Mental health in post-crisis and development contexts

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Mental health in post-crisis and development contexts

How to promote and develop projects to improve access to prevention and care, and the social participation for people living with mental health problems

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“Recent conflicts and natural disasters in Afghanistan, Indonesia, Sri Lanka and Sudan among many others involve substantial psychological and social suffering in the short term, which if not adequately addressed can lead to long-term mental health and psychosocial problems. These can threaten peace, people’s human rights and development.”

Joint news release from World Health Organization, UNICEF, 25 International humanitarian agencies,

New guidelines to improve psychological and social assistance in emergencies.
The decision to draw up a policy paper on mental health was made because many of Handicap International's projects are defined as psychological and social. However, these often develop in a compartmentalized manner with limited opportunity for exchange and in some cases, with no common points of reference. By their very nature, the mental health professions contain numerous heterogeneous disciplines: psychoanalysis, psychiatry, social work, behavioral, cognitive and systemic therapies etc. which often face the same difficulties.

A large number of Field Program Directors and Desk Officers have shown an interest in mental health but this interest is tempered by the difficulties in understanding its specificities and contours. This policy paper aims not to propose a standard mental health project, but rather to promote the implementation of interventions and theoretical discussions using pragmatic approaches to mental health, whilst offering a space for dialogue, confrontation and co-construction (across disciplines, across divisions, technical resources). This document draws a policy, not a rigid standard.

This Prevention and Health Unit initiative aims to change the way Handicap International staff look at mental health using specific tools for implementing mental health approaches and interventions. The term “mental health” cannot be used to refer solely to the matters treated by the psychiatrist, psychologist or psychoanalyst from the ivory tower of their practice. “Addressing mental health” is, above all, about allowing people to start or continue to live together. Today, mental health workers try not to treat individuals by simply labeling them with a condition. Their primary goal, which may well constitute a new form of care, is to socialize these individuals by considering what constitutes their place in society and in the world (their relationships, their motivation, their resources etc.).

Mental health projects aim to:
- Working with orphans in nurseries (Algeria);
- Preventing ethnic violence in the wake of the presidential elections (Kenya);
- Taking into consideration the intergenerational trauma suffered by adolescents whose parents lived through the genocide (Rwanda);
- Facilitating the setting up of a network for sharing best professional practices to better address vulnerability and social exclusion (France);
- Improving the carer-patient relationship in light of the stigma associated with certain pathologies (HIV, Buruli Ulcer, Diabetes);
- Setting up discussion groups in order to create spaces for families and individuals isolated by their disability (Mozambique);
- Working to improve the living conditions in prisons (Madagascar);
- Preventing sexual violence in refugee camps (Lebanon).

For each of these actions it is important to simultaneously measure, specify, attach and bind (see Latour, 2000) to the outside world. The aim for Handicap International's projects is to mediate across divisions, particularly those which are most challenging and complex, for example, relationships between children and parents, carers and patients, health workers and social workers, primary/secondary/tertiary institutions.
The initial intention of “Mental Health”, as understood in this document, is to focus the spotlight on the action (or rather the interaction) in progress. It must be removed from justifications based on “all-encompassing” structures (which dominate individuals) or the cognitive constraints of the stakeholders concerned (based on their individual psychology). Rather than working from the individual’s psychology and pre-established population categories, the originality of our approach is that it focuses on the situations which cause the suffering i.e. relationships between people but also their relationships to things, objects and natural beings (e.g. religious beliefs) which surround them. Technical and institutional innovations are the means of choice for this brand of “bottom-up” mental health as they can be used to understand how the natural and technical environment and the systems which govern them are co-constructed.

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Principles and Benchmarks

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Importance, context and definitions

A

A key issue, often neglected

The figures

According to the World Health Organization, mental illnesses rank third in terms of disease prevalence and are responsible for a quarter of all disabilities. In general practice they rank second in the world, just behind cardio-vascular disease. They affect one in five people every year, and one in three people in terms of prevalence across a person’s lifetime. The World Health Organization has singled out five mental illnesses in a list of the ten most worrying pathologies for the 21st Century: Schizophrenia, bipolar disorders, addictions, depression and obsessive compulsive disorders. All the estimates made indicate that unless specific measures are implemented very rapidly, the situation will only get worse, with a 50% increase by 2020 in the morbidity attributed to mental illness in terms of total morbidity across all diseases.

Disability and mental health

In many countries (not just developing countries) a considerable number of people suffering from mental and/or intellectual impairments do not receive specialized care management, either because this does not exist, or because there is not sufficient provision for these populations. These people are then cared for under the welfare system, often with no support or follow-up. Some slip through the net entirely. Furthermore, in addition to psychiatric pathologies, living in a disabling situation can cause psychical suffering resulting from complex, self-perpetuating factors (individual vulnerability, life events etc.) which can cause these people to gradually withdraw and not seek help.

Indeed, the assessment of people with mental health needs is often hindered by the absence of a clear request for care. It should be more easily detected and expressed by the professionals working with these populations (school teachers, community workers, doctors, social workers and mental health professionals where these exist). Experiencing mental suffering due to one’s disabling situation is a double burden. It masks the injustice incurred (discrimination, stigmatization, rejection, exclusion), and the needs required to fight against this injustice. Despite the lack of epidemiological data, the observation of mental suffering expressed in a social context is in itself an alert to the huge amount and complexity of mental health needs, beyond those engendered by mental illnesses alone.

Mental health problems relate to a broad range of complex personal, social and environmental situations. Handicap International’s mental health projects often concern vulnerable and isolated populations, particularly victims of war and genocide, orphans, female victims of violence, people with physical, sensory or intellectual impairments and people with disabling diseases.

However, regardless of the causal or contextual factors, “addressing” someone to a mental health system is generally done by another system (health, social, education, legal) which has identified the expression of mental suffering. It would seem necessary however, to better characterize this mental suffering which it is difficult to dissociate from the pathological nature of the representation or from non-pathological feelings of suffering (as felt in the ordinary life of any individual). Whilst it can be suggested that in countries with a mental health system only access to inpatient or outpatient healthcare makes it possible to establish a clear link between the declared
suffering (or limited activity) and actual mental suffering, what of countries in which there are no mental health institutions or professionals?

**Recommendations**

Any public health policy must contain a significant section on mental health, covering: prevention, care, follow-up and inclusion in the urban environment, the promotion of mental health, and the removal of the stigma associated with mental illnesses and the disabling situations these may cause. This policy must reinforce the institutional role of patients, their family and entourage as stakeholders in the health system in their own right, alongside health professionals. It should also encourage the assessment of structures, activities and practices in order to better understand and raise awareness of the importance of the actions undertaken. Offering comprehensive management with high levels of quality and security, with individualized treatment pathways for patients who cannot always request healthcare themselves, requires that at least three conditions are met: Proximity, a multi-disciplinary approach and excellent coordination between all stakeholders.

This document aims to first tackle these issues as a whole by presenting how Handicap International is trying to respond to these in a cross-disciplinary manner.

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There is currently no data available on psychological distress. This chapter deals solely with mental disorders, as defined below. The lack of data on psychological distress is a significant argument in favour of increasing the visibility of this issue and thereby of the disabilities with which it is associated. In order to further investigate this situation, specific attention should be paid to the implementation of studies on psychological distress in different post-crisis and development contexts (examples: In prisons or refugee camps, after a natural disaster etc.).
Background information

450 million people worldwide present a mental or neurological disorder or psychosocial problem (see World Health Organization, 2001).

Mental illness is a heavy burden for all countries: In a recent global health study, the World Health Organization, the World Bank and the University of Harvard found that mental illness represents 15% of the disease burden (more than cancer) in developed market economies such as the United States. Mental illness has a significant negative impact on productivity in both developed and developing countries. Three quarters of those affected live in developing countries (see WHO, 2001).

Mental disorders can lead people to commit or attempt to commit suicide: In 90% of cases the person who takes their own life has previously suffered from psychopathological episodes, often linked to depression.

Mental and physical health are interlinked: We have an increasingly good understanding of the very close relationship between mental and physical health. For example:
• Back pain is often the result of mental disorders
• Depression represents a risk factor for the onset of heart disease
Conversely, people suffering from chronic or long-term disease (HIV, diabetes etc.) are more likely to be affected by serious depression than the rest of the population. Furthermore comorbidity between mental disorders and physical impairments is associated with a lack of patient compliance in terms of their treatment and worse therapeutic results.

Mental disorders have a high social and economic cost: Mental disorders do not only constitute a public health issue. In addition to their impact on patients and their families, they also put a strain on society’s resources and its economic, educational, social, penal and judicial systems. They are one of the three main causes of absenteeism at work.

Mental health human resources in low and medium-income countries are severely lacking:
• In high-income countries there are more than 10 psychiatrists for 100,000 inhabitants, compared to 0 – 1 for 100,000 inhabitants in low-income countries.
• 76.3 – 85.4% of serious cases receive treatment within 12 months in developed countries, compared to only 35.5 – 50.3% in developing countries.

The percentage of the health budget allocated to the mental health budget remains insufficient: It ranges from 6.89% in high-income countries to 1.54% in low-income countries.
Common obstacles

- Political determination and economic commitments with regard to mental health are weak because:
  - Mental health advocacy is still formulated in an inconsistent and unclear way
  - People living with mental disorders and their families are generally not organized in a collective manner and have no political weight in most countries
  - The stigma associated with mental illness means there is a general lack of interest from both the general public and, most importantly, certain professionals: Doctors do not choose to work in psychiatry
  - It is widely thought that mental health provision is inefficient and unprofitable
  - As public health resources are limited, priority is often given to other interventions considered to be more effective

- Mental health resources are concentrated in and around large towns and institutions because:
  - Generally speaking, it costs more to reach out to populations in the community

- It is difficult to integrate mental health services into primary health services because:
  - Primary health service professionals already have an excessive workload
  - Once trained in mental health they receive no further supervision
  - They themselves have limited access to drugs, and in particular to psychotropic drugs

- Mental health managers generally lack expertise and experience in public health because:
  - Those who take on managerial roles are often clinicians and practitioners who are not trained in public health or project management
  - Public health programs do not always include mental health.
The concept of mental health

As for physical health, mental health is not just defined by the absence of disease.

The shift over the last thirty years in how the different positive/negative dimensions of mental health are taken into account has considerably enhanced the concept (see Focus on changes in the mental health concept). Whilst traditional psychiatry dealt primarily with mental pathologies, three areas of mental health are commonly identified i.e.:

Psychological distress

This is “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.”

When this psychological distress has a social cause it is known as psychosocial suffering (or socially-caused mental suffering). This distress does not necessarily lead to the onset of mental disorders (although it may be associated with these) and is not pathological but can be severe enough to warrant its inclusion in a negative definition of mental health (suffering which is extreme, incapacitating, disabling, alienating, etc.).

“Measuring the intensity, permanence and duration of the [psychological distress], as well as its consequences, can be used to identify the need for care management.”

Psychological distress is generally measured using the quality of life survey SF-36® which makes it possible to assess an individual’s physical and mental health by means of...
Principles and Benchmarks

thirty-six questions concerning eight health areas (physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional and mental health). The answers are given on a five-level response scale. A general score for mental health is calculated by adding the values for the responses to each question (with a final score of between 0 – 100). A score below or equal to 52 is considered to be indicative of a mental health problem. It does not make a specific diagnosis but makes it possible to estimate the percentage of the population in which the number and intensity of symptoms place them in an at-risk group for psychological distress. “When the psychological distress is temporary and follows a stressful event, it is considered to be a normal adaptive reaction. However, when it is intense and sustained it can be considered to signal a [mental] disorder.”

Mental disorders

Mental disorders are diagnosed using reference manuals (DSM IV° – ICD 10°). It refers to criteria and targeted therapeutic actions of variable duration and which can be more or less severe or disabling. Handicap International is concerned with the following mental disorders as these have high levels of mortality, morbidity and disability:

- **Psychotic disorders** (schizophrenia, manic depression, chronic delirium)
- **Depressive disorders** (depression, dysthymia)
- **Anxiety disorders** (post-traumatic syndromes, phobias, obsessive compulsive disorder)
- **Psychoactive substance abuse disorders** (alcohol, drugs and medical products)
- **Personality disorders** (including antisocial personality disorders)
- **Developmental disorders** resulting from chromosomal or genetic disease (Down’s, Fragile X, Prader-Willi, Smith-Magenis, and Williams syndromes)
- **Pervasive Developmental disorders** (autism spectrum disorders, Rett syndrome, childhood disintegrative disorders, Asperger’s syndrome, pervasive developmental disorder not otherwise specified).

Positive mental health

This “refers either to a state of well-being, a feeling of happiness and/or self-fulfillment or to personality traits (resilience, optimism, ability to deal with difficulties, feeling of control over one’s life, self-esteem). This is a positive state of balance and harmony between the structures of the individual and those of the environment they have to adapt to. This is the “health” element of mental health, which is not only defined by the absence of disorders but by a dynamic capacity or even “a permanent effort, a perpetual winning over of autonomy”.”

This split into three dimensions, invites us to look beyond the dual model opposing “being mentally ill” and “being in good mental health” in a neutral sense i.e. “not suffering from mental illness”. Furthermore it requires the identification of factors which are not necessarily the same for the absence of mental disorders, as those for positive mental health: A certain number of causes of stress affect mental disorders but are not necessarily have an impact on positive mental health. Conversely, physical activity is often associated with good mental health but has no impact on pathologies. Finally, mental illness and mental health are not necessarily mutually exclusive: A person suffering from a mental illness may present other aspects of positive mental health.”
“(...) From the 1950s onwards, perspectives on mental illness changed with the development of the main classes of psychotropic drugs (notably antipsychotics) which have brought about radical changes in the care provided to people suffering from mental disorders (prior to this there were practically no chemical substances capable of acting on the main mental syndromes). This change was the catalyst for the move towards de-institutionalization and alternatives to hospitalization. The reinvention of care provision for mental illness saw psychiatry integrated into the field of mental health: the “madman” is no longer someone who should be locked up, but as a person suffering from mental disorders who should both be supported towards autonomy and helped to control their pathology. Health and medico-social follow-up in an open environment is nonetheless problematic. It is an area which requires constant reform based on the diagnosis of a chronic lack of coordination between stakeholders and of inclusion for those affected (mental or intellectual disabilities).

Since the 1990s, psychological (...) distress, as opposed to pathology has been the focus of increasing attention. This is not because we are not aware of the entities by which forms of “ill-being” - symptoms of depression or anxiety, stress, psychosomatic disorders, feelings of guilt, and professional burn-out manifest themselves. However, because these have been increasingly associated with changes in lifestyle, social structures and institutions, these take on a new meaning. Where either an increase in aggression factors is observed (at work, at school etc.) or that mental suffering is designated as having a social origin (as in suffering of “condition” associated with vulnerability and exclusion), the hypothesis of a structural vulnerability which is expressed socially in the form of psychological distress can be advanced. The term “modern pathologies” sees the convergence of a whole range of concepts such as “suffering at work”, “psychosocial suffering” and “psychosocial risks”.

Most recently, the positive aspects of mental health have been included to characterize other expressions of subjectivity. The distinguishing of a third dimension to mental health creates a new coherence between a series of states which have been well-identified empirically: Self-fulfillment; feelings of personal worth (self-esteem); registers of “socio-emotional intelligence”, such as the accuracy of conscious perception and control of one’s emotions, an ability to express one’s emotions in an appropriate way, to identify other people’s emotions and knowing how to respond; feelings of influence and control (mastery) over one’s destiny and environment (the opposite of feelings of dispossession or impotence); ability to adapt (coping) and individual resilience, i.e. ability to cope with stress or difficult life events; states of satisfaction, well-being or happiness.

These different concepts may overlap and constitute basic common sense; they are not dissimilar to social frameworks of experience. The more an individual is rewarded for their autonomy and sociability, the greater the value placed on these impacts. Whilst work by researchers in the English-speaking world has had a decisive influence on the recognition of positive health, some analysts emphasize its close relationship to the specific values of English-speaking societies. This criticism relates to conflicts within the discipline: in France, the tenants of the psychodynamic or psychoanalytical approach often oppose the concept of positive mental health, inspired by cognitive or behavioral approaches. These theoretical difficulties
often however disappear in practice: Interventions by professionals (in the family, and work environment, etc.) generally integrate aspects of positive mental health as these have a fundamental impact on quality of life and the social functioning of individuals. (…)"

Based on the definitions above “mental health can be seen as the meeting point of two continuums, according to a model [inspired by] the Canadian Ministry of Health.

1st continuum: from poor mental health to optimal mental health

“Thereby the first continuum which runs between the two opposing points of optimal mental health and poor mental health. Optimal mental health is a situation in which the respective demands and contributions of the person, group and environment are correctly balanced. Poor mental health designates the state of psychological distress or mental suffering described above. The opposite of positive mental health is not mental illness but this distress (a permanent and destructive cause of stress) which has internal and external determinants.”

2nd continuum: from serious mental illness to no symptoms of mental illness

“The 2nd continuum runs from serious mental illness to no symptoms of mental illness. Between these two end points there are a variety of different situations in which the symptoms of mental disorders present to varying degrees.”

3rd continuum:

From these two continuums, we can also identify a 3rd continuum, from social exclusion to social participation, “which describes the impact impaired subjectivity (mental illness and poor mental health) has on the different aspects of daily life (physical, domestic, academic, professional activities etc.). This continuum depends on the two other dimensions previously mentioned (…) and thereby constitutes an approach to the Disability Creation Process (DCP), the main disability analysis model used by Handicap International.”
Three continuum mental health model

Adapted from the diagram found in the document:
The Disability Creation Process (DCP) is “a model which differentiates itself from diagnostic-focused biomedical models which define the person in terms of their pathology and place the responsibility for social exclusion on the person and their impairments and disabilities. However, it also provides an alternative to the socio-political models focused exclusively on structural, environmental obstacles to the social participation of people presenting functional or behavioral differences.

The DCP is a dynamic model which helps to understand that the quality of each person’s social participation and ability to exercise their citizenship is the result of the interaction between their specific organic, functional and identifying features and the features of the actual context in which they live on a micro (personal) meso (community) and macro (society) level. It is a positive model which widens the scope of possibilities for action and for the reconstruction of essential meaning that should be taken into account when defining life objectives. It shows that it is impossible to identify the possibilities for social participation using a diagnosis or functional profile. It is important to also take into account the context and the activities and social roles valued by the person themselves which give meaning to their life choices in accordance with their individual identity.

The DCP model is an effective, pedagogical tool that can be used to link together the changes in a person’s life choices which aim to offer them the widest possible choice and maximize their ability to exercise their citizenship by ensuring they find themselves in supportive, encouraging contexts. Originating in Quebec and widely publicized and used in French-speaking countries throughout the world, this model refers to people with disabilities as “people in disabling situations”. This describes all people in situations of social exclusion, regardless of their functional or behavioural differences. This model is however, largely unknown in the field of mental health and of people living with the social consequences of psychiatric disabilities. (…) [Still today in the field of mental health] there is a reticence to use the word “disability” which is seen as being a personal characteristic, which applies exclusively to people presenting motor, visual, auditory or speech impairments (…). [However,] the social exclusion experienced by people with mental disabilities does indeed contribute to the social and cultural construction of disability, no longer defined as a characteristic of the “patient” but as the interaction between the person (impairments, disabilities, identity) and their environment (obstacles) leading to this social exclusion (disabling situations) in some aspects of their life and produced in a fluctuating manner both in terms of intensity and frequency.”
RISK FACTORS

1. Biological risks
2. Physical environment risks
3. Social organisation risks
4. Social and individual behaviour risks

PERSONAL FACTORS

Organic systems
1. Nervous system
2. Auricular system
3. Ocular system
4. Digestive system
5. Respiratory system
6. Cardiovascular system
7. Hematopoietic and immune system
8. Urinary system
9. Endocrine system
10. Reproductive system
11. Cutaneous system
12. Muscular system
13. Skeletal system
14. Morphology

Capabilities
1. Intellectual capabilities
2. Language capabilities
3. Behaviour capabilities
4. Sense and perception capabilities
5. Motor activity capabilities
6. Breathing capabilities
7. Digestion capabilities
8. Excretion capabilities
9. Reproduction capabilities
10. Protection and resistance capabilities

Integrity ↔ Impairment

Ability ↔ Disability

Intellectual impairments
Psychological distress
Mental disorders
Psychosocial, mental and/or intellectual disabilities
ENVIRONMENTAL FACTORS

1. SOCIAL FACTORS
   1.1 Political economic factors
      1.1.2 Socio health system
      1.1.3 Medical care
      1.1.4 Rehabilitation
      1.1.5 Social assistance
      1.1.6 Education system
      1.1.7 Public infrastructures

1.2 Sociocultural factors
   1.2.1 Social network

2. PHYSICAL FACTORS
   2.1 Nature
   2.2 Development
      2.2.1 Architecture
      2.2.2 National and regional development
      2.2.3 Technology

LIFE HABITS

1. Nutrition
2. Fitness
3. Personal care
4. Communication
5. Housing
6. Mobility
7. Responsibility
8. Interpersonal relationship
9. Community life
10. Education
11. Employment
12. Recreation
13. Other habits

The Disability Creation Process* and the different issues and types of disabilities encountered in the mental health sector at Handicap International


A person living with psychological distress and/or a mental disorder is in a situation of exclusion or disability

Social participation <> Handicap situation
Definitions of disabilities relating to mental health

Psychosocial disabilities
Psychosocial disabilities are related to psychological distress, whatever the cause (migration, exile, natural disaster, poverty, homelessness, breakdown of family and/or social relationships, unemployment). The disabilities resulting from these situations should be acknowledged as such, as they adversely affect the social life of those concerned (incapacities in terms of behavior, language or intellectual activities) who lose their social skills and their ability to take care of themselves (incapacities concerning protection and assistance). The disabling situations resulting from psychosocial disabilities related to the surrounding environment, can be experienced by both adults and children. However, special attention must be paid to children and adolescents in vulnerable situations due to their upbringing: Emotional deprivation, physical abuse, precarious social environment, etc. We know that mental disorders presenting in adults are often rooted in childhood problems which have not been addressed.

Mental disabilities
Mental disabilities are associated with the chronification of serious mental disorders (schizophrenia, manic-depressive psychosis, depression). Onset is most common in adolescents and adults. The onset of post-traumatic stress syndrome, also considered as a serious mental disorder, follows a situation in which the physical and/or psychological integrity of the person (and/or their entourage) has been threatened or affected (serious accident, violent death, sexual aggression, physical aggression, serious illness, war, terrorist attack, serious flooding, etc.).

Most people suffering from these types of disorders can be “stabilized” medically, but often suffer serious after-effects. There are no systematic or permanent intellectual impairments but behavioral and emotional disabilities which translate into difficulties in acquiring or expressing psychosocial skills (incapacities in terms of language or behavior and those related to protection or assistance). This leads to attention deficit and difficulties in drawing up and following action plans, as well as the alternation between calm and stressful states.

Intellectual disabilities
Intellectual disabilities are related to intellectual impairments, usually associated with a developmental disorder or a pervasive developmental disorder, whatever the cause (genetic, chromosomal, bio-organic, and environmental including nutritional). By intellectual impairment we understand the significant, persistent and long-term limitation of a subject’s intellectual functions (assessed by measuring Intellectual Quotient) compared to other subjects of the same age who do not present this limitation. The resulting disabilities affect to a greater or less extent the person’s ability to learn, their knowledge acquisition and memorization, attention, communication, social and professional autonomy, emotional stability and their behavior. The intellectual impairment usually presents at birth or in the first few months of the child’s life. People with disabilities resulting from intellectual impairments in relation with their environment may also (but not necessarily) suffer from mental disorders (psychotic, depressive, anxious, addictive and personality disorders) and psychological distress.
Principles and Benchmarks
Why intervene

A

Scope of activity

Beneficiaries

Handicap International’s interventions on mental health have been shaped by:

→ the Federation’s designated scope of activity 23

→ a process of clarification and discussion regarding the needs and expectations of the Development Division, the Emergency Response Division, and the Technical Resources Division

→ the history of Handicap International’s mental health projects, given that most emerge in an emergency context before becoming part of a development program (see Appendix History of mental health at Handicap International).

It has now been established that the aim of mental health projects by Handicap International – in whatever context they arise (post-crisis or development) – is to prevent and treat:

• Psychological distress, notably in population suffering from disabling injuries and traumas (conflicts, natural disasters, gender based violence);

• Mental disorders, notably post-traumatic syndrome, developmental disorders and pervasive developmental disorders 24.
The link with disability

- The Convention on the Rights of Persons with Disabilities defines people with disabilities as persons “who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”.

- The term “disability” as used in the expressions “mental disability” or “intellectual disability” refers to personal factors (abilities). This is an important clarification as the Disability Creation Process uses the expression “disabling situations” with reference to the interaction between personal factors, the environment and lifestyle, in which the “disability” is something apart to which no qualifying adjective is added so as to avoid causal modeling. To ensure accuracy, under the framework of the Disability Creation Process, the appropriate terms to use are: Either “psychosocial, mental and/or intellectual disability” or “a disability of psychosocial, mental and/or intellectual origin”.

- Handicap International, drawing both on the Convention on the Rights of Persons with Disabilities and the Disability Creation Process defines persons with disabilities as: “Persons with lasting physical, mental, intellectual or sensorial impairments which, when combined with certain barriers, prevent them from participating in society on the same basis as other people and therefore call for compensation measures and work on the environment.”

Therefore, Handicap International’s mental health projects specifically address the mental health of people with psychosocial and mental disabilities or with intellectual disabilities.

As some people experience multiple mental health problems, the breakdown into categories is a limited approach. Whilst this classification aims to draw out the symptoms of distress and/or disorders, it is also important to stress their shifting rather than definitive nature. These disabilities are therefore a result of the aforementioned problems which should be prevented upstream. In order to do this, it is important to look at both the disabilities and the risk factors which threaten an individual’s social relationships, autonomy, dignity, and physical and mental integrity.
Focus on the concepts of risk factors and vulnerability

Risk factors are stressful events or personal or environmental situations which increase the likelihood that a subject will develop mental disorders or psychological distress.

“The concept of vulnerability [from the Latin “to wound”] is intrinsically linked to the notion of danger. Vulnerability is determined both by the risk potential (probability of incurring harm, a threat or a loss) and its impact (the risk of suffering its consequences). In situations of violence, some people or groups are at a greater risk of suffering trauma. From a mental health perspective they are more likely to develop disorders according to their pre-existing personal characteristics. The at-risk groups are children, the elderly, women, the sick, people with disabilities, ethnic minorities, people suffering from grief, people who have been raped or tortured, veterans etc. However the context affects the degree of vulnerability; for example, a female soldier who is not vulnerable may, when demobilized become vulnerable if her former status is stigmatized.”

Principles of intervention

Interventions built on three theories

Social/clinical psychology
Handicap International’s policy on mental health not only applies to people with disabilities but also their surrounding environment (family, community, social, political).
Handicap International’s teams seek to understand the “whole person in situation” i.e. how the person feels about, and reacts, to the difficulties they face, characterized by the attention paid to the social context of subjective disorders. In this way, Handicap International’s approach to mental health could be qualified as “social clinical psychology”. Notably, it does not presume that psychosocial care is (only) a dual or inter-individual relationship. The field of application concerns all interventions focusing on psychosocial care. This therefore includes, for example, social inclusion for therapeutic purposes, income-generating community support groups, therapy through dance or art etc. Generally speaking, this refers to any intervention in the social, economic or cultural sector which constitutes an attempt to initiate a therapeutic activity to contribute to a person’s well-being and social inclusion.

Social anthropology
The activity of psychosocial care is to a great extent defined from a socio-cultural perspective. It therefore presents variations according to society and culture despite the universal functioning and structures of the psyche. Prior to any mental health intervention, at least one social anthropological study should be carried out in order to assess the quality of the actions to be undertaken. However, beyond these studies, it is important to remember that this conception of disability is based on an anthropological vision of human development (see the Disability Creation Process model). In order to further the
Focus on community mental health

Community mental health (CMH) is a set of devolved actions regarding the provision of care for people with mental health problems.

Community mental health is based on a “biopsychosocial” model which is well-adapted for use in low and medium-income countries, as it makes it possible to take effective action using limited resources by exploiting existing skills within the community.

The principles of community mental health are:

- An approach which respects the person’s rights and takes the form of the following actions:
  - Allow people in disabling situations resulting from psychosocial, mental and/or intellectual disabilities to speak
  - Uphold their right to make decisions concerning their lives
  - Involve users at all stages of the development of the community mental health project
  - Facilitate full social inclusion
- An approach that is sensitive to culture and tradition
- A cross-cutting approach which creates links with other fields of action (social and economic) to offer overall (anthropological) care provision for the individual. Indeed, a lot of mental disorders, notably chronic disorders, require the implementation of a care model based on continuity and focused on the comprehensive nature of the resources needed and of the patient’s needs which are social, occupational and psychological.
There are three models of community mental health services:
• The integration of community mental health into primary health services
• Specialized mental health services, provided in proximity to and open to the community.
• The integration of community mental health into community-based rehabilitation (CBR) services.

Community mental health services are split between formal and informal services:
• Formal services are accessible, do not stigmatize the patient, and ensure those with the most serious disorders are followed closely (for example, community mental health centers, mobile units which move from village to village, monitoring users' livelihoods etc.). Some of the employees working in these services should be trained professionals with good qualifications.
• Informal services are offered by less qualified or unqualified people who support users and their families in the community (for example, daily care provided by neighbors). These informal interventions are extremely valuable in developing countries.

Mental health and inclusive development
Handicap International aims to meet two complementary goals:
- The development of specific measures to help people living with psychological distress and/or mental disorders in their day-to-day lives;
- An inclusive approach which aims, at community and society level, to achieve equal access to opportunities, equal opportunities and equal rights.

Using an inclusive approach to prevent the causes of impairments and disabilities (psychosocial, mental and intellectual) the association implements activities to address the whole community concerned, as well as more specific actions aimed at people in disabling situations who are particularly fragile and more vulnerable in the face of physical, mental and social risks.

Mental health and rights
In its mental health projects, Handicap International tries to implement actions built on people’s rights. This approach involves fighting against exclusion and promoting the rights of the poorest and most vulnerable populations. Furthermore it calls upon and/or supports the authorities to help them better uphold and guarantee people’s rights (in terms of education, training, access to healthcare and participation in social and democratic life). Handicap International is therefore particularly attentive to the impact it may have on any legislation which makes it possible to provide adequate and appropriate healthcare, to protect the rights of people suffering from psychological distress/mental disorders and to raise the population’s awareness of mental health.
Focus on gender and mental health

“The disadvantageous situation of women in society is now acknowledged internationally as an infringement of fundamental human rights and a major obstacle to development. It is also accepted that the subordination of women in society has been institutionalized by its structures, meaning they are marginalized in key sectors such as education and employment, but also in the definition, scheduling, implementation and monitoring of general policies and strategies. This pattern is found on all levels: Within families, at school, in commercial and political institutions and even in healthcare institutions. Priorities in all these sectors therefore reflect this reality: They are the priorities of men, and in particular of men from the most privileged and powerful social groups.

As regards health, men and women’s social, economic and political status determines their ability to protect and promote their physical, mental and emotional health.

In terms of public health the expressions of this iniquity therefore reflect both the often wide gap between women and men’s state of health, but also differences between different populations and socio-economic groups within the country. These gaps are also seen in differences with regard to risk, access to healthcare and access to information, and thereby in the social and economic consequences of illness. Furthermore, this includes, and calls into question, the systems and services for health and healthcare provision who do not offer universal access neither from a gender perspective nor an economic perspective.

The issues of gender and women’s rights therefore affect the health sector in a highly cross-cutting manner: The data and indicators for identifying inequalities and associated risk factors must be developed in order to analyze the issues related to gender and other social inequalities; programs and strategies which integrate these issues should be created within the health system, as in other areas of society, in parallel to advocacy work and to the consideration of women’s rights, primarily concerning the control they have over their body, their fertility and their sexuality.”

The Emotional Life and Sexuality Support Service (ELSS) measures instigated by Handicap International’s program in France are, in this case, particularly well-adapted.

In addition to the issue of sexual violence (which also concerns children and men), one of the key specificities of gender based violence is that it does not only concern a women’s body (whether she has disabilities or not) but the values considered to be feminine within a given culture such as “caring” or “attention for others”. This is why the professionals who support the survivors of this violence by providing care or social/legal support, are often themselves subject to stigmatization and discrimination. The projects therefore aim to work towards and strengthen empowerment through advocacy, awareness-raising and training activities amongst the professionals who care for the victims of gender based violence.

Handicap International’s gender approach is based on three principles:

1. Non-discrimination and protection at work
2. Dual inclusion of gender and disability, with a particular focus on discrimination against disabled women
3. The gender approach as a project quality criterion.
This memo is intended to be used to check that key elements of dual “gender and disability” inclusion are taken into consideration when implementing mental health projects. This includes both issues of programming and questions of situational analysis:

1. General analysis of the situation
   • Which key factors and contexts (cultural, sociological, biological etc.) increase the vulnerability of men and women, girls and boys with regard to disability?

2. Legal measures

3. State policy
   • Has the State signed the Convention on the Elimination of Discrimination against Women?
   • Does it respect the rules on equal opportunities for people with disabilities?
   • What legal measures and national policies are in place to prevent and punish violence against women, and to support victims?

4. Prevention
   • How is gender taken into account in public disability prevention programmes? In the analysis of exposure factors? In the implementation of prevention actions?
   • Are the prevention campaigns accessible to people with psychosocial, mental and/or intellectual disabilities?

5. Access to healthcare
   • Do mental health structures employ women?
   • Are mental health professionals aware of gender issues?

6. Data collection
   • Does the data collected on mental health mention gender and disability?

7. Civil society
   • Do local mental health associations include men and women with disabilities?
8. Project programming

- Are women with disabilities (with psychosocial, mental and/or intellectual disabilities) involved in project programming and decision making?
- Are the activities organized in locations and at times which are accessible and appropriate for men and women with disabilities?
- Does the project tackle the issue of differentiation between men and women with regard to the main factors of disability and disabling situations?
- Does the project encourage couples, parents and/or children with disabilities to discuss mental health?
- Does the project tackle issues related to mental health and the rights of women with disabilities?
- Does the project tackle the difficulties of access to healthcare (for example, use of psychotropes, absence of the mother from the home whilst hospitalized) from the perspective of men and women with different types of disabilities?
- Does the project make it possible to fight violence against women (political objectives, educational programs, legislation)?
- Does the project tackle the issue of representations of violence, local myths (for example the rape of mentally retarded women) and traditional practices?
- Does the project make it possible to increase the self-confidence of women and girls with disabilities?
- Does the project tackle the issue of the sexual abuse of women, men, girls and boys with disabilities?
- Does the project make it possible to ensure equal access to healthcare for men and women in disabling situations?
- Does the project tackle different financial problems (and their solutions) which affect women and men with disabilities, in particular sexual exploitation for financial gain?
- Does the project address the main barriers (financial, physical, cultural, social) to people with disabilities' access to healthcare? Are these barriers the same for men and women?
Focus on the Millennium Development Goals (MDG)

**Eradicate extreme poverty and hunger** (MDG n°1):
The poor are more exposed to developing mental health problems (mental disorders and psychological distress) and these contribute to creating poverty.

**Achieve universal primary education** (MDG n°2):
Mental health problems can lead to learning and attention deficit disorders in children.

**Reduce child mortality** (MDG n°4):
Child mortality due to malnutrition has been associated with maternal depression.

**Improve maternal health** (MDG n°5):
Maternal depression may result in suicidal behavior and/or neglect.

**Combat HIV/AIDS, malaria and other diseases** (MDG n°6):
Mental health problems often lead to high risk sexual behavior; furthermore, HIV/AIDS has an impact on the mental health of those suffering from the disease.

Mental health has a direct link with five out of eight of the MDG.

This focus can be used to persuade authorities reluctant to include mental health in national policies. It is also a reminder of the fact that mental health at Handicap International should be approached in liaison with other technical sectors.
Mental health, social inclusion and livelihoods

Mental Health, Social Inclusion and Livelihoods sectors often work with the same target population and use the same tools. Indeed, a person in a situation of exclusion, whose social relationships have broken down, who is unemployed or impoverished, who is perhaps suffering from psychological distress, may develop psychosocial disabilities as a result of this situation. Furthermore, the prevention of mental disabilities can also target at-risk populations of people in psychological distress. Faced with these situations, our mental health actions have implications in terms of social and/or economic inclusion: Discussion groups, referral activities (personalized addressing/orientation to specialized health, social, legal, educational services), sports and leisure activities, income-generating community support groups etc. At Handicap International, this response, usually termed a “psychosocial response”, calls on the expertise in these three sectors. It primarily concerns the intervention method entitled “promoting empowerment and social participation”, as laid out in Part 2 of this document.

Mental health and inclusive education

Inclusive education is a process which responds to the diversity of learners’ needs by increasing participation in learning and reducing exclusion from and through education. This process therefore takes into account the specific needs in terms of teaching and learning for all children and young people in marginalized and vulnerable situations: Street children, girls, groups of children from ethnic minorities, children from families with financial difficulties, children from nomadic families, children suffering from HIV/AIDS and children with disabilities. Inclusive education aims to guarantee equal rights and opportunities for these children with regard to education.

The Inclusive Education and Mental Health sectors share common target populations and a common approach (rights and inclusion). Whatever the level of advocacy or promotion of mental health, these two sectors share common activities which generally aim to improve guidance and training for primary school teachers and community workers in schools on their relationships with children with mental disorders and/or in psychological distress.

The activities which relate to both Mental Health and Inclusive Education include:
- Meetings between primary school teachers, parents and their children regarding the child’s mental health
- Specific training in mental health for primary school teachers (on enuresis, maturational lag, epilepsy, depression, hyperactivity, the child’s place in the family, etc.)
- Therapeutic mediation groups in schools (drawing, puppets, plasticine, etc.)
- Support for parental guidance.
Mental health and disabling diseases

Disabling diseases (HIV/AIDS, epilepsy, diabetes, lymphatic filariasis, Buruli ulcer etc) and mental health are two distinct problems for which the inadequacy of the responses available is a shared difficulty. These two themes often cross over because the psychosocial and economic determinants are very similar. Poverty, humanitarian crises, gender inequality, discrimination and stigmatization, the vulnerability of children and orphans, failings in the educational and family context, are all factors of risk and vulnerability to disabling diseases. The latter lead to difficulties in people’s day-to-day life: suppressed grief, personality, mood and behavioral disorders, and even disabling mental disorders (post-traumatic pathologies, phobias, obsessive-compulsive disorders etc.).

In the case of HIV/AIDS, the epidemiological data available shows higher prevalence in certain populations, notably drug users, homosexuals and sex workers. Other populations are also vulnerable to HIV/AIDS: Children through mother to child transmission, orphans, populations in socially vulnerable situations, migrants. However this data is patchy given that the overall strategic frameworks implemented by governments in some countries are unequal. There are often no systems for the epidemiological monitoring of mental health and specialist treatment and advisory structures in place. Traditional practitioners are often the only people available and willing to provide care in response to the psychological distress of the poorest populations.

Suffering from a disabling disease inevitably leads to psychological distress requiring specialist support. Therefore, the therapeutic mental/psychosocial activities (discussion groups, Balint groups, peer advice/counseling, occupational activities, etc.) can be used in disabling diseases projects.

End of Principles and Benchmarks
Principles and Benchmarks
METHODS

A. APPROACHES AND METHODOLOGY
- A territorial, multi-disciplinary and comprehensive approach
- A partnership approach
- Project methodology
- Intervention methods translate into programming

B. IMPROVING PREVENTION AND ACCESS TO HEALTHCARE

C. PROMOTING EMPOWERMENT AND SOCIAL PARTICIPATION

D. PROMOTING ADVOCACY AND DE-INSTITUTIONALIZATION

EXAMPLES OF LOGICAL FRAMEWORKS

A. Rwanda Mental Health Project 2010-2012
B. Lebanon Mental Health Project 2010

PERSPECTIVES FOR 2011-2015
Handicap International has field experience of mental health in emergency, post-emergency and development contexts dating back to the 1990s. From an initial mission on the prevention and treatment of disabling mental disorders resulting from war or genocide (post-traumatic stress disorder, depression, anxiety, psychosis, developmental disorders), the scope of its action has gradually broadened.

Today, Handicap International’s actions on mental health are mainly focused on care management for psychological distress resulting from a number of social, political and environmental issues (poverty, exclusion, vulnerability due to exile, migration, war, genocide, natural disasters). The mental health sector is also an important technical resource for projects tackling intellectual disorders to coordinate responses in other sectors (medical, social and medico-social) to people in disabling situations, whilst taking into account the clinical specificities of these disabilities.

### A territorial, multi-disciplinary and comprehensive approach

Whilst community-based actions take place alongside target populations, there is also a need to take into account the natural, infrastructural, social, economic, cultural and political parameters in a given country or region with regard to mental health.

Handicap International plans its interventions using a territorial approach. This aims to create services, spaces and mechanisms for negotiation / cooperation between the different stakeholders who make up the social fabric of a given territory. Mental health projects therefore develop different complementary projects and/or projects coordinated with other local stakeholders across a pre-defined territory. This aims to ensure that all the factors affecting the quality of life of people with disabilities are taken into account. This falls under the framework of existing local development processes in the country in question.

In the same vein, the many factors which influence the psychological distress suffered by people with disabilities cannot be taken into account unless a multidisciplinary approach is used. This is done through the coordinated implementation of a variety of complementary projects, deploying multi-disciplinary expertise. This requires a capacity for comprehensive analysis, a multi-factorial understanding of the problems to be resolved and the proposal of inter-dependent actions. It also requires the association to mobilize a variety of professional skills and use these in synergy with external national and international capacities.

In summary, the association must act in a comprehensive manner to accompany individuals and communities by supporting administrative and technical systems and services, and by advising on national and international mental health policies. Handicap International carries out its mission by implementing actions on prevention, risk management, personal development and adaptation to environmental factors. In this way, the work to improve medical, social and technical provision in conjunction with local stakeholders is designed to meet the expectations and life projects of its beneficiaries. This is accompanied by work to draw up social, legal and technical measures, thereby improving both the physical and financial access to services and social participation.

### Methods

#### Approaches and methodology

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A partnership approach

For mental health, as for the other thematic areas addressed by Handicap International, the first favorable condition (albeit a non-restrictive condition) is to be able to work with local non-governmental organizations or associations representing people with disabilities. Their presence and involvement is essential.

The second favorable condition is to work with the authorities open to this:
- At national level: Political stability, a political desire for decentralization or de-concentration which allows for the implementation of a community-based approach,
- At local level: Local independently managed authorities who accept the rules of participatory development, are aware of disability issues and want to work with a long-term perspective. Here again, the mobilization and interest of the local authorities in the theme of disability prior to the project is not a sine qua non condition for implementing a project. Indeed, in a context in which there is no local political commitment, the project’s activities can be developed in such a way as to prepare and organize advocacy initiatives with the long-term aim of effecting a change in attitudes and policies.

These conditions are qualified as “favorable” as there are situations in which the action must be implemented regardless of whether these conditions are met or not, notably in emergency or post-emergency crises. The type of project, the relationships and collaborations with professionals, the communities and non-governmental organizations and authorities involved should therefore be adapted to the threats and opportunities of the context. In other words, the development of mental health activities should be accompanied by advocacy initiatives designed to change the political and cultural environment and to overcome inertia and reticence in the local authorities and work towards their involvement.

Project methodology

Our quality approach, associated with community and inclusive approaches as translated into the intervention methods (see Intervention methods translate into programming), contribute to ensuring the sustainability of our actions. Handicap International has identified other principles which contribute to this viability, including those focused on the drawing up and implementation of research, monitoring and assessment tools in collaboration with local partners.

As previously mentioned, whether for the purposes of analysis and lesson learning from innovative mental health experiences, or for the purpose of orientating a program’s strategy prior to the implementation of a mental health project, social anthropological research should be made a priority as it makes it possible to collect relevant indicators at all levels of the pyramid of intervention (State, region, district, community, family, individual) and, most importantly, to connect these. The epidemiology may, in some cases, constitute an essential complement to this research and should also be assessed.

It is recommended that the activities are launched in the form of pilot projects rolled out across limited geographical areas. This pilot phase should serve to define, draw up, test, improve, and model the intervention methods at local level, training content and different tools etc. before deploying a system that has been tried and tested on a larger scale.
Throughout the project, it is important to develop the monitoring and assessment tools which will make it possible to follow project development and support the assessment process which will take place at the end of the project. These tools should also be used to re-orientate a project in progress, should it be found that the activities will not enable the project to meet its stated objective. At the end of the project, this work will make it possible to demonstrate whether the action carried out can be adapted and reproduced in another geographical area. With this in mind, Handicap International regularly carries out lesson-learning work with the aim of “learning from experience”.

**Intervention methods translate into programming**

Historically, Handicap International’s mental health interventions have developed in correspondence with how disability is perceived by health care professionals. From a psychoanalytical model which saw disability as an individual pathology, Handicap International moved to a more social anthropological model in which disability is seen as a “social pathology”, resulting from the interaction with an environment which generates “disabling situations”.

This historical process of understanding disability leads to a dual approach:
• On the one hand, supporting and developing initiatives directly aimed at people with disabilities or to prevent disabling situations using a capacity building, participatory approach
• On the other, initiatives which favor taking disability into account in development processes using an inclusive, equal opportunities approach

The participation of people with disabilities should result from the merging of these two approaches with the aim to fight against discrimination, segregation and marginalization.

Thereby, in Handicap International’s mental health projects, these two approaches translate into three intervention methods which strengthen each other mutually.
HEALTH AND INCLUSION

Handicap International’s mental health approaches are comprehensive, which means working:
• continuously: from prevention to healthcare, and from rehabilitation to socio-économic inclusion;
• on different levels: that of the individual and their community, through to national and international.
Improving prevention and access to healthcare

General objective

Provide accessible, high-quality mental health prevention and treatment services.

Specific objectives

- Reduce the incidence of psychological distress/mental disorders by tackling the risk factors and pathogenic situations.
- Improve the quality of life of people living with psychological distress/mental disorders, notably by ensuring their compliance with regard to the care provided.

Expected results

- Improved access for people suffering from psychological distress and/or mental disorders to prevention, screening and mental health services.
- Strengthened health and social services specialized in mental health (primary, secondary and tertiary prevention).
- Health and social institutions and local associations, work more in network in order to ensure continuity in the care management of people living with psychological distress and/or mental disorders.
- Improved information and communication for professionals, people living with mental disorders and/or psychological distress.
- The ability of each individual living with psychological distress and/or a mental disorder to take responsibility for their own mental health, regardless of their social or economic status, is improved.
- The social and health systems targeting people living with psychological distress and/or mental disorders are more effective thanks to improved coordination with other public systems.
- The implementation of specific actions targeting social groups or people with specific pathologies (children and adolescents, female victims of violence, people in vulnerable situations, displaced persons, etc.).
Examples of activities

- Technical support for carrying out workshops for drawing up training plans and Information, Education, Communication (IEC) tools.
- Technical support for implementing specific mental health activities: Individual psychotherapy sessions, mobile multi-disciplinary teams in the community, therapeutic discussion groups, income-generating community support groups, house visits, therapeutic education for the patient and their family, etc.
- Organizational support: the structure and functioning of institutions (health institutions for example) and associations (the life of the association, democratic practices, management, administrative and financial management, etc.).
- Technical support for health professionals: counseling, quality of healthcare, psychopathology, training on systems for supporting clinical practice (clinical supervision, discussion groups such as Balint groups for professionals, analysis of practices, etc.).
- The training of institutional and association trainers.
- Carrying out studies (sociological, knowledge-attitudes-practices of targeted stakeholders and the beginning and the end of the project) to back up intervention strategies and assess the quality of the project.

Examples of objective indicators

- Reduction in the prevalence of mental disorders or psychological distress (requires an epidemiological survey to be carried out before and after the project).
- Increase in the number of admissions/consultations in decentralized and/or centralized mental health structures.
- Improvement in the knowledge, attitudes and practices of the project’s target populations (by integrating a social anthropological dimension and a gender dimension).
- Existence of an institutional project integrating monitoring and assessment tools (healthcare protocols, quality of life assessments, satisfaction surveys) regarding the quality of healthcare and counseling.
- Increase in the number of mental health professionals per 100,000 inhabitants (based on the World Health Organization’s data for the country).
- Increase in the number of tools for monitoring and assessing the country’s health management system (integrating the mental health indicators).
**General objective**

Develop the capacity to act and the social participation of people living with psychological distress and/or mental disorders.

**Specific objectives**

- Use interventions backed up by existing community systems (family, neighbors, associations, community leaders etc.) to improve the mental health of people living with psychological distress and/or mental disorders.
- Promote the approaches used in the projects (community mental health, psychosocial, peer advice) amongst professionals and the general public.
- Create networks of people with disabilities, their families and communities, and mental health professionals in order to work together to advocate for the inclusion of people with disabilities in drawing up the public policies which affect them (health, social, education justice).

**Expected results**

- Training and guidance is provided for community focal points.
- A network of partners (collective, platform or new organization) including people living with psychological distress and/or mental disorders and their families has been set up and organizes joint awareness-raising and advocacy actions.
- National mental health policies integrate the strategic positions on mental health of relevant associations and institutions, notably those of people psychological distress and/or mental disorders and their families.
- Different local partners, notably the decision-makers, institutions and organizations responsible for defining health, social and education strategies and implementing them on operational level, identify psychosocial, mental and/or intellectual disabilities as themes which must be taken into consideration.
**Examples of activities**

- Training and support (supervision) for community workers, psychosocial counselors, mediators and mental health workers.
- Creation of a collective of mental health workers and provision of shared premises and equipment.
- Support for the launch and operation of a forum of mental health users’ institutions and associations, support in structuring this forum.
- Technical and financial support for implementing joint actions between psychiatrists, social workers and patients’ families.

**Examples of objective indicators**

- Increase in the number of peer groups working on a project in a given territory.
- Increase in the number of autonomous mental health community focal points.
- Results of a satisfaction survey of the project’s beneficiaries.
- The number of Information, Education, Communication (IEC) mental health tools produced and the number of professionals aware of the approach used for the project.
- The democratic functioning of the network (representatives elected at regular intervals, a one-year mandate before re-election, a rotating presidency, etc.).
- Minimum number of local associations representing the different types of mental health disability.
- Existence of national mental health policies or a national mental health plan (which impacts on laws and implementation decrees).
- Existence of a budget (usually the Ministry of Health budget) specifically allocated to a mental health program.
Methods

Promoting advocacy and de-institutionalization

General objective

Develop joint advocacy (by people with disabilities, their families, mental health professionals) for the social participation of people living with psychological distress and/or mental disorders, notably by including them in the drawing up of national mental health policies.

Specific objectives

- De-institutionalize mental health services by creating a network of different health, social and community professionals and ensuring their coordination.
- Promote the issue of mental health amongst political decision-makers by promoting (advocacy) awareness-raising and training activities for mental health stakeholders (healthcare personnel, social workers and community stakeholders, such as primary school teachers, religious leaders, traditional practitioners).

Expected results

- The reinforcement of a certain number of community-based actions in order to ensure that people with disabilities and their families can access medical, social, legal and economic services in proximity to their homes which will allow them to participate in social life.
- Care management for people living with mental disorders in community-based establishments, rather than long-stay institutions (hospitals specialized in psychiatry).
- The creation of a multi-factorial network of local services (health, rehabilitation, social, economic, legal) and information, referral and guidance towards these services.
- Support for mental health institutions and professionals to improve resources and skills in order to effectively lobby the political powers in place for the improvement of specialized services to access prevention and care.
- Raising awareness and providing training for local resources within the community and for health, social and education professionals so they incorporate mental health into their day-to-day practices and can implement inclusive development initiatives.
- The integration into national mental health policies of the strategic positions on mental health of relevant associations and institutions, notably those of people psychological distress and/or mental disorders and their families.
Examples of activities

- Carrying out awareness-raising workshops for community workers (primary school teachers, elected officials, technical workers, health, social and educational administrations, lawyers and jurists, health and social centre personnel, teachers, professional trainers, association managers, etc.).
- Participation in drafting and revising national mental health policies.
- Technical and financial support for the implementation or strengthening of a national mental health plan.
- Carrying out of seminars, workshops, support for creating national collectives/forums of mental health professionals and/or institutions.
- Training pools of “disability awareness-raisers”, mental health users, and members of disabled people’s organizations.
- Implementation of an integration, information and advice system.
- Setting up a regional inter-professional platform.

Examples of objective indicators

- Increase in the provision of community-based services and access to these services (health, social, legal and economic) for people living with psychological distress and/or mental disorders, as well as their families.
- Introduction or revision of national mental health policy.
- Increase in the budget for implementing the Ministry of Health mental health plan.
- Establishment of a local information and advice centre for people living with psychological distress and/or mental disorders.
- Increase in the rate of trained and operational mental health professionals and/or community workers operating in the integration, information and advice systems.
- Increase in the number of medical, paramedical and social training courses which include mental health in their curricula.
- Definition of the minimum number of media involved in the project.
- Minimum number of representatives of different types of disabilities carrying out lobbying actions.
Examples of logical frameworks

The examples below show how our three intervention methods can be combined. These combinations mainly depend on the context and local specificities of each country of intervention. These examples are therefore one-offs and not models to be reproduced in other contexts.

Title

Strengthening the community mental health approach by targeting populations in situations of psychological and social vulnerability, notably those exposed to gender based violence in Rwanda.

General objectives

- The Rwandan populations in situations of psychological and social vulnerability, notably those exposed to gender based violence, regain or preserve good mental health by means of an intervention based on existing community systems (family, neighbors, associations of vulnerable persons, etc.).
- Rwandan professionals and the general public are more aware of community mental health approaches.
- The population’s mental health is a cross-cutting issue which is better taken into account in the policies developed by the Rwandan authorities.

Specific objective

- In four of the country’s administrative sectors, populations in situations of psychological and social vulnerability, in particular the victims of gender based violence enjoy improved mental health due to a community mental health approach adapted to the context, within a recognized and sustainable institutional and professional framework.
Expected results 1

Community mental health systems, which rely on community mental health mediators and workers present in the communities of the four targeted sectors are developed and/or reinforced in order to ensure primary prevention for the at-risk groups identified and the provision of care for population groups in situations of psychological and social vulnerability.

Activity 1.1. Identification of population groups in situations of psychological and social vulnerability and drawing up a map of “territorial resources” for each sector of intervention.

Activity 1.2. Identification and training of reference persons and mediators in community mental health intervention methods.

Activity 1.3. Guidance and supervision for community mental health reference persons and mediators.

Activity 1.4. Setting up of curative care provision for the community health reference persons and mediators who request it.

Expected results 2

The population groups in situations of psychological and social vulnerability, and notably those exposed to gender based violence regain or preserve their mental health and increase their “ability to act” due to the implementation of curative and preventative measures involving community mental health reference persons and mediators in the four targeted sectors.

Activity 2.1. Constitution and/or support for population groups in situations of psychological and social vulnerability, with regard to their “ability to take action” and, if required, providing them with psychotherapeutic care management.

Activity 2.2. Constitution of population groups in vulnerable situations with the aim of eliminating the risk factors of psychosocial suffering by implementing primary prevention systems/activities.

Activity 2.3. Implementation of cross-sector coordination to work in network on each sector of intervention.

Activity 2.4. Implement a system for monitoring and assessing the community health intervention providing health training in the sector concerned, and for making a final external assessment.

Expected results 3

Mental health workers in the country harmonize, draw up and/or improve community mental health approaches which are more effective, corresponding to the Rwandan context and understood by the Rwandan authorities and the general public.

Activity 3.1. Organizational support for the Collective of Mental Health Workers in Rwanda.

Activity 3.2. Organization of seminars to present/disseminate community mental health in higher education establishments which provide mental health training.

Activity 3.3. Study trips to other countries in the region.

Activity 3.4. Advocacy towards the Rwandan government to promote mental health by means of a community-based approach.
Expected results 4

The sustainability of the community mental health action is guaranteed due to the implementation or reinforcement of a sustainable local structure, capable of mobilizing the financial, material and human resources required to continue with this approach.

Activity 4.1. Identification and analysis of the different types of national structure available to pursue the project’s community mental health activities and choice of the structure best able to meet this objective.

Activity 4.2. Support for the selected national structure with the aim of restarting the project’s action.

Objective indicators regarding the general objectives

- At the end of the 3rd year, 3,600 people in situations of psychological and social vulnerability have benefited from the project’s care provision and prevention actions.
- At the end of the 3rd year, 400 reference persons and 40 mediators in community mental health run the systems put into place and will continue their intervention after the end of the project.
- The AVEGA, IBUKA and CAFOD associations, the main civil society stakeholders in the mental health sector in Rwanda have improved their mental health interventions to make them more community based.
- A documentary has been broadcast by Rwandan television and radio stations schedule more regular programmes on mental health issues.
- The “community-based health” department of the Ministry of Health includes community mental health in its policy documents and in the practices of community health workers.
- The Ministry of the Family and Gender, the Ministry of Local Administration and Social Affairs, and the Ministry of Education recognize the importance of including mental health issues in their policies and actions.

Objective indicators regarding the specific objective

- At the end of the 3rd year, 75% of people in situations of psychological and social vulnerability in the target sectors affected by the project, stated they felt an improvement in their mental health and connect this with the activities proposed by the project.
- At the end of the 3rd year, the Ministry of Health recognizes the validity of community mental health approaches and these are included in the policies and practices of its “community-based health” department.
- At the end of the 3rd year, a local structure takes over the project activities.
**ECHO Funding**

This project demonstrates how the intervention methods “Improving prevention and access to healthcare” and “Promoting empowerment and social participation” can mutually reinforce each other to improve access to healthcare whilst allowing the community to support children in psychological distress and their families, and thereby improving their social participation.

**Title**

Access to mental health rehabilitation services for children with psychological distress living in Palestinian camps and gatherings in North Lebanon and in Tyre area.

**General objective**

Children with psychological distress (CwPD) living in Palestinian camps (PC) and gatherings in Lebanon have improved access to mental health rehabilitation services.

**Specific objective**

CwPD living in PC and Gatherings in North and Tyre areas of Lebanon benefit from comprehensive Mental Health rehabilitation provided by civil society and care givers.

**Expected results 1**

Care givers of CwPD are actively involved in the therapies of their children.
- Activity 1.1. Identification of care givers of CwPD by community workers coordinated by ROCs (Resources and Orientation Centres).
- Activity 1.2. Organisation by FGC (Family Guidance Centre) and CBRA (Community Based Rehabilitation Association) of information and training to care givers of CwPD.
- Activity 1.3. Facilitation of the creation and running of parents discussion groups by community workers supported by ROCs.
- Activity 1.4. Implementation by ROCs of community awareness campaign related to Children with psychological distress.

**Expected results 2**

Service providers have enhanced and developed quality rehabilitation services for children with psychological distress.
- Activity 2.1. Facilitation of access to technical information for partners’ service providers.
- Activity 2.2. Provision of mental health treatment to CwPD by partners through centre and home based services.
- Activity 2.3. Provision of formal and on the job training in management to partners.
- Activity 2.4. Awareness raising of relevant stakeholders on the situation and challenges faced by CwPD in Palestinian camps and gathering.
Objectively verifiable indicators regarding the specific objective

300 CwPD benefited from quality Mental Health treatment, representing 56% of total need in targeted areas.

Objectively verifiable indicators regarding the expected results

Expected results 1

- 350 care givers of CwPD not involved in treatment process are identified by 30 trained community based stakeholders.
- 85% of the 100 care givers participating in parents discussion groups find it mutually supportive.
- Average number of visitors to the ROCs over a period of 3 months increased by 60% between the beginning and the end of the project.

Expected results 2

- 80% of child treatment process have been implemented following 100 % of the quality criteria set.
- 40 relevant stakeholders (INGOs, NGOs, Donors) have increased their knowledge on the situation of CwPD in Palestinian camps.
- 11264 rehabilitation sessions have been delivered by child professionals of the two centers.
Perspectives for 2011-2015

For the period 2011-2015, the mental health sector in Handicap International is expected to undertake the following:

- Pool the tools for implementing mental health projects and create a common base of reference (CD-Rom).
- Develop a methodological guide for mental health programming.
- Develop quality indicators in order to improve the coherence and visibility of Handicap International’s mental health actions (impact).
- Create closer links between emergency, post-emergency and development (with a cross-sector approach involving Social Inclusion, Livelihoods and Inclusive Education) projects (and notably projects with psychosocial connections) and implementing where necessary, a strategy for ensuring continuity between them.
- Strengthen links with functional rehabilitation projects, in order to better take into account the psychological distress of people with motor, visual and hearing impairments.
- Better define and assess the psychological distress of people in disabling situations affected by natural disasters and armed conflict.
- Make the sources of mental health funding more visible in order to increase the number of mental health projects.
- Strengthen technical expertise at head office and in the field, by increasing technical resources (head office, local and expatriate).

End of Intervention methods
# HISTORY OF MENTAL HEALTH AT HANDICAP INTERNATIONAL

- Genesis
- Projects history
- Current situation

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# FOOTNOTES

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History of mental health at Handicap International

Genesis

In 1991 Handicap International’s management sought the support of Lyon-based psychiatrists and psychologists, as a number of expatriate staff members were facing (personal or professional or both) difficulties due to the stressful, complex and sometimes violent contexts in which they were working. The psychological distress expressed by Handicap International expatriate staff in Romania, after the fall of the Ceausescu regime was heard both by an expatriate psychologist and by one of Handicap International’s senior managers. This led to the implementation of an original system of monthly supervision sessions carried out by a group of six practicing psychiatrists and psychologists. This offered those expatriates facing major difficulties (in their interactions with both abandoned children and the staff working in orphanages – both of whom had also been abandoned by the Romanian regime) the opportunity to speak to a third-party with some awareness of the situation and its emotional impact: Feelings of emptiness, invasion, being reduced to nothing, the emergence of non-sense. This continuous work over two years helped expatriate staff to express their difficulties and discover their own inherently conflicting feelings in the difficult context of violence in Romania.

This experience in Romania, clearly shows that an individual can, in a given situation, come into conflict with the surrounding environment, with others and with himself (in this case, the situation of being expatriated to a neighboring European country reinforced the mixed feelings: of false familiarity and also of “worrying strangeness”). This also raises the difficult issue of the difference between what is normal and what is pathological, and of the weight of the political, social and cultural context, as well as the individual’s own history.

The foundation and objectives of this group of mental health professionals were therefore established:

- Build on clinical psychology, in particular psychodynamic therapy, to reinforce links (inter-subject) between individuals and groups where, at each moment of the meeting, the protagonists are involved in an action defined by the situation in which they meet and the interaction between them
- Open up spaces for discussion to support professionals working with the teams who work in direct contact with sufferers
- Interlink, at different levels of psychical working out, what has been lived through in situ, and what can be understood, transformed, created

Having started out as a simple, internal support service to better understand the difficulties experienced by expatriate staff during their mission, this group of professionals then went on to implement and supervise mental health projects for Handicap International, aimed at populations caught up in the conflict in the former Yugoslavia and formed the “psychosocial resource group”.

In 1998, this became the Psychology Technical Coordination Unit. From 2001 the Psychology Technical Coordination Unit this was managed by a clinical psychologist and formed part of Handicap International’s Health, Care and Rehabilitation Unit from 2004 - 2009.
Projects history

1990 – 2003
In Romania, direct interventions in Romanian orphanages which evolved into supervision and support for the training of care professionals working in orphanages and centers for mothers (discussion, support, guidance) through discussion between Romanian and French professionals.

In the former Yugoslavia, from the start of the emergency phase, psychological support was provided for refugees fleeing the conflict on the Croatian coast, and for children, adolescents and their families traumatized by war.

1993 – 1995
In Egypt, support for a project for people with disabilities.

1994 – 1998
In the South of Tunisia, follow-up and support for the mobile team working with children with disabilities.

1995 – 2007
In Rwanda, a diverse program supporting unaccompanied children and widows, victims of the war and genocide. Very quickly, the program focused on mental health care for children in orphanages and Unaccompanied Children’s Centers using a range of methods: Creative workshops, art therapy groups, individual psychotherapy. Then, in light of the reunification policy implemented by the Rwandan State “a family for every child” support was provided for children and families engaged in this process by a psychosocial team. In parallel, actions were developed for children with mental disabilities or with multiple disabilities who more than other populations, were suffering from abandonment. Help was provided to take into account this population and provide access to education. Then psychosocial support and mental health care for so-called “reunited” children, orphans, and street children in partnership with several local associations. A series of awareness-raising actions in mental health for teachers, working with educators from children’s centers through practice analysis groups, and creating places for outpatient care with these partners for children, adolescents and young adults.

1995 – 1997
In Mozambique, psychological support for child soldiers, in liaison with the local association Associação Moçambicana de Saúde Pública (AMOSAPU).

1996 – 2007
In Sierra Leone, psychological support for people affected by war; guidance for professionals at centres for former child and adolescent soldiers and centers for orphaned children; guidance for rehabilitation teams; training for social workers in partnership with the Freetown Institute of Social Workers; and work with street children in Freetown.

1996 – 1998
In France, support for voluntary academic support workers for children and adolescents with disabilities (ranging from motor disabilities to autism via numerous other pathologies). A group was set up for analysing practices with regard to the follow-up of children and adolescents about whom support workers had raised a large number of issues, notably the position to take in relation to the parents, issues of attachment and separation etc.
1997 - 2003
In Russia, partnership with different associations working with children with mental disabilities and presenting psychiatric disorders, in order to promote comprehensive care management which includes the psychic aspects of adolescents and young adults with mental disabilities.

1997 - 2005
In Burkina Faso, development of a local medico-psychological health care structure for children, adolescents and adults. Development and support for structures which take in abandoned children and a mother and child accommodation centre.

1999 - 2003
In Albania, psychological support in Spring 1999 for refugees from Kosovo. From 2000 - 2003, contribution to the development of clinical psychology in Albania in partnership with the Albanian association of clinical psychologists “Return to Self” which works with infants and premature babies hospitalized in maternity units.

1999 - 2009
In Algeria, support for sharing experiences between stakeholders (health, mental health, etc.) opening up to autistic children, children with serious and/or fatal disabling diseases, children with mental disabilities, children abandoned at birth due to their disability, or disabled due to their abandonment. Support for rehabilitation professionals. Support for parents in associations of families of people with muscular dystrophy.

2002 - 2004
In Senegal direct and indirect psychological support for the victims of antipersonnel landmines. Setting up a framework for psychological listening and support, training and guidance for professionals in health care centers.

2002
In Palestine, in partnership with the local association Guidance and Training Center for the child and family (GTC), psychological support for children and families, victims of the conflict in the occupied territories.

Since 2003
In Lebanon, a psychosocial support project for Palestinian children and families living in refugee camps in Lebanon, by means of a guidance and advisory service for children suffering from psychological distress and the provision of support for the various professionals working with these children and their families. Since the war in July 2006, numerous training courses have been offered to teachers on the early detection of mental disorders and the implementation of activities for therapeutic mediation.
Current situation

In 2009, the Psychology Technical Coordination Unit was replaced by the Mental Health Sector as part of the restructuring of the Technical Resources Division.

Today, Handicap International’s mental health projects, generally speaking, seek to tackle any types of vulnerability or risk factors which lead to, or can lead to, psychological distress and/or mental disorders reducing a person’s defence capacities and ability to adapt to the social, cultural and political demands of his surrounding environment. The approach adopted remains the same, i.e. an essentially community-based approach which aims to strengthen local capacities (local patient associations, health systems, social systems and networks) in order to ensure comprehensive action is taken, from prevention to health care and socio-economic inclusion. Handicap International is also trying to set out its methods with a factual basis using socio-anthropological studies and giving priority to multi-disciplinary actions. Sustainability is a constant concern, in terms of guaranteeing access to services for the most impoverished and the continuity of actions by strengthening health systems at regional and national levels. At the time of writing, Handicap International currently implements mental health projects in Rwanda, Burundi, Algeria, Kenya, Bangladesh, Lebanon and Madagascar.
Policy paper bibliography


- La santé mentale des Canadiens : vers un juste équilibre, Minister Of Health-Canada. 1998.


Handicap International publications bibliography

Clinical psychology and psychiatry

ALGERIA


BURKINA FASO


EGYPT

Let’s play at your place: an experiment in a community based approach in caring for persons with mental disabilities in three underprivileged neighbourhoods of Caro, Richardier Eve, Handicap International, 1995, 26 min.

FORMER YOUGOSLAVIA


FRANCE


KENYA


INDONESIA


LEBANON


ROUMANIA


RWANDA

- Enfants non accompagnés au Rwanda, Lasnepre Céline, Nziguheba Augustin, in Sud-Nord n°17, 2002, p. 107-114

SIERRA LEONE

- The Psychological impact of the civil war in Sierra Leone, Em Gbegba Victor, Koroma Hassan, Document réalisé dans le cadre d’une intervention au Congrès International de la santé mentale face aux mutations sociales, Lyon, Octobre 2004.
- Enfants de la guerre en Sierra Leone, Gomez Paula, in Sud-Nord n° 17, 2002, p. 123–130
- Sierra Leone and civil war: neglected trauma and forgotten children, Heeren Nicolas. in Revue Humanitaire n° XX, 2004, 7 pages.

Lesson-learning documents

ALGERIA PROGRAM

Le groupe de parole de mamans d’enfants handicapés moteurs en situation de dépendance en Algérie, 2009.
Les groupes de parole de soignants de type Balint en Algérie, 2009.
Une expérience de trois années de pratique et d’accompagnement psychologique à domicile des familles et des personnes atteintes de maladies neuromusculaires, 2010.

BANGLADESH PROGRAM


FRANCE PROGRAM


LEBANON PROGRAM

Pilot project on mental health among Palestinian refugee children and adolescents in Lebanon, Findings and recommendations after one year of work, 2004.
Towards psychological well-being of Palestinian Youth in Lebanon, 2006.

MADAGASCAR PROGRAM

Les groupes de parole en prison.

MORROCCO PROGRAM


RWANDA PROGRAM


SHARE-SEE PROGRAM

Call me by my name: Glimpses into self-determination of people with disabilities in South-East Europe, 2004.

TUNISIA PROGRAM

Study reports


Tools


- Harvard Program In Refugee Trauma. Harvard Trauma Questionnaire. Six versions according to cultural contexts.


Mental health reference websites

Links valid on 19th July 2011.

Mental health organizations of families and users

Alcohol Anonymous: http://www.aa.org

European Federation of Associations of Families of People with Mental Illness: http://www.eufami.org

International Rehabilitation Council for Torture Victims: http://www.irct.org

World Fellowship for Schizophrenia and Allied Disorders: http://www.world-schizophrenia.org and http://www.wfmh.org/00CtrCarerConsumer.htm

World Network of Users and Survivors of Psychiatry: http://www.wnusp.net

Research / Lessons-learned / Approaches

Association Internationale d’Ethnopsychanalyse http://www.clinique-transculturelle.org

Association Québécoise pour la Réadaptation Psychosociale http://www.aqrp-sm.org

Department for International Development (DFID) http://www.dfid.gov.uk

Ethnopsychiatrie http://www.ethnopsychiatrie.net

Fogarty International Center http://www.fic.nih.gov
Forced Migration Online
http://www.forcedmigration.org/psychosocial

Groupe Urgence Réhabilitation Développement
http://urd.org

Harvard Program in Refugee Trauma
http://hprt-cambridge.org

International Network on the Disability Creation Process:
http://www.ripph.qc.ca/?rub2=0&rub=nouvelles&lang=en

Lancet (The) - Global mental health
http://www.thelancet.com/series/global-mental-health

Médecins Sans Frontières - Capitalisation
http://fieldresearch.msf.org/msf

Méthodologie du Je au Nous
http://www.dujeaunous.com

National Institute of Mental Health
http://www.nimh.nih.gov

Peace Building Initiative:
http://www.peacebuildinginitiative.org

Réseau documentaire en santé mentale
http://www.ascodocpsy.org

Sexual Violence Research Initiative
http://www.svri.org/index.htm

Université de Genève - Recherche
http://www.unige.ch/collaborateurs/recherche/profil.html

Wellcome Trust
http://www.wellcome.ac.uk

Handicap International’s main partners

Association française de psychologie communautaire

Cittadinanza:
http://en.cittadinanza.org

Psychologues pour les peuples dans le monde (convention technique de partenariat signée en 2009)
http://www.psipopoli-trentino.org/index.html

Main community mental health networks

Global Forum for Community Mental Health
http://www.gfcmh.com

Global Journal of Community Psychology Practice
http://www.gjcpp.org/en

Mental Health and Psycho Social Support Network: http://www.mhpss.net

Mental Health Community
http://www.mhcommunity.net

Mental Health Social network
http://www.mentalhealthsocial.com

Movement for Global Mental Health
http://www.globalmentalhealth.org

Society for Emotional Well-being Worldwide
http://www.seww.org

Other international organizations, non-governmental organizations and platforms involved in mental health

Action Contre la Faim
http://www.actioncontrelafaim.org

Basic Needs
http://www.basicneeds.org
Christian Blind Mission (CBM)
http://www.cbm.org

Convention on the Elimination of All Forms of Discrimination against Women

Inter-Agency Standing Committee
http://www.humanitarianinfo.org/iasc

International Crisis Group
http://www.crisisgroup.org

Médecins du Monde (MDM)
http://www.medecinsdumonde.org

Médecins sans Frontières (MSF)
http://www.msf.fr

Observatoire National des pratiques en Santé Mentale et Précarité
http://orspere.fr

Save The Children
http://www.savethechildren.org

TPO (transcultural psychosocial organisation)
http://www.healthnetinternational.org/nl

Word Federation for Mental Health
http://www.wfmh.org/index.html

World Health Organization
Social determinants of health

**Funding opportunities**

Agence Française de Développement (AFD)
http://www.afd.fr

Big Lottery Fund
http://www.biglotteryfund.org.uk

Délégation Catholique pour la Coopération (DCC)
http://www.ladcc.org

Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)
http://www.gtz.de/en

ECHO - European Commission Humanitarian Aid department
http://ec.europa.eu/echo/index_en.htm

European Union
http://europa.eu/index_en.htm

Fondation Accentus
http://www.accentus.ch/english/index.htm

Institute for Foreign Cultural Relation
http://www.deutsche-kultur-international.de/en.html

OAK Foundation
http://www.oakfnd.org

United States Agency for International Development
http://www.usaid.gov

World Bank
http://www.worldbank.org
1. Mental illness is the cause of stigmatization and discrimination. In traditional societies, people living with mental health problems are often rejected by the community and struggle to return to full socio-professional inclusion, even when their problems are resolved.

2. This “invisibility” results less from the difficulty in perceiving psychical suffering (compared to mental impairments for example) than the fact that the specificities of the consequences of mental suffering by society are not taken into account. This is all the more the case as the lack of perception is relative, given that the effects of mental illness and its treatment on the person’s physical appearance are most often both visible and worrying.

3. “Addressing” goes much further than simple referral. This involves personalized guidance which takes into account the person’s needs and resources given the specificity of their mental issues.

4. Sources:
   - Benedetto SARACENO, World Health Organization, Director of the Mental Health and Substance Abuse Department, *Strengthening mental health systems in low and middle income countries*, International meeting, Rimini, 21–24 April 2009.


6. This section is inspired by the following document: Boisson M., Godot C., Sauneron S. *La santé mentale, l’affaire de tous. Pour une approche cohérente de la qualité de vie*. Paris: Centre d’analyse stratégique, 2009, p. 20–24. The speech marks indicate quotes from this report, unless otherwise indicated: http://lesrapports.ladocumentationfrancaise.fr/BRP/094000556/0000.pdf

7. With regard to psychosocial suffering, psychosocial clinical practice takes into consideration all situations which generate exclusion and social vulnerability: Poverty, homelessness, breakdown of family and/or social relationships, unemployment, loss of status, recognition or value, loss of what allow us to form relationships. Psychosocial clinical practice is at the crossroads of psychiatry and the social sector. It is defined by the taking into account of mental suffering when this manifests in social spaces, when “social objects” (mainly work, money, housing) are lost. At this level the difference between a psychiatric pathology and psychical suffering is no longer relevant as this psychosocial suffering is a new reality which requires new methods for coordination between stakeholders in order to treat it. In the absence of this coordination the clinical forms of the expression of suffering cannot be relieved by support and assistance which address them.


9. DSM IV (Diagnostic and Statistical Manual, revision 4) is a tool for the classification of mental disorders published by the American Psychiatric Association. It is the result of efforts over the last thirty years in the United States to more accurately define these disorders.

10. ICD 10 (International Classification of Disease, revision 10) is published by the WHO to record the causes of morbidity and mortality of human beings across the world. Since 1893 (publication of the first version) the ICD allows us to categorize diseases, traumas and all health problems which result in a consultation with health services.


13. The dual inscription, both social and psychological, of suffering stokes the controversy on the “psychologization of society” or the “medicalization of social issues”. It is largely aporetic, this intrication being characteristic of the “general mindset” of our societies, where the “concepts of project, motivation and communication are today the norms” which structure how we live together. The language of “mass individual vulnerability” allows us to name the new tensions in people’s life pathways characterized both by personal responsibility and insecurity (see Ehrenberg E., La Fatigue d’être soi. Dépression et société, Paris, Odile Jacob, 2000).

14. See the seminal works of Hélène Strohl and Antoine Lazarus: Une souffrance qu’on ne peut plus cacher, Délégation interministérielle à la ville, 1995, on vulnerability, and of Christophe Dejours, Souffrance en France. La banalisation de l’injustice sociale, Paris, Seuil, 1998, focusing more on work.

15. This is not without contradictions. The aspirations of individuals, in relation to the environment, mean they have more or less stringent demands: The more demanding they are, the more opportunities they have for satisfaction, but also dissatisfaction and the risks to their mental health increase, see Henry B. Murphy, Comparative psychiatry: the international and intercultural distribution of mental illness, Berlin New-York, Springer-Verlag, 1982.


17. Concepts are more cross-disciplinary such as psychological “maturity” understood as control acquired on several levels: Feeling of coherence in identity, intimacy (ability to bond without fear of losing one’s self), generativity (ability to take an interest in others outside of their usual entourage), integrity (ability to consider their life with satisfaction), etc., Erik Erikson, “Growth and Crisis of the ‘healthy personality’”, Childhood and Society, New-York, WW Norton, 1950.
18. In his definition of the results of the “cure” Freud accepts “the ability to love and work” as the norms of psychological well-being, something which is very close to the idea of “functioning”. Psychoanalytical tradition also conceives mental health in relation to the expression of internal energy, which, when not suppressed, allows the person to fulfil their intellectual, sexual and emotional aspirations and refers to “personal fulfillment”. Defense mechanisms, the strength of self and the intra-psychic dynamic are also concepts coherent with positive health as an ability to adapt. In North-American mental health definitions, the concept of the ability to adapt is however more standardized and places greater emphasis on avoiding suffering, whereas the psychoanalytical approach recognizes the role of suffering in psychical work. These theoretical differences have an impact on care management. See Viviane Kovess-Masféty, Épidémiologie et santé mentale, Paris, Flammarion, 1996.


http://lesrapports.idocumentationfrancaise.fr/BRP/094000556/0000.pdf

21. Social functioning is the person’s (or group’s or collective’s) ability to play a role within society. It refers to the accomplishment of various social roles, a range of observed behaviors (gestures, words, attitudes), mental processes, an individual’s ability (or inability) to organize their daily life. Highlighting this process improves understanding of the rehabilitation and psychosocial rehabilitation approaches, focused on re-establishing autonomy (by building capacities and relationships with the environment). The Global Assessment of Functioning (GAF) scale, contained in the DSM-IV, assesses psychological, social and professional functioning on a continuum which runs between mental health and mental illness. On a scale of 100, different states are graded from “Superior functioning in a wide range of activities” (score from 100 – 91) – “life’s problems never seem to get out of hand, is sought out by others because of his/her many positive qualities” –, to serious symptoms or serious impairment in social, occupational, or school functioning (score from 50 – 41) – “no friends, unable to keep a job” – “Persistent danger of severely hurting self or others” or “persistent inability to maintain minimal personal hygiene” (score from 10 – 1).

22. Source: Fougeyrollas P., St-Onge M., Le modèle du Processus de production du handicap et son potentiel pour mieux comprendre et intervenir sur les déterminants de la participation sociale et de l’exercice de la citoyenneté en santé mentale

24. Project’s which aim to improve the positive mental health of individuals are not a major theme in mental health. In these cases, mental health is a secondary objective or indirect impact resulting from activities implemented under the project framework to address other themes (disabling diseases, orthopedics, social inclusion and economic inclusion etc.).


31. Source (with the authors’ permission): Santé mentale et droits humains - Un compendium pédagogique - L’approche de genre, un défi pour la santé publique et les droits humains, entretien avec Jane Cottingham, responsable technique Santé et Recherche génésiques, et Claudia Garcia Moreno, coordinatrice Genre et santé des femmes, Organisation mondiale de la Santé.


33. Some mental health problems have different characteristics and rates of prevalence with regard to gender. For example, the prevalence of depression, anxiety disorders, eating disorders and suicide attempts is higher for women than for men.

34. Men and women do not solicit the same type of care for example. See http://www.cwhn.ca/fr/node/41860


40. This section of the Policy paper appendix was written by Isabelle-Anne Rouby, former Head of the Psychology Technical Coordination Unit

End of the appendices.
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Mental health in post-crisis and development contexts

This policy paper describes Handicap International’s mandate and values in operational terms applied to mental health in post-crisis and development contexts. It presents the approaches and reference elements for Handicap International’s actions, choices and commitments. It aims to ensure coherence in terms of practices whilst taking into account differing contexts. So this is a guidance document for the teams working on mental health. It defines the topic and explains its relationship with the mandate of the organization. It also outlines the target populations, methods of intervention (expected results, activities), indicators for monitoring and evaluation. This policy document aims to ensure that all projects and activities carried out by programs are consistent with the modalities of intervention presented.