing on severe mental illness such as psychosis or mood disorders.

Most of HI’s projects belong to the first category (integrated into other sectors). They first and foremost address physical and social problems and subsequently the psychological consequences of these as a complement. Of course, this does not mean we can anticipate the type of mental health disorders or their severity. The psychological symptoms these different projects encounter are potentially the same: distress, depression, anxiety, fear, apathy etc. Furthermore the resulting stigma and discrimination are a cross-cutting issue which adds an additional layer of difficulty regardless of the original problem.

It is important to distinguish between these different methods in order to identify the specificities of the community mental health projects developed by HI. Are they a complementary component of other projects or are they stand-alone projects?

Regardless of the project method (integrated or stand-alone) they have certain shared characteristics which are set out below.
3. Cross-cutting characteristics

The following characteristics are probably not systematically found in all projects, but do appear to form part of the identity of HI projects.

Community consultation

Community consultation, notably via a socio-anthropological study, allows HI to identify the actors in place, the influences, the power balance between actors etc. This is the basis of all HI projects. Community consultation requires an analysis of the mental health issues experienced in communities and an understanding of individuals’ cultural context and constraints.

In many situations, it is vital that we work with religious and community leaders, notably by setting up project consultation committees responsible for promoting the project within the community, issuing advice, and resolving conflicts. These committees, composed of influential members of the community, are tasked with helping to define the most locally relevant intervention strategy and to inform the community about the project and its activities.

Work with non-specialists

We feel it is important to support the work of non-specialists, who may be required to intervene in any type of situation, for any type of problem, including for diagnosed psychiatric pathologies. Non-specialists may also be community health workers who we have already talked about extensively in the previous section. However, they can also be social workers who play an important role in many projects. They are responsible for secondary prevention, i.e. early screening, advice, basic psychological support, case management coordination, and for working in networks with other actors, municipalities and local authorities. They support people, through dialogue, to assess what needs to be done, what is feasible or not, the objectives that need to be supported. They carry out home visits, provide family/psychological support as part of acceptance, and put into place technical actions (medical equipment). They often play a central role, which ensures their interventions are coherent and coordinated, and avoids implementing contradictory actions, etc.

RWANDA

In the wake of the genocide of the Tutsis in Rwanda, HI identified large numbers of people affected by, or likely to be affected by, mental health issues. Certain target populations are particularly vulnerable: child heads of household, female victims of violence, children and teenagers with or affected by HIV/AIDS, child mothers, prostitutes, young people in poverty, widows (due to the genocide or HIV/AIDS).

The project developed in this situation was based on community participation, aiming to restore social connections, communication and get solidarity mechanisms within the community working again to support and manage vulnerable people and improve their mental health. The key component of this project was to identify and train focal persons within communities who can activate this community leverage (HI 2009a, 2012c, 2012d). These people mediate between the beneficiaries and other bodies, making referrals as appropriate given the problems experienced by the beneficiaries. Each focal person is responsible for several «groupings» and takes on the role of an elder or «parent» for orphans. This «parental» role restructures individuals and sets boundaries for them.
Support groups

HI has paid particular attention to support groups over the last few years and they have become a central part of our mental health intervention. HI has produced numerous documents on the relevance, organisation, and facilitation of these types of groups:

- A guide for facilitators of prison support groups (HI 2012b). A practical guide to facilitating discussion / emotional and sex life groups (HI 2007).
- A training module on facilitating free expression discussion groups (Madagascar programme).
- The discussion group for mothers of dependent children with physical disabilities in Algeria, capitalisation document (HI 2009b).
- Research into the emergence and structuring of support groups for people in prison with mental health issues in Togo, Madagascar, Lebanon and South Sudan (HI 2016, 2017).

4. Types of intervention

There are a wide variety of mental health and psychosocial support (MHPSS) interventions. At HI these can take the form of:

- Community prevention and awareness-raising
- Support and development of the health care system
- Support and development of social support
- Collective support mechanisms
- Advocacy

Community prevention and awareness-raising

HI develops projects to mobilise and raise the awareness of communities. These projects aim to change people’s representations of mental health, or to promote behaviours which favour good mental health. These actions may target the most vulnerable populations, as well as marginalised people.

One intervention method would appear to be particularly appropriate in this type of situation: the Information, Education, Communication programme (IEC). IEC is an intervention which aims to provoke or consolidate changes in behaviour in target individuals, in order to promote their well-being. This is a learning process though which individuals and communities voluntarily adopt and maintain behaviours which are beneficial to their health.

Support and development of the health care system

Some of HI’s projects related to mental health aim to set up and develop community mental health care services. This may involve directly organising services, in collaboration with local partners, or developing local service capacity and operators.

Mental health care and referrals

HI puts into place mechanisms for referring vulnerable people to different services (health, education, basic needs, specialist mental health services etc.). This requires liaison and coordination mechanisms with specialist partners to facilitate access to care.

In some projects, referrals are managed by creating referral groups which bring together professionals from different organisations and horizons. They use a screening tool and review the situations of patients with mental health and physical disorders. The aim, in conjunction with a HI psychologist, is to assess the need to refer them to a specialist, and to support the professional in the process of assisting the person and their family.

HI also supports multi-disciplinary mental health teams which provide individual psychotherapy consultations, guidance, home visits etc.
Capacity-building for services

HI works to reinforce specialized mental health services, notably to support their structuring and improving the functioning of their collective organisation: democratic practices, management, administrative and financial management, etc. In some projects, HI helps to develop and implement an institutional plan i.e. a set of coherent actions defined through shared objectives and focused on people’s needs. The intention is to build a vision, a strategy and set short, medium, and long-term objectives. This then makes it possible to determine how the teams will work, the internal organisation, the role and place of each person, the decision-making and regulatory bodies, relationships with the exterior, and all aspects of the proper functioning of services. From a practical point of view, one of the objectives of a HI project should be to ensure that adjustments are made to the premises to ensure they meet the sanitary needs for the service (HI 2011).

HI also organises seminars and workshops to support the setting up of national collectives/forums of mental health professionals/institutions. HI supports the development of local associations and services working in networks, allowing them to share their experience and communicate on the impact of the approaches instigated, in order to ensure the continuity of care for people in psychological distress and/or with a mental health disorder.

Capacity-building of psychosocial support workers

HI has developed numerous tools and practices to provide technical support to health professionals concerning enabling relationships, quality of care, psychosispathology, etc. These can be used by all sorts of community workers: primary school teachers, elected officials, technical workers, the health, social and education authorities, legal advisors and lawyers, health and social centre staff, teachers, vocational training trainers, managers of organisations. HI is able to mobilise the following tools:

- Training and awareness-raising of non-specialist mental health care personnel (HI 2011).
- Training and support for institutional managers: in order to implement sustainable projects managers also need to be trained to be able to support workers in the field. If this does not happen, the latter will find themselves in difficulty, recommending interventions they cannot put into practice.
- Clinical supervision: the aim of supervision is to provide support for each team member individually to work on their relationship to the situations of vulnerable people in order to consolidate their professional autonomy.
- Analysis of professional practice: the aim of this analysis is to allow professionals to reflect on their practices with their peers and to find practical resources relating to the difficulties they may encounter. This activity also aims to prevent burn-out (HI 2012a). In the same vein, there are discussion groups, such as Balint, for professionals. Faced with illness, suffering and death, health professionals need space to share and maintain a so-called professional distance from the people helped (HI 2009c). These groups should ensure workers to not find themselves isolated, build their confidence in their own practice, and give them the opportunity to share their knowledge and experience, etc.

LEBANON

This project was deployed in the Palestinian refugee camps in Lebanon. Originally, a study backed by HI into the situation of children in this type of camp revealed the precarity of their living conditions which lead to many children...
developing mental health problems (Maamari and Pégon 2012; HI 2010). These children face significant difficulties: their parents’ unemployment, violence within the family, neglect, poverty, an uncertain future, political instability and insecurity, chronic conflicts and precarious living conditions. They can develop a number of symptoms: enuresia, anxiety, mood disorders, behavioural problems, difficulties constructing satisfactory relationships with their entourage, isolation and cognitive difficulties.

As part of this project, HI supports two types of centres:

- Resource and referral centres, located in the camps and run by two social workers. These centres facilitate access to specialist services and non-specialist services and build links between actors in the education and health sectors. These centres provide guidance and information for families, set up training for community workers and run awareness-raising campaigns.

- Mental health services centres or health care centres in the community. These services are staffed by multidisciplinary teams including specialised therapists and community workers. Care is provided at the centre, at home, or at school. The team also supports parents and helps them to get involved in their child’s care plan, through interviews, advice, training, and group awareness-raising.

The health care centres and referral and resource centres are complementary. They work in coordination, notably on referral and awareness-raising activities. The project calls on both professionals and non-specialist community workers. Various mechanisms within the project allow them to share their different types of expertise. For example, scaffolding meetings are held each week to build on good practice.

The main objective for HI’s technical team is to coordinate and share approaches, and to pass on its expertise and know-how on disability and mental health.

### Psychological first aid

The aim of this type of intervention is to provide immediate relief to people exposed to potentially traumatic event(s). It involves providing practical care and support, which does not intrude; assessing needs and concerns; helping people to address basic needs (for example, food and water, information); listening to people, but not pressuring them to talk; comforting people and helping them to feel calm; helping people connect to information, services and social supports; protecting people from further harm (WHO 2012). This is a very specific type of intervention. It is used in projects deployed in emergency settings.

### Support and development of social support

HI also develops support projects and projects in collaboration with social and community services or focused on social inclusion. These projects mainly call on social workers or community workers (volunteers or employees). Their role involves acting as the intermediary between the beneficiaries and the specialist services by means of appropriate referrals. They also play a part in mobilising the community, so that beneficiaries and communities as a whole increase their capacity for self-management. These workers are trained and benefit from intervisions (practice sharing between peers), liaison mechanisms with other services and a large panel of tools that can be used according to the needs:

- Individual and family interviews: the aim is to provide individual support and assess the state of the most vulnerable in order to provide psychological support. These interviews identify the most vulnerable people requiring support and can help with any referrals required.

- Family mediation: the aim here is to construct or reconstruct a family relationship damaged by a rupture or separation. This work is often combined with group work.
• Information, Education, Communication programmes (IEC) which can be specifically used in this framework as a tool for the psychoeducation of people with mental health disorders.

• Drafting of a support plan: the aim is to determine how the needs can be met as part of any of the activities deployed. In other contexts, this plan is called the «personalised life plan». This project is established with the person themselves to meet their general and specific needs, as part of an approach to promote their long-term inclusion. It incorporates personal (diseases, impairments, aptitudes), and environmental factors, as well as life habits.

• Income-Generating Activities (IGA): these are livelihood activities which require little financial, human or material resources. The aim is not only to increase people's resources, but also to improve their well-being and quality of life by enabling them to activate themselves the economic and community resources needed to meet their basic needs (HI 2016).

• Job assistance: this involves support the person to identify personal goals and undertake training or help them in their relations with potential employers.

Personalised social support (PSS) is a framework which incorporates all of these different tools and which clarifies the role of social workers. It aligns actors with a series of fundamental values. The aim of PSS is to improve vulnerable people’s social participation and living conditions through outreach programmes providing social support adapted to each individual's needs and resources. It builds their self-confidence and their faith in their abilities. On a practical level, this support helps to:

• Mobilise individuals, families, organisations and communities
• Reduce inequalities and injustice through the inclusion of marginalised, vulnerable, excluded and at-risk groups
• Effect social change (application of laws, influencing social policy).

The specificity of PSS is that it is not solely focused on the person, but also includes matching with the services available, finding solutions and adapting these to each user’s situation, and preparing them to receive the support provided (HI 2009d).

Personalised social support (PSS) is not yet used in its own right in HI’s community mental health projects. However, it does group together numerous tools already used in these projects and which correspond to values upheld by HI, including social participation and beneficiary involvement.

Collective support mechanisms (support groups)

Social support mechanisms also use collective i.e. group support tools. These are very frequently used in HI’s projects and are considered to be an extremely important part of the whole range of tools HI can use in its mental health projects.

Several studies have been carried out within HI in recent years to investigate these groups and their use in the organisation's projects (HI 2016, 2012a, 2012b, 2017). Here we will mainly focus on two types of groups: discussion groups and community self-help groups. Both types of group target beneficiaries and their family and friends. We will not detail here group practices targeting health professionals (see above).

Discussion groups

L’objectif de ces groupes est d’améliorer la santé mentale des personnes vulnérables par leur participation à un groupe de pairs favorisant la dynamique de groupe, les interactions et les liens entre les participants. Le groupe de parole favorise la verbalisation du mal-être, encourager les échanges et la création de liens sociaux. Ces groupes peuvent avoir une vocation The aim of these
Prison overcrowding, in rundown buildings with no or very substandard sanitation and hygiene facilities, has very severe consequences on the health of inmates. The duration of detention often causes family breakdown and exacerbates the isolation and psychological discomfort resulting from the incarceration. Access to care is difficult, the quality of care is limited and the prison authorities struggle to tackle these issues. HI has identified numerous problems: relating to the hygiene conditions and nutrition, to the social recognition of detainees, to the lack of professional inclusion processes, to the access and the upholding of rights, as well as to political and institutional problems.

In order to tackle these issues, HI has developed a project consisting of three interdependent and complementary components (health and nutrition, legal and psychosocial):

• The psychosocial component includes educational and socio-cultural activities; discussion groups during the person’s incarceration and prior to their release; support activities to maintain links between prisoners and their families; individual psychosocial interviews; professional inclusion activities; and activities to support their return home.

• The legal component includes upholding the rights of prisoners and former prisoners and helping draft requests for early release.

• The health and nutrition component includes care and monitoring of prisoners suffering from malnutrition, access to care, management of the nursing staff, promotion of hygiene practices.

Self-help groups

The aim of these groups is to improve the mental health of members of the Community Self-help Groups (CSG) by helping them make the most of their economic, social and community resources themselves (collectively), thus enabling them to meet their own needs/wants.

Advocacy

In this way, HI supports the deinstitutionalisation of mental health by developing networks of health, social and community professionals and supporting coordination between them. HI in this way attempts to influence the relevant authorities on this subject and may even take part in drafting or revising national mental health policies or providing its technical or financial support to implement or reinforce a national mental health plan.
5. Nourishing our practice: new theoretical input?

Two guest experts were invited to share their expertise with us at the seminar: Prof. Rachel Thibeault (University of Ottawa) on resilience and Mr. François Wyngaerden (Université Catholique de Louvain) on recovery.

Resilience

What is resilience?

Long defined as an innate capacity to cope with the trials of life, resilience is now understood as a dynamic learning process which not only helps people cope with crises, but allows them to bounce back from the psychological disruption inevitably experienced as a result. It is now considered utopic to imagine that a person can go through a crisis with no psychological impact and this new definition takes this into account by presenting resilience as a skill that can be learned and maintained and allows people to regulate their response in the face of adversity. Feeling distressed or sad is not a sign of a lack of resilience, but the sign of the first stage of the resilience construction process, which will allow the person to return to their initial state of psychological well-being, prior to the situation of adversity.

In a crisis situation there are three standard reactions:

1. The first reaction is «inadequate resolution» which corresponds to an individual’s inability to mobilise the internal and external resources required to return to their initial state of well-being. The person remains in a depressive or anxious state which becomes chronic and underpins their entire existence.

2. The second reaction is «resilience» which corresponds to the healthy mobilisation of the individual’s internal and external resources which translates into the restoration of the state of well-being preceding the trauma or crisis.

3. The third reaction is known as «post-traumatic growth» and corresponds to the mobilisation of internal and external resources which ultimates leads to the individual attaining a state of improved well-being in comparison to their initial situation prior to the trauma. The trial leads the person to develop a latent potential by forcing them to meet challenges which require resilience and are meaningful to them.

Individuals who show post-traumatic growth are the focus of research into resilience because they are the best placed to identify the keys to this move towards improved well-being. Their strategies most often combine cognitive components, emotional anchors, and tangible gestures which allow them to cope with their testing circumstances in the most versatile, efficient, and sustainable way possible.

Drawing on neurosciences, conventional psychology and recent research into intentional activities, therapists specialised in resilience have based their approach on four main aspects: outlook, intentional activities, resilience-building attitudes, and emotional regulation.

Outlook

Martin Seligman, the award-winning researcher at the US National Institute of Mental Health has produced the most influential work on resilience. He has clearly demonstrated that resilience, and even happiness, depend on a fundamental choice every young adult has to make one day or
another, regarding their ideal life. There are four possible scenarios.

A pleasant life in which the ideal is a quest for comfort. The person wants to avoid any effort or pain, this is a utopic choice which rapidly undermines resilience. Resilience is forged by meeting and overcoming regular, calibrated psychological challenges, the inertia of this scenario results in atrophied resilience.

A good life in which the ideal is to develop one’s talents but in a narcissistic manner. It is possible to choose to do a certain sport, for example, purely for the selfish pleasure one derives from the activity. This choice does however, present certain challenges and allows the person to develop the rudiments of resilience.

A meaningful life which like the good life focuses on self-fulfilment but in this case for the greater good. The person develops their talents with an altruistic aim, as part of life plans which aim to give back. This choice usually results in much higher levels of resilience than the first two scenarios.

A full life which includes all the components of a meaningful life but also includes a further component: an ability to take pleasure in the little things in life. Whether that might be a sunset, a child’s laughter or good food, a day-to-day attitude of wonder and gratitude contributes significantly to building resilience. People who adopt this ideal combining altruism and gratitude appear to cope better with life’s trials and tribulations.

### Intentional activities

The work of numerous researchers, including Lyubomirsky and Fredrickson, has established that resilience largely depends on regularly engaging in activities which generate dopamine, serotonin, and other neuro-transmitters associated with psychological well-being. These activities, known as eudaimonic intentional activities can be divided into five categories:

1. Centration: These activities take two distinct forms: the first involves tidying up or putting things away (for example: doing the washing up, dusting etc.), and the second vigorous exercise (for example: skiing, jogging etc.). Both types of activity generate dopamine and remove the restlessness which can often act as a barrier to deep centration. By evacuating the disruptive tension, these activities form a kind of necessary preamble to a state of mindfulness.

2. Contemplation: These activities cover all conventional and non-conventional mindfulness strategies. Contemplation can include prayer, meditation, calm observation of nature, silent relaxation in the bath or any other practice which leads to a sustained state of mindfulness.

3. Creation: These activities are based on doing, on the act of creating something. This is not only about creation in an artistic sense, but about producing a work or a new and pleasant experience. Successfully following a recipe, a well-written letter, an attractive picture, a piece of knitting: all these forms contribute to building resilience. Not only does the act of creating build resilience, but the act of genuinely appreciating something someone else has created (music, food, art etc.) also reinforces resilience, although to a lesser extent.

4. Contribution: these activities refer to opportunities for people to give back. Whether this may be through voluntary work, a job well done or mutual support, altruism is one of the pillars of resilience. Research has confirmed the massively positive impact of this strategy, even for highly vulnerable populations.

5. Connectedness: Connectedness refers to activities which develop a sense of belonging and connect us with the living world in all its forms. This might be a family dinner, a football game with friends, a morning spent gardening or playing with a pet. All these situations contribute to developing and improving the significant relationships (with people, animals, plant life) which weave the fabric of our lives and represent key anchors of resilience.
Attitudes conducive to resilience

In the last ten years, neuroscience and psychology research has identified numerous attitudes conducive to resilience. In particular, the work of Richard Davidson and Martin Seligman has brought to light neurological virtues (Davidson’s terminology) or personal strengths (Seligman’s terminology) that should be nurtured over time. According to both researchers, our choice of attitudes (healthy or unhealthy) can significantly change the growth of specific neural networks which stimulate or undermine our resilience. This is not the place to produce a full list of these attitudes, but the most beneficial in terms of positive neuroplasticity are discussed below.

Mindfulness: mindfulness comes top of the list of beneficial attitudes associated with resilience. There is a general consensus that moments of silence and solitude experienced with a psychological posture of open-mindedness and calm observation are vital to good mental health. In traditional societies, these moments formed an integral part of our daily lives. In the era of modern technology our life habits have been shaken up and these moments of centration, attention, and calm have been replaced with almost constant interaction, often at a frenetic pace. These constant external solicitations translate into a marked reduction in attention span, internal confusion, a weakening of social connections, and consequently reduced resilience. People often confuse mindfulness and formal meditation which can be off-putting. Indeed, although meditation is one of the most visible practices in the field of mindfulness, it is not the only one. Mindfulness can also be achieved through a slow walk in the countryside, relaxing in a hot bath with a scented candle, from the flow experienced when the boundaries of oneself dissolve in an intense period of creative or sporting activity, or even by simply doing the washing up without rushing. The most important thing is not to sit in the lotus position, but to learn to devote at least twenty minutes a day to calm observation, preferably continuously, which is the minimum required to maintain a psychological balance.

Compassion, love and tenderness: also known as the compassion cluster, evoke the positive attachment which is vital to people’s emotional well-being. This generates maximal plasticity when expressed frequently and in a variety of forms. In the same day one can show love for a partner, affection for a dog, benevolence towards colleagues. This repeat desire to ensure other people’s well-being gradually shapes new neural networks like a river which carves out its bed over time.

Gratitude: seeing the glass half full rather than half empty has a profound effect on resilience. This does not mean constantly showing unbridled optimism, but rather regular cognitive reframing which accentuates the positive aspects of a situation, thus countering human beings’ natural tendency to focus on threatening or irritating details.

Forgiveness: recent studies in neuroscience have shown that resentment strongly activates the neural networks in the right prefrontal lobe, the target site for negative feelings. This overstimulates the amygdal, the cerebral structure responsible for perceptions of fear and the physical reactions this provokes, which traps the individual between an overwhelming desire to fight or flee. Overcoming resentment requires forgiveness or at the very least resolving the conflict in question in order to achieve the state of internal stability required to show resilience.

Justice: from a very young age, around 6 months old, most human beings already have a well-developed sense of justice
The following aspects should be given particular consideration:

- Training staff members in personal resilience strategies for their own personal benefit (to counter the risk of burnout).
- Using the notions of resilience, in particular the 5Cs, in order to modify working environments and make them more conducive to resilience.
- Train the response teams in the collective application of these concepts to vulnerable and marginalised populations in order to jointly foster resilience and empowerment.
- Using the notions of resilience, in particular the 5Cs, in order to modify working environments and make them more conducive to resilience.
- These principles could also be used as a framework for drawing up health policies with a view to developing psychological resilience.

Recovery

When we hear the word «recovery» we immediately think about «getting better». We think about how flu symptoms disappear and allow us to return to our normal daily lives. In the field of mental health, the notion of recovery is somewhat different. The symptoms have a huge impact on people’s lives. Treating them requires much more than a few days in bed. They can damage people’s relationships with their partners, force them to change their career and cause them to lose friends. Very often this leads them to consider their life, values, objectives and future perspectives from a new angle. In mental health, recovery is a process of transformation. It is a journey towards a genuinely meaningful life. This journey is unique and personal to each individual. It is not about returning to the point of departure, to «normality». This is impossible because the disorder has changed everything. It is about rebuilding a new life. It is even possible that this life will prove to be more interesting than the impairment-free one which preceded it!

The recovery movement began in the second half of the 1980s. At this time, in the United States, service users began
Part 2: community mental health practices

to speak about their experience and talk about the recovery process (Lovejoy 1984, 1982; P. E. Deegan 1988; P. Deegan 1996; Leete 1989, 1987; Unzicker 1989). They talked about hope, acceptance, reconstruction, a positive self-image, engagement in the life of society. For Patricia Deegan, one of the movement’s leading figures in this “Recovery is a process. It is a way of life. It is an attitude and a way of approaching the day’s challenges ... Recovery is marked by an ever-deepening acceptance of our limitations. But now, rather than being an occasion for despair, we find our personal limitations are the ground from which springs our own unique possibilities. This is the paradox of recovery ... that in accepting what we cannot do or be, we begin to discover what we can be and what we can do.”

Recovery is built around two key ideas: hope and choice. Currently, as the recovery concept is being developed, a large corpus of scientific studies have already demonstrated that it is possible to get better, that many people with severe mental illness can live a normal life with minimal support from health professionals and that a non-negligible percentage will actually no longer meet the diagnostic criteria and will, in fine, be considered to be no longer ill. However, too many professionals still continue to present disorders as systematically chronic and with little hope of improvement, even stating that they will inevitably deteriorate. The recovery movement asserts loudly and clearly that it is possible to get better, that there is hope. But getting better in this context does not necessarily mean that the person’s symptoms will disappear. What is does mean is that it is possible to find one’s place alongside others to live a worthwhile and meaningful life, to make choices for yourself, and to involve yourself in a socially valuable role, even if the disorder persists.

The second central tenet of recovery is the assertion that the people concerned have control over their recovery: it is always a person who recovers, not professionals who «recover» someone. It is therefore the person who needs to make choices for themselves. For a long time it was considered that people with mental health disorders were unable to manage their own lives and make decisions about their future. But this is not the case. Nor is it possible to imagine someone other than the person concerned making decisions about their recovery goals. Nobody knows better than the person themselves. This does not mean that the person does not need support and guidance on the way and help with the decision-making process. However, in the end the choice must always be theirs.

Definitions

Out of these first writings by users, more formal definitions of recovery were developed. The best known is that of William Anthony at the Boston University Centre for Psychiatric Rehabilitation: «Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.» (Anthony 1993). Another conceptualisation of recovery is currently in widespread use: the CHIME factors (Leamy et al. 2011). Based on interviews with users, it highlights five aspects of the recovery process.

- **Connectedness**
  Connectedness is the feeling of being connected with other people. We know that solitude and isolation have an impact on both people’s physical and mental
health, which is why connectedness is so important. Relationships with family and friends are one way of feeling connected. This feeling can also come from support from people who have had a similar experience (peer support), as well as from health professionals listening to and valuing people. Some people also place great importance on relationships with their neighbours or members of the local community. Generally speaking, spending time with supportive people and accepting people as they are, with no judgement, can genuinely help.

- **Hope**

Hope is particularly important for recovery and well-being. When a person experiences distress and despair, they need to know that things can get better. Relationships help to keep hope alive and prevent feelings of impotence and despair. These relationships can be with family, friends, peers or professionals. However, some relationships do not build hope and may even tear it down. If people say to you «you will probably never work again» or «you’re ill you can’t do that», this clearly takes away hope. These sorts of remarks are entirely unjustified. There is now much scientific proof that people can get better and improve their quality of life regardless of their diagnosis.

- **Identity**

Developing or rediscovering an identity other than that of a «patient» is an important part of the recovery process. For some, this means returning to previously held roles in society, such as a job. For others the aim is to develop a new identity. Many people say they need to feel that they have an identity other than that of a patient. This is true for everybody, we all have a distinct identity made up of different components influenced by our gender, culture, beliefs, interests, and values. Once again, relationships with people who consider the person as an individual in their own right are a key factor.

- **Meaning**

Having a meaningful life simply means having a reason to get up in the morning, a goal. This is different for each person, but everybody needs to feel this. For some people, this might mean working or volunteering, for others it might be going for a walk, doing the shopping or calling a friend. Meaning and objectives are defined individually. These are not necessarily major, life-changing events. They just need to have meaning for the person concerned. For many people, it is also important that they find meaning in their psychological or traumatic experience. Living with a disorder can be perceived as a spiritual experience, a medical problem, a response to stress, and many other things. It is the person themselves who will find their own response.

- **Empowerment**

There are numerous definitions of empowerment, but they all refer to choices and the control one has over one’s own life. A person can be empowered by being involved in the decision-making process regarding their treatment and care, which also involves supporting them in making choices where the outcomes are not 100% certain (such as coming off medication).

Empowerment is also linked to a feeling of control and the ability to cope with day-to-day responsibilities regarding their health and well-being. This also involves knowing when to ask for help. People who are positive about their recovery process, have almost certainly been through an empowerment process, they have identified their strengths and built on this foundation.

**Recovery-focused services**

The recovery movement also positioned itself in relation to psychosocial rehabilitation, which dominates the organisation of mental health care. The development of rehabilitation services brought with it numerous advantages compared to the organisation of mental health care in asylums. Focused on the inclusion of people in everyday life by focusing on their strengths and developing their skills, these services have supported the idea that people with mental health
disorders can play a valuable role in society. Furthermore, many rehabilitation programmes have a proven track record and are still widely used (psychoeducation, intensive support in the community, job assistance, sheltered housing etc.) (Bond and Campbell 2008). However, the recovery movement considered psychosocial rehabilitation to be too focused on services to the detriment of people. The objectives were too often determined by professionals and not enough by the users themselves. The role of the users themselves in the recovery process has not been sufficiently placed at the forefront. The professionals remain the ones who know best, even though it is always the person who recovers, never professionals who “recover” people.

This leads us to question the role professionals play in supporting the recovery process. If people are responsible for their own recovery, what are health professionals supposed to do? The key is to offer people genuine, explicit choices, to offer them real opportunities in terms of their plans, social engagement - not only in dead-end roles - and finally, to believe in their chances of succeeding in their undertakings. That said, research has been conducted in this area to identify the characteristics of recovery-focused services (Williams et al. 2012; Mancini 2006). Several recurrent aspects have emerged:

• **Integrated services**
  A team focused on recovery should be able to offer a wide range of assistance and care (including basic care) using different methods (individual, group, peers): general medical care, medication, diet, hygiene and clothing, employment/training, daily activities, family support, treatment of addiction, psychotherapy, trauma care, well-being, welfare, other rights.

• **Individual care management**
  A team focused on recovery assesses the person’s needs, preferences, strengths and capacities. It offers very different forms of care management from one person to another. The professionals adapt to the person not the other way around.

• **Community resources**
  Support from the person’s environment should be identified and involved in the planning and provision of services, and promoting their inclusion in the community. This involves referring them to peer-support groups, proactive support into employment, links with activities outside of mental health etc.

• **User participation**
  A team focused on recovery allows users to control the organisation and planning of their assistance and care. A team focused on recovery arranges for opportunities for users to influence how the service operates and how care policy is defined.

In addition to the widely-used psychosocial rehabilitation tools, other support tools have been specifically developed to support the recovery process, often by users themselves:

• **CommonGround** is a web application which helps people to prepare their consultations with their psychiatrist or care team in order to determine together the best treatment and support. It is a psychoeducation tool, which provides users with relevant information on disorders and treatments; a self-management tool which allows users to self-assess their situation from day to day and to act accordingly; and a shared-decision making tool as it supports the user in the event of any negotiation with the physician regarding their treatment.

• **The Wellness Recovery Action Plan (WRAP)** is a personalised well-being and recovery process, based on the principles of empowerment. It can be used to get better, stay better, or change your life as you see fit. It is a set of tools developed in 1997, by users and ex-users, who wanted to overcome their
mental health problems to live their lives, fulfill their dreams and follow their plans. This set of tools is used as part of a peer support group, based on mutual support and sharing experiences. It is facilitated by two trained users, who have used the tool in their own recovery pathway. The WRAP is now an internationally recognised tool which has been assessed and studied (Copeland 2002; Fukui et al. 2011; Cook et al. 2012).

- Refocus® is a training programme for caregivers focusing on the working relationship between caregivers and service users. Staff are trained to identify and understand the values and preferences of users, to support and assess users’ strengths, and to support users in identifying goals (Slade et al. 2011).

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1. Translator’s note, free translation from French source
2. Translator’s note, free translation from French source
3. In basic terms a disability (or handicap) is a disadvantage in terms of weight, distance or points imposed on the person with the greatest chance of winning (as used in golf, horse racing or sailing).
Part 3: challenges, stakes and perspectives

1. Challenges

A number of challenges were raised during the discussions between seminar participants. These were related both to the contexts in which the different projects are deployed and to HI’s positioning on mental health projects.

The context

There are numerous problems, but they generally all revolve around the same issue: the lack of resources. As described in the first part of this document, specialist mental health resources are often concentrated in large cities and specialist psychiatric institutions. Decentralised health centres have very few resources.

At each stage of the person’s care pathway we can identify specific gaps:
- Firstly, in the districts, there is nobody capable of diagnosing a psychiatric disorder or even assessing potential severity with a view to referring the person to a specialist service for confirmation. People generally have to wait a very long time for a diagnosis.
- The districts also do not have any specialist centres or mental health professionals (psychiatrists, psychologists) to whom people likely to suffer from mental health disorders can be referred. The absence of specialist health centres also complicates access to medication and other therapies.
- Finally, for the people referred to a specialist service, usually a psychiatric hospital in the country’s capital, there is a lack of resources for supporting the person’s return to their community after hospitalisation. When the referral process does work in one direction, it also needs to work in the opposite direction. Furthermore, there remain high levels of stigma around mental health disorders, and when they return to their community the person’s social resources have often been eroded, generating social exclusion.

Many participants also raised the lack of proper mental health policies in numerous countries, which results in a lack of investment in mental health services at all levels.

Poor ownership of the framework document on mental health

The seminar highlighted the lack of shared guidelines for HI’s different mental health projects. The concept of community mental health itself was not clear to most participants. Whilst many of them had their own vision of what community mental health is, no shared vision emerged. This meant that there were a number of projects which could have been presented at the seminar but their managers did not see the connection with community mental health. Conversely, some of the projects which were presented only had a tenuous link with community mental health. There was little consistency and coherence across the different projects presented at the seminar.

In order to strengthen HI’s projects in the mental health field and make them more coherent, it would be interesting to set out the principles and guidelines followed by HI in the area of mental health in an updated framework document. The stakes laid out in the following paragraph should be discussed to establish these principles and guidelines.
2. Stakes and perspectives

Disability and mental health disorders

Many projects are not specifically focused on mental health disorders, or even on improving the mental health of vulnerable categories of the population. Most projects are primarily focused on physical (impairment, chronic disease etc) or social (gender-related issues, domestic violence etc.) issues and have a psychosocial dimension. These difficulties can cause mental health disorders or impact people’s mental health. However, it became clear through the seminar that HI does not have any guidelines on the mental health issues experienced by people with disabilities or on how to manage these. What psychological problems do amputees face? What type of care management has been shown to be successful in this type of situation?

HI needs to specifically explore the potential psychological consequences of the impairments and chronic diseases it most commonly encounters. In addition to identifying the most common disorders in the literature and how these are managed, this type of approach could lead to the delivery of training courses for actors in the field.

Do all projects have a psychosocial dimension?

Many of HI’s projects are likely to have a psychosocial dimension. People made vulnerable due to violence, natural disasters, social exclusion or health problems are likely to develop mental health disorders. It is very unlikely that a sub-project on the care-management of mental health disorders could be added to all HI’s projects. However, one realistic and relevant objective would be to raise the awareness of the people involved in a project of how to behave towards these people so they do not feel rejected and stigmatised and that they benefit from the same services as everyone else. When faced with mental health disorders, even severe ones, it is important not to simply automatically refer these people to specialist services and consider they cannot be helped via a social support mechanism in the community. It is important to consider, following on from the continuum of theories set out above, that even if people with severe mental illness require specialist care, they may also require social support in the community, peer-support, or job assistance.

It would be wise to put into place awareness-raising and training tools which are accessible to HI workers and our partners. This training should include an understanding of mental health symptoms but not of mental illness. The key here is not the ability to diagnose a disorder. A diagnosis is useful when determining a medical intervention. Here, the objective is to support workers to ensure they adopt the right attitudes towards people with mental health disorders, so they can better understand what these people are going through, and know how to behave when the person shows signs of a disorder, how to create a secure context, etc. It would be interesting to work on the right attitudes to adopt when faced with people living with anxiety, delusions or hallucinations, depression or apathy, post-traumatic stress or a highly-stigmatised trauma. In addition it would be useful to work on people's ability to identify the warning signs which require referral to a specialist.

Beneficiary involvement in their care pathway

Beneficiary involvement is one of HI’s key concerns. Over the course of the seminar, all participants mentioned this as a key feature of HI’s positioning. However, the distinction between beneficiary involvement and social participation is not always clear. Social participation is found in a variety of forms in HI’s projects: designing and implementing projects in collaboration with local managers, supporting people with disabilities to help them find a place in their community, or supporting the organisation of groups of people to claim and contest.
However, beneficiary involvement also refers to something else: it is about supporting people to make their own choices and construct their own objectives, their own vision of the situation.

In order to do this, project workers need to ensure that the people supported can actively participate in decision making throughout all stages of the support process. The project workers need to adopt an attitude of «know-not», a humble attitude, focused on listening to the person and their vision of the situation. This means the first objective is not to explain to beneficiaries the situation they are in and the attitudes they should adopt - even when there are things they objectively need to know about their disorder - but to support them to make meaningful decisions for themselves. Given the interactions observed at the seminar, this is not obvious for everybody. Adopting these attitudes is naturally considered to be important, but is not easy to put into practice.

It might be appropriate to include components in the training courses offered to HI workers to help them develop a «patient-focused attitude». Carl Rogers spoke about three fundamental attitudes. The first attitude is «congruence» and concerns the caregiver’s ability to correctly connect with the complex feelings, thoughts and attitudes they experience whilst keeping track of the thoughts and feelings of the person they are supporting. The second attitude is the «unconditional positive regard», i.e. total and unconditional acceptance of the person being supported. The third attitude is «empathic understanding», trying to understand the world of the person supported without being overwhelmed by it. Practically speaking, the project worker will check their understanding of the person’s world by summarising and reformulating etc. HI’s practice could be inspired by this.

Furthermore, HI could also equip its workers with tools to explore the context in which the person finds themselves, their resources, the stigma and barriers they face, the people they depend on, etc. There are also specific tools to help a person to specify their own objectives, the issues that are important to them, and from this, build a project and set goals. These types of tools already exist in the field of psychosocial rehabilitation and recovery. These tools make it possible to work as closely as possible to the reality of the person’s situation and help project workers to avoid suggesting what they believe are the best solutions, without taking into account the issues the person is facing.

**Mental health projects based on community-based rehabilitation**

Numerous international recommendations encourage the inclusion of mental health services in mainstream services, such as primary health care services or community-based rehabilitation services, not only to reduce stigma, but also to compensate for the stark lack of resources in certain countries. In terms of HI’s experience, it has extensively used a range of support tools for people with disabilities: community-based rehabilitation (CBR), personalised social support (PSS) and community workers, both voluntary and salaried workers. These tools can be used to increase people’s involvement in their care pathway, as mentioned above.

HI should develop mental health projects using the CBR and PSS tools. This is already the case in a number of projects. This option is supported by the scientific literature which has demonstrated their effectiveness and relevance. In practical terms, using these intervention methods will require a certain adaptation. For example, PSS support plans may include specific systems for organising a coordinated reaction in crisis episodes or relapses. Furthermore, there are specific
mental health guidelines in the WHO’s CBR guide. The advantage of this option is that it also supports HI’s stance on mental health: a social vision of mental health disorders focused on improving people’s social participation.

**What about interventions in emergency settings?**

Community mental health also has a role to play in emergency situations. The use of standard tools such as psychological first aid is worth considering. These are often used systematically and by people with little training (Zimmermann 2016).

In emergency situations, HI could also move into rehabilitation in a second phase, following the crisis, whilst paying particular attention to people already made vulnerable, in order to limit the impact of traumatic events.

It would be wise to make a clear decision on these types of issues, especially as very few projects currently work in emergency settings, yet a number of the reference documents and conceptual tools used have been developed based on emergency response expertise.

**Advocacy to promote robust mental health policies**

Most of the countries where HI operates have no national mental health policy and fail to invest in mental health services. HI supports the deinstitutionalisation of mental health by developing networks of health, social and community professionals and supporting coordination between them. HI supports the development of community-based services.

It would be advisable to work off these basic principles to develop a vision of the organisation of mental health care, its requisite components and how these work together. This could be based on the service pyramid, adapted for use in the Palestine project, for example. This would allow us to present a coherent vision of the desired care system to the relevant authorities.

**Updating HI’s mental health policy**

The various components discussed herein, no doubt along with other aspects of note, could be summarised and thought through as part of an update of the 2011 framework document. The latter could contain:

- HI’s vision of mental health and psychosocial support projects, which, if we take the components from the second part is: a social vision of psychological disorders and/or distress, involving beneficiaries in their care pathway, with a clear goal of ensuring their social participation.
- A reaffirmation of what community mental health is from HI’s perspective, bearing in mind that this is largely developed in the 2011 framework document.
- Choices in terms of the priority populations: people suffering from disorders and/or distress typically associated with other physical (disability) or social (detention, gender-based violence etc.) issues, people with moderate to severe mental disorders (pre-existing and/or exacerbated by the context in which HI is operating), people suffering distress relating to the context (war, internal conflicts, natural disasters, vulnerability) etc.
- The intervention method, «stand-alone» project or integrated mental-health component.
- The tools to use (or not) depending on the contexts and issues identified: peer support groups, individual or group psychotherapy, psychoeducation, psychological first aid etc.
- The minimum competence of mental health and psychosocial support workers (knowledge, soft and hard skills).
- Priorities in terms of advocacy.
Today, with more than 30 years’ experience in the field working in constantly changing socio-political contexts, the mental health and psychosocial support sector wants to rethink its intervention methods in order to best meet the needs of the populations we support.

Why hold this seminar?

In many countries, people living with a psychosocial disability suffer from discrimination and stigma linked to the expression of their psychological suffering or psychopathological disorder. These people are sometimes the victims of violence, abuse and exploitation, as the representations associated with psychological suffering and mental health disorders are extremely negative.

Receiving little or no support, these people are often isolated and are often unable to cope with the difficulties they encounter in their daily life and in being recognised as actors in society in their own right. They do not necessarily have access to community services or aid and development and mutual support mechanisms which help them to fully participate in society. This is the situation we encounter in many of the countries where HI operates.

On the one hand, we see a lack of mental health services or very poor quality services, concentrated in the country’s capital and in private or central hospitals. There are very few mental health professionals and they do not always have training and supervision available to them to improve the quality of their services.

On the other hand, people with mental health issues and their families do not always reach out to existing health services, for a number of reasons. First of all, the fear people seeking support have of being stigmatised and labelled by members of the community. Then there is the difficulty the
person themselves or their family members have in acknowledging the existence of mental health issues and the need for external support. Some people will prefer other forms of assistance and will turn to traditional healers or other alternative therapies aligned with their beliefs and convictions.

How can we help people access quality mental health services given the challenges associated with access to services? How can we reinforce solidarity mechanisms to support people with mental health issues to be actors in society in their own right and have their basic rights upheld? How can we engage decision-makers, service providers and the community in investigating innovative and tangible practices and strategies to promote positive mental health, prevention and support for people with mental health problems.

One of the approaches favoured by Handicap International for meeting mental health challenges is the community-based approach.

This approach is based on theoretical guidelines from clinical psychology, social anthropology and inclusive local development. It aims to reconnect the person with themselves and others by:

- Empowering the person living with a mental health issue
- Mobilising community actors to engage in the mental health sector
- Implementing actions to mobilise aid and development mechanisms and community living

The principles behind this approach are generally as follows:

- A rights-based intervention in order to:
- Give a voice to people living with mental health issues
- Uphold their right to make decisions about their own lives
- Involve «mental health users» in all the projects affecting them
- Facilitate full social participation
- An intervention that is sensitive to social, cultural, anthropological and traditional dynamics.
- An intervention which aims to forge links with other areas of activity (social, economic, justice, education etc.) to provide comprehensive care management for the person which meets all of their needs.

**Seminar objectives**

HI’s has a wealth of experience in the community mental health sector which varies widely in terms of context (emergency response, post-emergency, chronic crisis, development), socio-cultural dynamics, the problems met in the mental health sector, the project objectives, duration, how they are managed and the people involved etc.

It now appears important to consolidate and formalise this knowledge and expertise in community mental health, and to enhance this with the experiences of other organisations to build our expertise in this sector.

**MAIN OBJECTIVES**

Discuss and capitalise on this approach to consolidate our expertise internally with the aim of improving the quality of our interventions whether in emergency response, post-crisis or development contexts.

**SPECIFIC OBJECTIVES**

- Share and collect good practices from different community mental health models
- Ensure a shared understanding of community mental health in order to ensure the coherence of our actions
- Define a work methodology to formalise and develop expertise in community mental health

**Expected results**

- The participants understand the different community mental health approaches (the theoretical guidelines and practical implementation)
- The participants know about the different experiences of community mental health at HI
Appendices

- The participants discuss and share good practices in building a community-based mental health intervention
- The participants think about a methodology for community-based interventions based on the experiences and discussions at the seminar

Deliverable

- A document on community-based interventions

Detailed programme

THURSDAY
Place: Plenary – main room

__08.30 - 09.00__  Reception and Registration

__09.00 - 10.15__  Seminar Opening and Introduction

Session moderator: Maximilien, Mental Health TA
Speakers: Jean-François Michel, Field Programme Director (to be confirmed)
Joëlle Gustin, HI Luxembourg (to be confirmed)

__10.15 - 10.30__  Seminar Introduction: Objectives and programme, introduction of guest experts

Speaker: Maximilien, Mental Health TA

__10.30 - 11.00__  Health break

__11.00 - 12.00__  Plenary Round Table 1 – CONCEPTS

Speakers: Maximilien, François

__12.00 - 12.30__  Theory Wrap-Up: Mental Health TA

Speakers: Maximilien, François

__12.30 - 14.00__  Lunch

__14.00 - 15.30__  Plenary round table 2 – PRACTICES

COUNTRY presentations: (Rwanda, Haiti, Bolivia, Cuba, Colombia, subject to modifications)

__15.30 - 16.00__  Health break

__16.00 - 17.00__  Round Table, Presentations and Discussions (continued)

__17.00 - 18.00__  Presentation 1: CAPITALISATION tool: the Group at HI

COUNTRY presentations: (Togo, Madagascar, Sierra Leone, South Sudan)

Speaker: Aude Bosson with collaboration from the Mental Health TA

Programme Coordinator: «Touching Minds Raising Dignity»
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46

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Appendices


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Appendices


This document is a compilation of thinking resulting from the seminar held in Kigali (Rwanda) on December 7 - 9, 2017, which brought together 45 participants from 12 countries to discuss community mental health concepts and practices. This document aims to provide a basis for exploring these concepts as part of more in-depth work, including an update of the 2011 mental health framework document.

The first part of this document focuses on the theoretical aspects and provides an overview of the literature on community mental health. The second part explores the practices. It sets out the specificities of HI’s positioning on community mental health, its projects and their shared characteristics, as well as the types of mental health and psychosocial support interventions deployed. This exploration closes with theoretical input looking at two key concepts which resonate with our practices: recovery and resilience.

Finally, the last part reminds us of the day-to-day challenges we face in the field, and the issues and perspectives for improving our mental health and psychosocial support practices.