Community Development and Mental Health Promotion

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Abstract

It is estimated that 450 million people are experiencing mental illness at any one time, most of whom live in developing countries and a great majority of them being women (World Health Organization, 2001). Mental illness affects one in four people at some stage during their lives. This paper based on a review of literature delineates the scope of community development in mental health promotion. To make more meaning relevant Australian references are utilised in this review essay. Mental illness is common in Australia with one in five Australians experiencing a mental illness at some stage in their lives, and many experiencing more than one mental illness at one time (Mindframe National Media Initiative, 2011). In this paper the authors review perspectives currently available for health promotion in social work in relation to mental health. The authors emphasise the importance of strength-based community development perspectives in mental health practice and an attempt is made to put forward an integrated model for addressing mental health issues in a community context. The model looks at highlighting the need for developing and sustaining community spirit and promoting resilience in communities.

Keywords: Mental health, Community development, Strengths perspective, Gender issues, Women’s health

Introduction

As an important practice method in social work and human service, community development offers high impact and has a high propensity to bring people together through a range of initiatives that assist individuals, families and neighbourhoods to feel empowered. As a method it lets the community voice into the mainstream.

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In this paper, we look at the efficacy of community development in mental health promotion. In today's world, the issue of mental health is everyone's business; therefore, ‘the need for mental health promotion is universal and of relevance to everyone’ (UK Department of Health (DH), 2001, p. 28). The questions that this paper considers are:

- Can the process of community development empower and help communities realise good, robust mental health?
- What proactive steps are needed to make sound mental health a local reality?

Attempts to approach mental health in community practice are significantly impacted by concerns within the community relating to stigma towards mental health needs and the varying degree of community responses towards stigma. This is the starting point for the practice of community development or working with people.

The inset below relates to the alarming figures for mental health the world over and Australia. To make more meaning, the authors utilise Australian references in this review as one in five Australians experience a mental illness at some stage in their lives and many report more than one mental illness at one time (Mindframe National Media Initiative, 2011; World Health Organization [WHO], 2003).

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<th>World at large</th>
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<td>One in four families has at least one member with a mental disorder. Family members are often the primary caregivers of people with mental disorders. (WHO, 2003, p. 4)</td>
<td>One in five (20%) Australians experience a mental illness in any year. The most common mental illnesses are depressive, anxiety and substance use disorder. (Black Dog Institute, 2012)</td>
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The extent of the burden of mental disorders on family members is difficult to assess and quantify, and is consequently often ignored. However, it does have a significant impact on the family's quality of life. In addition to the health and social costs, those suffering from mental illnesses are also victims of human rights violations, stigma and discrimination, both inside and outside psychiatric institutions. (WHO, 2003, p. 4)

Despite the numbers affected by mental illness, those experiencing it battle not only the symptoms and effects of the illness, but an accompanying stigma and shame (Bland, Renouf & Tullgren, 2009). A widening gap exists between the need for appropriate supports and resources for those with a mental illness and their families, friends and carers and the actual services available (WHO, 2011). As a result, social workers are likely to work with people experiencing mental health issues in almost every area of practice (Bland, Renouf & Tullgren, 2009). In their work, ‘the intentional utilization of a community resource – social capital – can
foster a sense of belonging which supports recovery and social inclusion for people
with major mental health problems’ (Fieldhouse, 2012, p. 584).

The above facts are quite disheartening and compel us to look at proactive
ways to respond at local levels. A community development approach is very likely
to bring a shift in the focus of the delivery of services and programs to the
communities, where community members have an opportunity to become more
involved in the process of bringing changes in their own lives and those of their
communities. The challenge, however, is in the processes that are utilised to
empower the communities so that the vision of mentally healthy communities
becomes a reality. Community development case studies from around the world
have demonstrated that when the community is involved and when the communities
own the projects, the creativity and power of the communities are visible in their
actions. Such a change is foreseen in this paper that, when communities are
empowered to take control of their situation, they will excel in their efforts to
address the issues. This is the hope in which this paper is written and by doing so
we aim to discuss some strategies and offer suggestions for future practice in the
field of community development.

**Understanding Community Development (CD)**

This book itself is about community development; therefore the authors of this
chapter delve only into some salient features of community development (CD).
CD processes involve ‘working with communities to help them identify workable
solutions to the problems they have identified … listening to and supporting the
local people to progress these solutions to their own problems’ (Burchill, Higgins,
Ramsamy, & Taylor, 2006, p. 52; Stephens, Baird, & Tsey, 2013, p. 277). Thus,
community development is a process in which social and political change can be
orchestrated. Taylor, Wilkinson and Cheers (2008, p. 22) define community through
two broad understandings: one is through a geographic or locality-based
understanding and the other is the relational concept of community which is the
interactions and social ties that pull people together. However, Kenny (2011) offers
multiple perspectives of what a community can be. Her conceptualisation includes:

- People who share a common identity – such as ethnicity or religion
- Physical location – such as a geographical area (Kenny 2011, p. 8).

Communities are important as they serve to fulfil a desire to be in a relationship,
belong and to be connected to others (Wheatley & Kellner-Rogers, 1998, p. 15).
Community development is a process in which social and political change is
organised; it is an approach or philosophy as well as a job or profession. It is
through processes, practices and visions that communities are empowered to take
united responsibility for their own development and that the aim of enabling
communities to have effective control of their own futures is realised (Kenny, 2011).
‘There is growing international interest in community development (CD) approaches
to addressing mental distress and promoting mental well-being, generated by major changes in mental health policy, provision and the growing voice of mental health service users’ (McCabe & Davis, 2012, p. 506).

Three core issues that have emerged from the review of literature are:

• The tendency of targeted or whole population mental health promotion interventions to be rooted in models of community pathology rather than individual and collective strengths;

• The focus of mental health policies on individual determinants of, and responsibilities for, mental health and wellbeing, which frame CD as a ‘value-free’ approach to promoting self-help rather than a challenge to the structural inequalities associated with mental health and distress;

• How ‘measures’ of the impact of CD as a long-term process of change are compromised in a policy environment favouring brief interventions and outcomes. (McCabe & Davis, 2012, p. 507)

**Mental Health, Mental Health Problems, and Mental Illness**

Mental health is integral to overall human health and wellbeing. However, when people narrowly define mental health, it may be conceptualised as the absence of mental illness. Recognition that mental health influences many aspects of people’s lives, including how people feel about themselves, how people feel about others and how people are able to meet the demands within their lives, has led to a broadening of this definition. In such a broad sense, mental health can be thought of as representing the balance of physical, social, spiritual and emotional wellbeing. Mental health impacts on the ways in which individuals manage their surroundings and make choices in their lives. While mental health is often discussed at the level of the individual, by extension it is clear that positive mental health is a significant factor in determining the wellbeing of communities. It is also clear therefore, that the presence of mental health problems and illness in individuals will also have impacts at the wider community and societal levels.

The terms ‘mental health problems’ and ‘mental illness’, while often contested, refer more specifically to the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people. Mental health problems are the most commonly reported type of mental health complaint and are commonly the result of a reaction to life stresses or negative life experiences. A mental health problem can interfere with an individual on a cognitive, emotional, behavioural or societal level, but is characterised as being a temporary impairment or a situation with a less dramatic impact than a mental illness or disorder. However, it is broadly accepted that many mental health problems have the potential to develop into a full mental illness if not addressed in appropriate and timely responses.

Mental health is a positive concept related to the social and emotional wellbeing of individuals and communities. The concept is culturally defined, but generally
relates to the enjoyment of life, ability to cope with stresses and sadness, the fulfillment of goals and potential, and a sense of connection to others. The term ‘mental health’ is often misunderstood and interpreted as referring to mental ill-health. This can be confusing, especially since our ‘mental health services’ have been mostly concerned with the treatment of mental illness, rather than mental health per se. (Hunter Institute of Mental Health, 2013, Para 1)

By comparison, a mental illness, or disorder, is a diagnosable condition that severely interferes with an individual’s cognitive, behavioural and emotional wellbeing, preventing them from engaging coherently in social activities that would otherwise be a simple task. Mental illnesses come in a wide variety, each with its own symptoms, impacts and degree of severity. There are many major mental illnesses that can affect the public on either a micro, meso or macro level. As Bland, Renouf and Tullgren point out,

Mental illness doesn’t occur in splendid biological or genetic isolation; it evolves out of the messy reality of our lives (epidemiological factors). The ‘knock-on’ effects of mental illness in our lives may include homelessness, poverty, estrangement from family and friends, underemployment or unemployment, and a myriad of other experiences that speak of our marginalisation or otherness. This is the ‘lived experience’ of madness, and for each of us it is unique. (2009, p. 21)

Mental problems and illness alter the way people think and how they perceive their environments. They can affect levels of hope, trust, self-efficacy and personal relationships, thereby clearly having knock-on effects on community wellbeing. Mental illness comprises the construction of our identities at a time when we are trying to make sense of who we are, meaningfully and coherently, in relation to ourselves, others and the wider society (Bland et al., 2009, p. 23). The World Health Organization states that mental health is ‘a state of well-being in which the individual realises his or her own abilities, can cope with the normal stressors of life, can work productively and fruitfully, and is able to make a contribution to his or her community’ (WHO, 2001, p. 1). This definition focuses our attention on the need to adopt a positive approach to issues of mental health, and suggests that there is great potential for preventing the emergence of mental illness by focusing on building strong and resilient communities, characterised by positive mental health.

**Mental Health Promotion**

Mental health promotion is any action taken to maximise mental health and wellbeing among populations and individuals. Mental health promotion is applicable across the entire spectrum of mental health interventions and is focused on the promotion of wellbeing rather than illness prevention or treatment. It is
based on the premise that the emotional and social wellbeing of everyone in a community can be enhanced through promotion activities that build the community’s capacity to support mental health. (Commonwealth Department of Health and Aged Care, 2000, p. 29)

People with a mental illness can be among the most disadvantaged in society, and they often confront many barriers as a direct result of their illness. Stigma and discrimination are major barriers and can often be worse than the illness itself. Changing perceptions about mental illness can go a long way towards breaking down some of the barriers that stigma and discrimination create (Mental Health Council of Australia, 2013). Mental health promotion incorporates any action taken to maximise mental health and wellbeing among populations and individuals by addressing the potentially modifiable determinants of mental health. This includes:

- Influencing the social and economic factors that determine mental health, such as income, social status, education, employment, working conditions, access to appropriate health services and the physical environment;
- Strengthening the understanding and the skills of individuals in ways that support their efforts to achieve and maintain mental health.

Mental health promotion focuses on enabling people to maximise their wellbeing through influence on the social determinants of mental health. Where social environments promote good mental health and reduce harm, and individuals are equipped with the skills to maintain mental health, improvements in quality of life, resilience and social and economic participation are often observed. The gains from mental health promotion activities often extend to improvements in physical health as well as productivity in the school, home and workplace (Commonwealth Department of Health and Aged Care, Australia, 2000). Community development is premised on the assumption that improving the mental health and wellbeing of children, adolescents and their families can only be achieved through working in partnership with the community (WHO, 2004a). It is clear that mental health services cannot work in isolation, but must work together in an integrated way. Moreover, mental health services have a responsibility to strengthen the ability of services to manage the needs of children whose needs are being met in the community. This is an area where we see CD processes promoting the importance of service integration and co-ordination; access to the service for communities with special needs; early intervention and mental health promotion initiatives; and client participation strategies.

**Approaches to Practice**

While biomedical responses to mental illness predominate in the field, there are a number of different approaches that can be utilised in communities that resonate with the core concerns of social work, relating to human rights, self-
determination, family relationships and welfare, employment, housing, community and life chances (Bland, Renouf, & Tullgren, 2009). An important aspect of social work in community development may be valuing the lived experience of community members with mental illnesses. Certainly, concerns with participation and empowerment, and issues of social inclusion/exclusion of people with mental illnesses in our communities require addressing; these issues and concerns can be very effectively addressed through community development and health promotion. An emphasis on strengths rather than deficits (Pulla, 2012; Francis, 2013a, 2013b) and practice of a level of critical consciousness and belief in anti-oppressive work are important in community development as well. It may sound rather radical, but for community development practitioners who work with a strengths approach, it is all about those very principles of partnership, mutuality and empowerment in the face of recovery and building hope which in the first place could not have been achieved if the lived experience of consumers/clients and their families and carers was discounted (Pulla, 2013). In practice this means that strengths-based community development workers will take time to build a relationship of trust and respect for each other, and the position and experience of both the facilitator and the client. They will be open and transparent about the position they hold, the responsibilities that they have, the rights and responsibilities of the clients and the communities and the processes that are open to them both. The responsibility for caring for the relationship is taken by these community development facilitators. The responsibility for change and outcomes is not. The facilitator takes care of the development of conditions that support change. The client owns any change and is encouraged to recall the story of their own success – not that of the facilitator. The strengths-based mental health practice will ensure that there is great emphasis on partnership and mutuality; that social workers recognise the value of families and carers, and that people are recognised, not as labelled or diagnosed individuals, but as people (Pulla, 2013).

The above perspective is an increasingly significant and influential perspective within social work, based on the belief that individuals and communities possess abilities and inner resources that allow them to cope effectively with the challenges of living (Rothman, 1994; Weick 1983; Weick & Pope, 1998, all as cited in Brun & Rapp, 2001, p. 279; Pulla, 2012, 2013; Francis, 2012, 2013a, 2013b). This perspective emerges as particularly important when applied to work in the field of mental health, and has been recognised as having relevance to practice at both individual and community levels. According to this perspective, all people and service users can be seen in the light of their capacities, talents, competencies, possibilities, visions, values and hopes, however dashed and distorted these may have become through circumstance (Saleebey, 1996).
Given its humanistic roots, at the core of the Strengths Perspective is the belief that humans have the capacity for growth and change (Early & GlenMaye, 2000). In addition, believing that people are capable of making their own choices and taking charge of their own lives promotes empowerment. It means that human beings have the potential to use their strengths and overcome adversity as well as to contribute to society (Cowger, 1994). It implies a belief that people are doing the best they can (Weick, Rapp, Sullivan, & Kisthardt, 1998), as is reflected in the following underlying assumptions:

- Every individual and every environment have strengths and resources, that is, knowledge, talents, capacities, skills, and resources to mobilise in order to pursue their aspirations (Saleebey, 2009).
- People who face adversity typically develop ideas, capacities, and strategies that eventually serve them well (Saleebey, 2009). In other words, every individual is resilient.
- All human beings have an innate capacity for health and self-righting, which is a drive, a life force that heals and transforms.
- Almost always, people know what is right for them. This requires a nonjudgmental attitude; instead, the principles of knowing what is best and doing what is best places the power of decision where it should be—with the person whose life is being lived (Weick et al., 1998, p. 353).
- A personal, friendly, empathic, and accepting relationship provides the atmosphere for healing, transformation, regeneration, and resilience.

Working from a strengths perspective requires a paradigm shift away from a deficit (problem-focused) model of practice to one that aligns with possibility, promise and hope for the future. Emphasising agency and capacity may increase a person's potential for positive change and reinforce the importance of resilience and empowerment (O'Connor, Wilson, Setterlund, & Hughes, 2008). When 'problems' are reformulated this way, therapy becomes 'possibility' focused (Saleebey, 1997). Working with clients' strengths can foster ‘...a growing awareness in both the worker and client of the client's strengths relative to their goals rather than the client's deficiencies relative to their problem’ (De Jong & Miller, 1995, p. 731). This process may help clients to see themselves as competent individuals or communities and empower them to identify new ways of mobilising personal or collective resources to address the issues. The strengths-based approach discussed above has also proven influential in shaping community development practices. It can be argued that a combination of developmental and strengths-based perspectives creates a non–pathologising approach to working with communities, where people’s strengths are instrumental in decision making processes, which values the lived experience of the community and which works towards building a safe community thorough co-operation, participation and focusing on relationships.
Mental Health Promotion – Who Should Do This?

Many now argue that the strong association between mental distress and economic disadvantage, social inequality and discrimination requires health promotion strategies which challenge the broader social processes and structures undermining the mental health of individuals, families and communities (Friedli, 2009). Ife and Tesoriero (2006) argue that community development is more likely to achieve its longer-term objectives when the wider implications of its actions are considered, and when it has a vision incorporating ideals such as social justice and sustainability. The ‘Ghandian approach’ considers that ‘the process must reflect the outcome as the outcome will most certainly reflect the process’ (Ife & Tesoriero, 2006, p. 273). In designing any health promotion activities the practitioner needs to be aware of the social structure and the value positions one holds. In order to facilitate effective community work outcomes a bottom-up rather than a top-down approach is the most effective. Ife (2002) argues that ‘the community should be able to determine its own needs and how they should be met, that people at local level know best what they need and that communities should be self-directing and self-reliant…’ (p. 101). Ife (2002) describes five principles that underpin a bottom-up approach to community work – ‘valuing local knowledge, valuing local culture, valuing local resources, valuing local skills and valuing local processes’ (p. 101).

As discussed, mental health is everyone’s business and communities must be empowered to assume greater responsibilities; authors have alluded to this in their comments that ‘mental health is significant for community development, and in turn offers sustainable solutions to tackling the mental health crisis as part of a wider campaign for a just and sustainable world’ (Carpenter & Raj, 2012, p. 465). Mental health is a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual wellbeing and the effective functioning of a community. Promoting mental health through community development would mean arriving at inter-sectoral collaborations (WHO, 2010) and utilising existing program methodologies, such as:

• early childhood interventions (e.g. home visits for pregnant women, pre-school psycho-social activities, combined nutritional and psycho-social help for disadvantaged populations);
• support to children (e.g. skills building programs, child and youth development programs);
• socio-economic empowerment of women (e.g. improving access to education and microcredit schemes);
• social support for elderly populations (e.g. befriending initiatives, community and day centres for the aged);
• programs targeted at vulnerable groups, including minorities, indigenous people, migrants and people affected by conflicts and disasters (e.g. psychosocial interventions after disasters);
• mental health promotional activities in schools (e.g. programs supporting ecological changes in schools and child-friendly schools);
• mental health interventions at work (e.g. stress prevention programmes);
• housing policies (e.g. housing improvement);
• violence prevention programs (e.g. community policing initiatives); and
• Community development programs (e.g. ‘Communities That Care’ initiatives, integrated rural development). (WHO, 2010)

Mental Health Promotion Approaches

A mental health promotion framework represents a public health approach to mental illness prevention. Advocates of this preventative perspective have identified a number of key social and economic determinants of community and individual mental health (WHO, 2004a, 2004b) which will form the focus of mental health promotion strategies. These include:

1. Social inclusion: social relationships, involvement in group activities, civic engagement;
2. Freedom from discrimination and violence: valuing diversity, physical security, self-determination and control over one’s life;
3. Access to economic resources: work, education, housing and money.

The argument underpinning this approach is that promoting mental health by addressing these determinants is a strategy for preventing mental illness. Two models that provide illustrative examples of this approach are Tones and Tilford’s (2001) ‘Empowerment Model of Health Promotion’, and Raeburn and Rootman’s (1998) ‘People-Centred Model of Health Promotion’. Empowerment is at the heart of both, referring both to the intention to build people’s capacity to manage and control their own health and to a professional style of working in which citizens are partners in change processes and senior partners as much as is feasible. Health promoters have the intention of working with people in a participatory way, with first-order goals set by the realities of the setting and task and second-order goals of building capacity and control that have transferability to a wide range of future challenges and opportunities.

The Ottawa Charter of Health Promotion (WHO, 1986) provides a foundation for health promotion strategies and can be considered a guide for the promotion of mental health. It draws attention to individual, social, and environmental factors
that influence health. The Ottawa Charter provides a sound framework for this positive approach, with its new public health philosophy and its emphasis on healthy policy, supportive environments, and control of health issues by people in their everyday settings. Its main strategies are building healthy public policies, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services (WHO, 2004b, p. 51). In developing such health promotion strategies, the Jakarta Declaration on Health Promotion (WHO, 1997) emphasises the need for inter-sectoral collaboration: ‘There is a need to break through traditional boundaries within government sectors, between government and non-government organisations, and between public and private sectors. Cooperation is essential … this requires the creation of new partnerships’ (p. 3) Thus, those working collaboratively need to

• build on existing activity in sectors, settings and organisations;
• create different partnerships for different purposes, at varying levels; and
• Create collaborative action ‘horizontally’ within government departments and organisations, and between those expert in policy, practice, and research.

Mental health promotion is one way in which awareness of mental health and acceptance of the issue is discussed and shared. Promotion aims to enhance the coping strategies of both communities and individuals as well as improving environments that affect mental health (Commonwealth Department of Health & Aged Care, 2000). Respectful, equitable relationships among workers, consumers and family carers are central to effective participation in such strategies. Mental health promotion is any action taken to maximise mental health and wellbeing among populations and individuals. Many of the broadly based community work interventions of social workers in general health and welfare settings can be recognised as mental health promotion or prevention programs. This is recognised as a highly creative area for social work intervention (AASW, 2008, pp. 18-19).

A Model for Mental Health Promotion

An integrated model for mental health promotion would be based on a social work perspective, using community developmental approaches and incorporating proven health promotion strategies and practice wisdom. With such an approach, practitioners can promote positive mental health in the communities and build stronger and more resilient communities. An example of enduring therapeutic engagement at community level practised in India is given by Patel in Gaining ground on mental health (2004), which discusses the issues of women and mental health. She reports an expert’s view that ‘The women’s movement helped avert many breakdowns’. Enduring therapeutic engagement at community level can be group
singing, festival celebrations, discourses on women’s issues and public meetings. Reversing the process of alienation by consciously building community networks is a must. The beneficial effects of social support have been acknowledged. The model is based on the Alma Ata Declaration on Primary Health Care (1978) and the Ottawa Charter for Health Promotion (1986). In this model we have looked at the relevance of inter-sectoral action, healthy public policy and community responses as central elements for the promotion of mental health in the achievement of health equity, and the realisation of health as a human right. This indeed calls for a response from social work/community development practitioners as it is based on the fundamental principles of social justice and human rights. By adopting a community-based approach, we build an inclusive community, develop a caring community and allow the communities to assume greater responsibility. In considering a model we believe that we need to look at the influences of a strengths approach that connotes valuing and respecting the local knowledge, people, culture and assets of the community and establish a relationship based on mutuality, trust and reciprocity. Here the community becomes experts in their own issues, and the community development worker becomes an agent of change (Francis, 2012; Pulla, 2012). Paulo Freire considered education and conscientisation as fundamental to social change. Community development workers take on the role of both facilitator and activist. There are many models and principles that a community worker can use in their professional practice such as those described by Jim Ife (2013): an ecological perspective, a social justice perspective or a post-enlightenment perspective (p. 31). However,

A commonly referenced mental health promotion practice model is one which addressed three levels of intervention. First, strengthening individuals by increasing emotional resilience through promoting self-esteem, life and coping skills. Secondly, strengthening communities by increasing social inclusion and participation, improving neighbourhood environments, and tackling bullying at school and work and building self-help networks. Finally, reducing structural barriers to mental health, by reducing discrimination and inequality and promoting access to education, employment housing and support for those who are vulnerable. (DH, 2001; Government Office for Science (GOS), 2008; Her Majesty’s Government, 2009, 2011, as cited in McCabe & Davis, 2012, p. 509)

Rose and Thompson (2012) proposed a model based on their community development experience in Sydney, Australia, which highlighted the importance of mental health promotion. They have drawn on Macintyre (2002); and Harris et al., (2007) to develop a framework which is based around people, space and place where:
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- People are individuals and groups in the community;
- Space is the physical environment;
- Place is the nexus between people and space, or the sociocultural and historical characteristics of communities. (p. 606)

Hence the task for the community worker is to work at three levels to achieve an outcome. They are:

1. People: the effort here is to promote individual capabilities. This is based on the concept of empowerment, strengths and optimal human functioning rather than limitations;
2. Space: the focus here is to create enabling environmental infrastructure; and
3. Place (developing soft infrastructure). The soft infrastructure refers to shared values, interests and understanding of place as articulated by its members. In this context, ‘mental health promotion involved bringing local residents together in purposeful action to challenge native notions of place and create new understandings of neighbourhood to support empowerment’ (p. 608).

Figure 1, Towards a Positive Synthesis Model (Francis, 2010, p. 36)
Strengths and Limitations of this Approach

Bringing together the positive attributes of the perspectives discussed above creates a synthesised model (see Figure 1) that maximises the potential for addressing mental health issues in a community context. One of the advantages of this model is that it has drawn on knowledge from diverse fields of human service, but is clearly based on the principles of social justice and human rights. It recognises the importance and worth of each individual, and every community, and places an emphasis on recognising and developing the power and capacity to change. We expect that, by applying this model in the field, practitioners will be involved in generating field-based knowledge that further develops the links between theory and practice. The other advantage is that, this model can be applied in various settings, but the underpinning philosophies will remain intact. The model is both process and outcome oriented and strengths focused, aiming to empower communities to take responsibility to work collectively to address the mental health issues of concern to them. As with any model of practice, this approach also has limitations. A strong social work/community development approach orientation will be important in applying this model in the field as it envisages building social capital and moving towards social action.

Challenges

Changing perceptions about mental illness is a challenge in the present context. ‘It is not enough for mental health services to know what is “out there” in the community, it is necessary to actively engage with community partners and jointly develop routes into it’ (Fieldhouse, 2012, p. 584). Promotion, prevention and early intervention highlight the importance of the health and wellbeing of the entire population, including all levels of mental health needs within the community.

On a government policy level, it must eliminate the silo approach to mental health, but this is a challenge in the current environment for practice. The policies should recognise that mental health is not solely the responsibility of the mental health treatment sector, but other sectors such as housing, disability and employment also play important roles in an individual’s mental health and wellbeing. This again recognises the need to build stronger partnerships with consumers, families, carers, and government and non-government services to achieve better outcomes and build the capacities of the agencies and the client. From a social justice perspective such policies should also aim at reducing stigma and discrimination experienced by people with mental illness. For example, the 1995 report, *Ways forward: National Aboriginal and Torres Strait Islander mental health policy*, highlighted the importance of participation and consultation of Aboriginal people in future mental health policy, planning and program delivery in Australia (Purdie, Dudgeon, & Walker, 2010).
Therefore, social workers need to establish respectful relationships among other professionals, organisations, consumers and family carers to help the client in the decision making process. This again helps in empowering the clients based on shared responsibility for treatment and care (Bland et al., 2009). This also needs to be reflected in the community work we do in our practice.

Prevention is defined as an intervention that occurs before the initial onset of a disorder. ‘Early intervention refers to interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder and people developing or experiencing a first episode of mental disorder’ (Commonwealth Department of Health and Aged Care, 2000, p. 32). For example, targeting risk and protective factors for the prevention of high prevalence disorders is essential. Widespread grief and loss; child removals and unresolved trauma; cultural dislocation and identity issues; economic and social disadvantage; physical health problems; violence; family violence and substance abuse all contribute to identify risk factors to wellbeing for Aboriginal and Torres Strait Islander people. Therefore the social worker uses the psychosocial risk assessment tool that is the most challenging part of social work practice. This includes assessing and screening risk factors, depression, and demand for support, treatment, protection and control. Building supportive and inclusive environments, and resilient individuals and communities are also important tasks in promoting mental health into the future. This can be achieved by intervening early with high risk groups and delivering recovery-oriented services. The recovery approach forms a set of principles to guide social work practice in mental health. The approach has an emphasis on relationship, valuing the lived experiences of illness, the importance of hope, empowerment and strengths which is consistent with social work practice (Bland et al., 2009). The plan also highlights improving and integrating the care system by providing high quality treatment and care for consumers, and promoting resilience and recovery. WHO’s Comprehensive Mental Health Action Plan 2013-2020 in May 2013 has identified:

Four major objectives…: more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research. The plan sets important new directions for mental health including a central role for provision of community based care and a greater emphasis on human rights. It introduces the notion of recovery, moving away from a pure medical model, and addresses income generation and education opportunities,
housing and social services and other social determinants of mental health in order to ensure a comprehensive response to mental health. The action plan also emphasises the empowerment of people with mental disabilities, the need to develop a strong civil society and the importance of promotion and prevention activities including for preventing suicides. (WHO, 2013)

Conclusions and Looking Forward

Those interested in promoting mental health of communities in countries need to consider the extent to which the very concept of ‘mental health promotion’ may imply a set of attitudes and assumptions that are not universally held. Mental health promotion programs are intertwined as with fundamental assumptions about how people can and should live their lives. Drawing on this evidence, this model has been discussed in the light of the strength-based approach. As discussed here, by adopting this model of community practice, we will be able to facilitate better social relationships, involvement in group activities, and civic engagement for people in communities which will lead to community empowerment and positive mental health outcomes. Carpenter and Raj (2012) through their writings have analysed the community and have concluded that

Above all, then, at a time of economic crisis and democratic challenge, there is need to recognize that while top-down policy solutions to pressing problems and better professional provision have a role to play, they cannot work unless they first seek to achieve social justice in ways that are grounded in efforts to build cohesive and diverse communities from the bottom up. In other words, while community development (CD) needs to embrace mental health issues and concerns, successful mental health policy and practice must also be grounded in principles of CD. (p. 465)

In the current context of change and uncertainty, it is important to try to preserve them. In particular, it is essential that CD workers acknowledge that mental health is their concern, and to build knowledge and skills to recognise and deal with the increased mental distress they will encounter in marginalised communities. In doing so, it is vital to pursue social justice agendas combining the radical understandings of both service user and survivor movements and radical CD practice, emphasising the role of structural inequalities to challenge current ‘value free’ shifts to individual self-help and -care. (McCabe & Davis, 2012, p. 517). What is more important is to review the deficit models of individual and community pathology to more structural social, economic and political reflections of community life and the assets that can be channelled to mental health promotion. Because it is everyone’s business.
References


