

The Global Model of Public Mental Health through the WHO QualityRights project

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Abstract

Purpose – *The purpose of this paper is to update the Global Model of Public Mental Health (GMPMH) in light of the WHO QualityRights project.*

Design/methodology/approach – *Being able to refer to international conventions and human rights standards is a key component of a genuine global approach that is supportive of individuals and communities in their quest for recovery and full citizenship. The GMPMH was inspired by the ecological approach in health promotion programs, adding to that approach the individuals as agents of mental health policies and legislation transformation. The GMPMH integrates recovery- and citizenship-oriented psychiatric practices through the Ottawa Charter for Health Promotion (WHO, 1986).*

Findings – *Updating the GMPMH through the WHO QualityRights Toolkit highlights the need for a new form of governance body, namely the Civic Forum, which is inclusive of local communities and persons in recovery. People with mental health disabilities, intellectual disabilities, and substance use conditions can be “included in the community” (UN Convention on the Rights of Persons with Disabilities, Article 19) only if the community is informed and welcoming, for instance through a Civic Forum and its organizing Local Council of Mental Health.*

Research limitations/implications – *Transition from social marginalization to full citizenship represents a daunting challenge in public mental health care. An approach that focuses primarily on individuals is not sufficient in creating access to valued roles those individuals will be able to occupy in community settings. Instead, public intervention and debate are required to promote and monitor the bond of citizenship that connects people to their communities.*

Originality/value – *The GMPMH is the result of a conceptual cross-breeding between recovery and health promotion (WHO, 1986). The GMPMH is an offspring of the ecological approach in health promotion programs, adding to that approach individuals as agents of mental health transformation. It refers to international conventions and human rights standards as a central component of a genuine global approach. A community-based participatory research design is well suited, which includes a Civic Forum for local communities to become involved and supportive of service users in their quality and human rights assessments.*

Keywords *Empowerment, Civic Forum, Civic recovery, Full citizenship, Global Model of Public Mental Health, Local Council of Mental Health*

Paper type *Conceptual paper*

Introduction

The Global Model of Public Mental Health (GMPMH) is the result of a conceptual cross-breeding between recovery and health promotion. This rapprochement was initiated in the wake of the 20th anniversary of the Ottawa Charter for Health Promotion (World Health Organization, 1986). Some of the commemorative events and scientific activities of that time were about the legacy of the Ottawa Charter for Health Promotion, for instance, over mental health and mental health promotion (Navarro *et al.*, 2007).

The GMPMH (Pelletier *et al.*, 2009) is also an offspring of the ecological approach in health promotion programs (Richard *et al.*, 1996), adding to that approach individuals as agents of mental health transformation. The GMPMH integrates recovery- and citizenship-oriented psychiatric practices through the five strategies of the Ottawa Charter for Health Promotion. It refers to international conventions and human rights standards as a central component of a genuine global approach. Such conventions and standards can be invoked by individuals, organizations, and communities in their political and legal advocacy for recovery and full citizenship, in particular with regards to the elaboration of mental health action plans, strategies, and policies. Among other international conventions and human rights standards are the QualityRights project (World Health Organization (WHO), 2012), the UN Convention on the Rights of Persons with Disabilities (CRDP; United Nations, 2006), and more recently, the WHO Mental Health Action Plan 2013-2020 (World Health Organization (WHO), 2013). The World Assembly invites various partners, including the research community, to take note of that comprehensive Mental Health Action Plan, to which the QualityRights toolkit is complementary.

In this paper, we revisit the GMPMH mainly in light of the QualityRights project. The QualityRights toolkit is a technical document elaborated to support states in improving quality and respecting the human rights of persons with mental disorders in health and mental health services. The intention is to move decisively from evidence to action and evaluation, by assessing and improving quality and the observation of human rights in both inpatient and outpatient facilities. We argue that people with the experience of having lived with mental health disorders ought to be supported to exert leadership in such matters. A community-based participatory research (CBPR) design is discussed, which includes a Civic Forum for local communities to become involved and supportive.

The Civic Forum is a one day event that brings together mental health professionals, community workers, users of mental health services and their families, organizations that represent them, as well as the local community and its elected representatives. This event aims to collectively agree upon targets and concrete actions to promote and support the full citizenship of mental health service users by asking what the person can do, what organizations can do, and what the community can do to achieve this state of full citizenship (Pelletier and Besançon, 2011). Full citizenship is the response we get to a specific question addressed to people who use mental health services: *For me, being a citizen means [...]* (Rowe *et al.*, 2012).

From disease control to recovery in mental health

In 1978, the International Conference on Primary Health Care stated in Alma Ata that health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (World Health Organization, 1978). From this moment on, the concept of health supplanted that of disease and does not consist anymore simply of the absence of disease or infirmity. Then the Ottawa Charter for Health Promotion was adopted as a means to reduce inequalities and inequities in health by empowering individuals and communities in their own health and well-being, seeking more than the control or absence of disease and including mental health. Since 2003, WHO has striven to further shift mental health from the periphery of health policies and practices to a more prominent position in the field of public health (World Health Organization, 2003), advocating for comprehensive mental health plans and for greater involvement of people with the experience of having lived with mental health disorders; in policy making, quality assessment, and recovery-oriented service delivery.

Following on the heels of the social movements of the 1960s and 1970s, recovery took root in the psychiatric rehabilitation field, with its aim and principle of maintaining people in the community through community support and development of personal skills (Anthony, 1993). Recovery has also been defined as a vision (Anthony, 2000, 2003), a movement (Glynn *et al.*, 2006), a conceptual model (Jacobson and Greenley, 2001), and an imminent organizing principle (Pelletier and Davidson, 2009).

Following a similar path in parallel, health promotion has been defined as a process (World Health Organization, 2005), a science (O'Donnell, 1989), or a movement (Robertson and Minkler, 1994). There are several possible definitions of recovery and of health promotion.

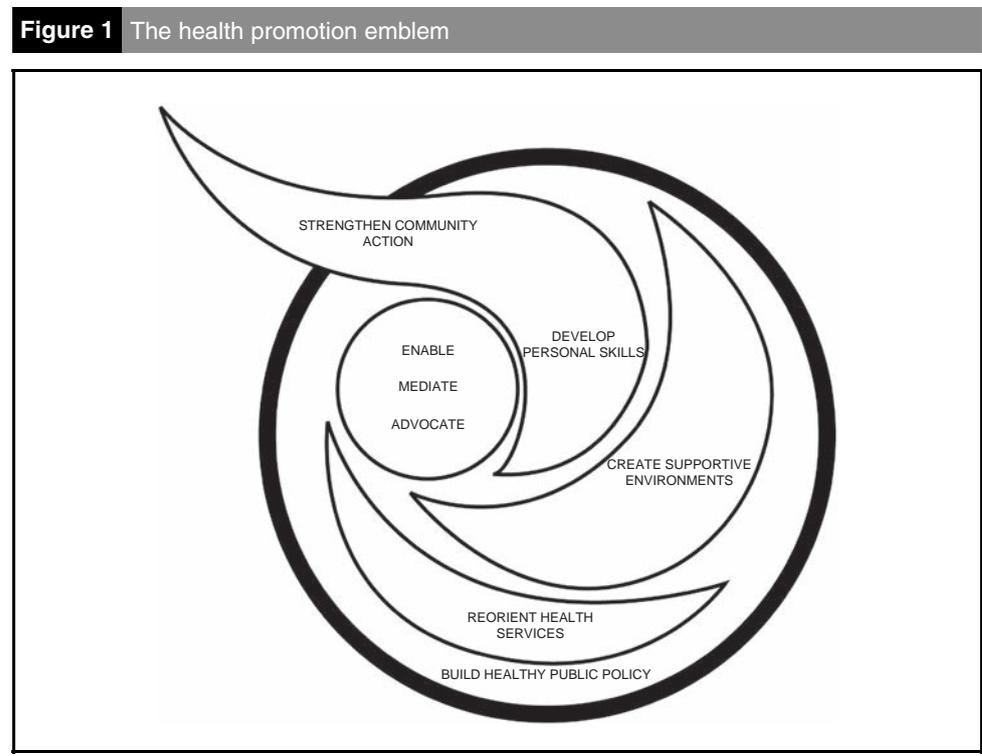
The origins of what has come to be called the “Recovery Movement” are well-documented (e.g. Slade *et al.*, 2012), as is also the case with the “Health Promotion Movement” (e.g. World Health Organization, 2009). Their origins are not discussed here. What this paper considers, instead, is the interplay of health promotion and recovery through the GMPMH in order to bring this model more into line with recent international conventions and human rights standards, namely to the WHO QualityRights project. This exercise can contribute to recovery- and citizenship-oriented mental health services transformation, as discussed in the following section through the headings of the Ottawa Charter for Health Promotion, which are depicted in Figure 1.

(1) Build healthy public policies

Both health promotion and recovery go beyond health care stakeholders to influence the agenda of policymakers in all sectors and at all levels (Ottawa Charter), as they seek to put health and mental health at the forefront of public and governmental attention and into the electoral debate. The objective here is to establish a more collective sense of responsibility for the physical and mental health of a population, with persons with mental and behavioural disorders being active agents and empowered to take on such responsibilities too, for example, within quality assessment committees or governing bodies.

(2) Creating supportive environments

Supportive environments are critical to health promotion and to recovery because a negative physical and/or social environment can generate isolation which affects the ability of marginalized people and communities to cope with physical health problems and mental health difficulties. This isolation may result in a lack of social networks and diminished social capital, which can contribute to obesity, cardiovascular disease, mental health problems, and increased rates of mortality (Srinivasan *et al.*, 2003). Hence it is important to create supportive environments like workplaces, and to include research as an inclusive environment through a CBPR approach.



(3) Strengthen community actions

By acting upon their environment, communities can strengthen their actions in order to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters (Ottawa Charter). Part of recovery is the extent to which individuals with the lived experience of mental health problems can carry out their aims and satisfy their basic needs to evolve and take an active part as full citizens in their respective communities. This is a reason why communities need to be welcoming and integrating. To this end, gaining a sharper awareness of the potential negative impact of a community's more or less spontaneous actions, like the "not in my backyard" phenomenon, is part of becoming more collectively reflexive. For example, a public Civic Forum can address such issues by diffusing and sharing appropriate information about how to support full citizenship.

(4) Develop personal skills

In order to recover, one has to be supported to practice empowerment and agency, but in turn, to exercise empowerment (Green *et al.*, 2000) and agency (Bandura, 1999) one has to be mentally healthy enough because it takes a considerable amount of energy. It is therefore necessary to act simultaneously on the individual's lifestyle and on the environmental setting, where social norms can sometimes convey hopelessness to those already feeling lost because they are perceived and perceive themselves solely as chronically ill. There are many allusions in the recovery literature to resilience as a positive and dynamic process, especially in connection with a difficult, if not dramatic, event or life trajectory. In a system centred on recovery and full citizenship, mental health service users and communities are both urged to take part in developing, planning, and implementing such policies and services (Bradstreet and Connor, 2005). But that capacity is not a given; it remains a challenge for many (Mezzina *et al.*, 2006) and has to be developed, particularly towards and among people who have been segregated and historically kept apart from the deliberative scene.

(5) Reorient health services

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person (Ottawa Charter). To reorient mental health services in order to make them recovery- and citizenship-oriented is critical to reducing inequalities, because people with mental and behavioural disorders can remain intimidated by the prestige of the psychiatric and medical institution, to such a degree at times that they simply avoid contact with it and renounce seeking help. This may explain why <50 per cent of people who have a diagnosable mental illness and are in need of care do seek professional assistance (Kovess *et al.*, 2001). Psychiatric and mental health services should thus be more integrated and disseminated in community-based settings, instead of being delivered in distinctive facilities where people are reluctant to go partly because of the stigma that is attached to those specialized facilities or simply because they are difficult to access. A global approach is needed here, for instance, by including communities to support such a trend towards psychiatric services to be delivered in primary care facilities.

While the five strategies of the Ottawa Charter are interdependent, one strategy does not stand without the others, and the Charter itself is structured in such a manner that one strategy logically leads to the next. Overlaps are inevitable, and certain strategies have goals and challenges in common, converging altogether within the ecological approach, which is well-known in public health and health promotion. Similarly, recovery is a guiding principle and operational framework for the system of care that should colour all existing services to render different communities, environments and settings more propitious to full citizenship.

Two broad classes of relationship exist between potential targets of an ecological approach. A first type refers to the direct transformation of one or many aspects of a given target, for example, to change the intrapersonal determinants of an individual (such as building personal skills), or to bring structural changes between influential decision makers in an organization (e.g. to build healthy public policy, or reorient health services). The other type of intervention involves the

creation of a network between two or more targets (e.g. create supportive environments and build personal skills). The particular arrangement of targets and types of relationships defines an intervention strategy. Primary themes of an ecological analysis include interdependence and mutual interaction among persons/organisms and settings (McLaren and Hawe, 2005). Yet, the ecological approach, as depicted in Figure 2, remains a top-down approach, with its arrows exclusively pointing to the individual (the client), and never from the individual.

The GMPMH makes room for individuals in recovery to assume their leadership and agency in order to develop political skills for themselves and awareness for everyone. The GMPMH (Figure 3) is comprised of five levels of possible intervention, which are interconnected and sometimes overlapping: supranational, state, community, organizational, and individual, with arrows pointing to, as well as from, each level of possible intervention. To these levels corresponds a domain for promoting recovery and full citizenship: political, socio-economic, cultural, inter-personal, and intrapersonal. A global analysis adds interactions among the supranational level and the individual level for them to re-enforce one another with the active

Figure 2 Schematic representation of the ecological approach in health promotion programs

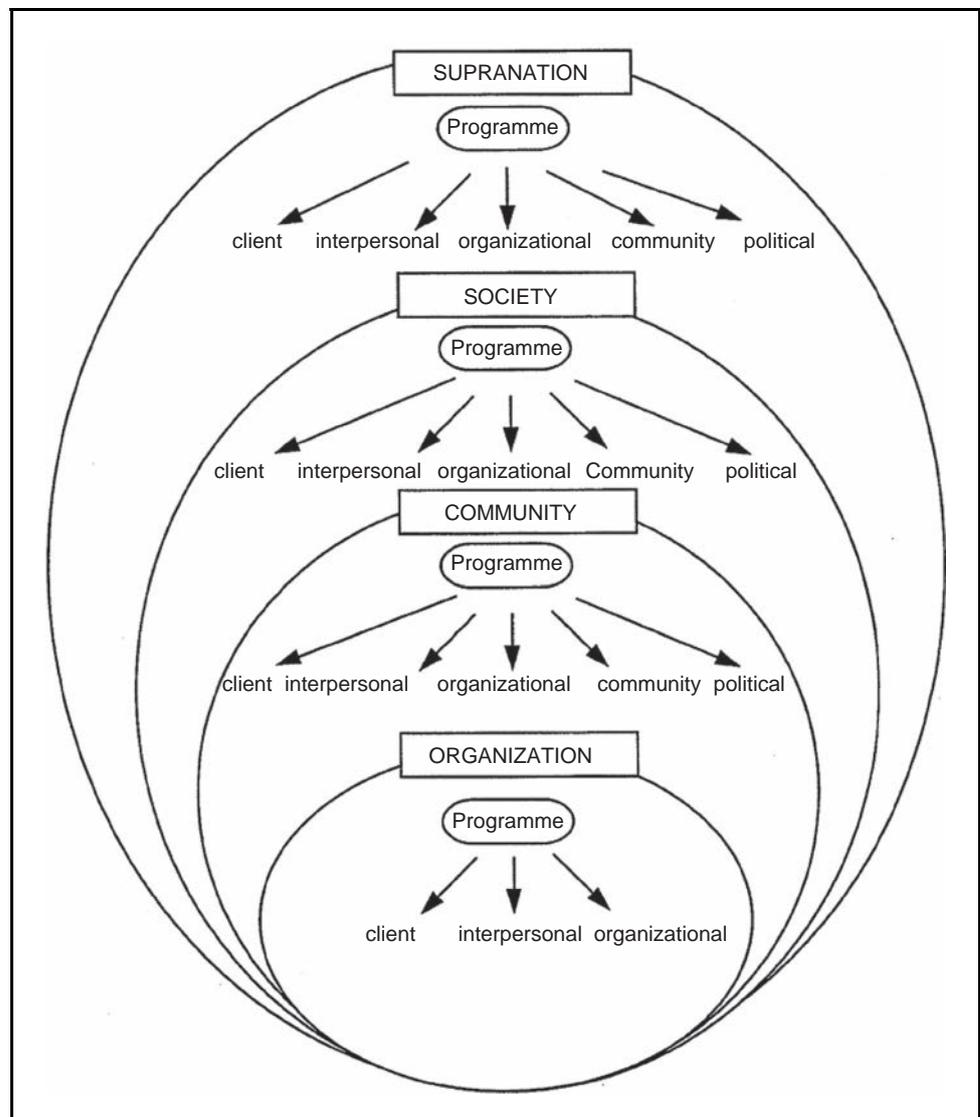
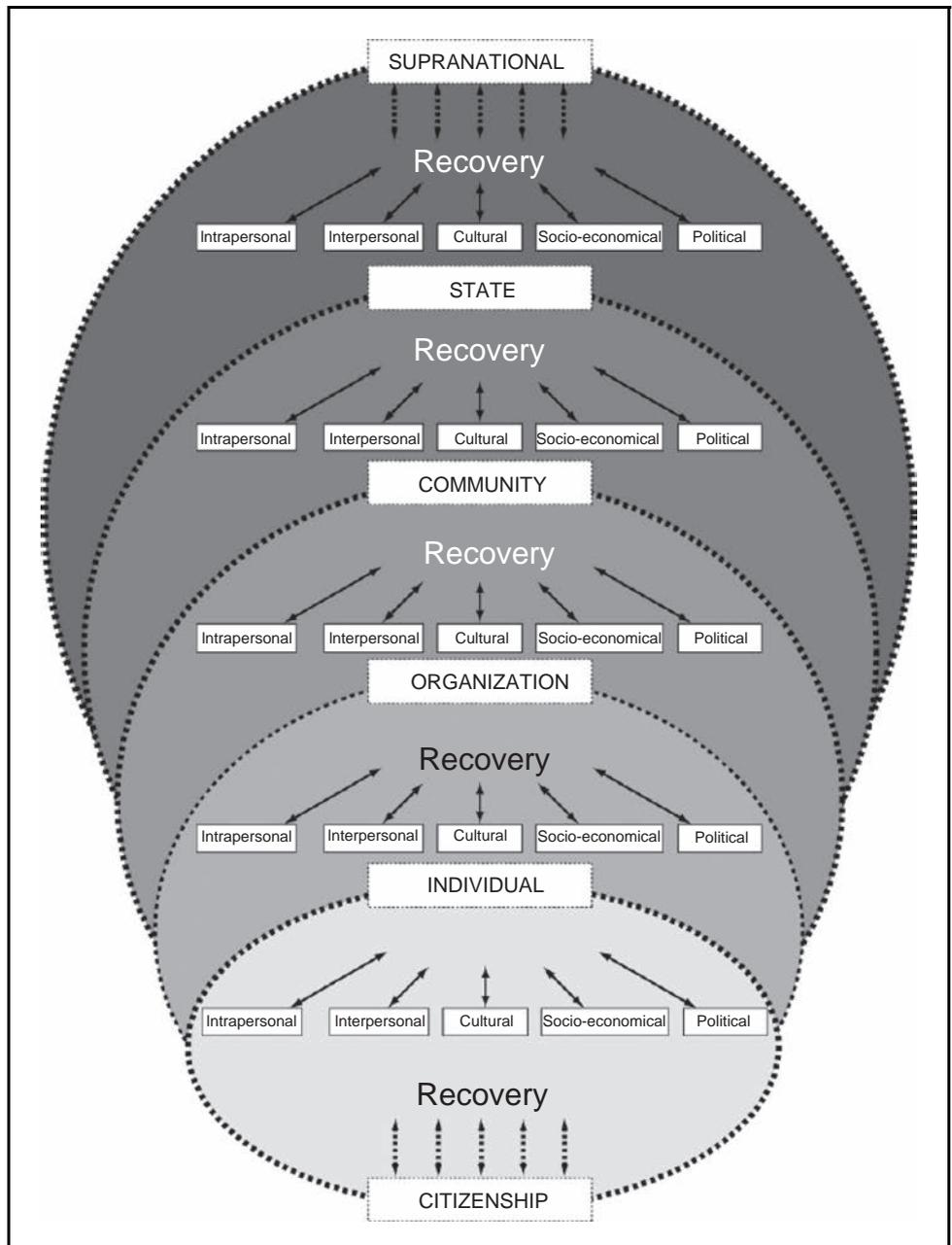


Figure 3 The Global Model of Public Mental Health



participation of mental health service-users in international initiatives, for instance through the QualityRights project and the organizing committee of the Civic Forum.

Assessing quality and human rights with a community-based approach

The WHO QualityRights project covers five rights drawn from the UN CRDP. At the community level, each of these rights can be assessed by people in recovery with the support of various stakeholders gathered into a Local Council of Mental Health (LCMH), which can act as the organizing committee of a Civic Forum. In France, LCMHs were put in place in accordance with

the Law of 4 March 2002 on Patients' rights and the quality of the health system, also called *Loi Kouchner* on Health Democracy (*démocratie sanitaire*). It was with the enactment of this Law that people with mental health issues were first to be recognized as citizens with legal rights as any other citizens (Roelandt, 2005). A LCMH is typically composed of representatives from a variety of backgrounds, including elected representatives like city councillors. The LCMH can be an appropriate body for the management of community-based QualityRights projects in which people in recovery would be supported to conduct the quality and human rights assessments, in interaction with the community through the Civic Forum:

1. The right to an adequate standard of living and social protection (Article 28 of the CRPD): in Montreal, Canada, on 16 May 2013 a third local Civic Forum was held at a community centre in a neighbourhood where there is a high concentration of residential facilities for mentally ill persons. Co-habitation does not always go as smoothly as it could or should. The theme of that Civic Forum was about standards of living, with a special focus on standards of housing. The public was invited to discuss ways of improving co-habitation and changing social misrepresentations of mental illness (cultural domain of the GMPMH).
2. The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD): the organizing committee of the abovementioned third Civic Forum in Montreal included a community organizer (*organisatrice communautaire*) from the Health and Social Services Centre (in French; Centre de santé et de services sociaux - CSSS). In the Province of Quebec, CSSSs are responsible for the population health of about 100,000 inhabitants, delivering primary care through local health networks. A public approach to mental health "requires that the mental health community be intimately involved in any and all discussions of health care policy" (Power, 2009). The Civic Forum and its organizing body, the LCMH, are good occasions for stakeholders to be in touch with each other and with the collectivity, to show their support to people in recovery and to community organizations, and to discuss ways of better integrating physical and mental health care (organizational domain of the GMPMH).
3. The right to exercise legal capacity and the right to personal liberty and the security of the person (Articles 12 and 14 of the CRPD): among the speakers at the third Civic Forum was a policeman from the Montreal Police Department. That Department receives about 40,000 emergency calls per year for mental health crises and there now is a special plan of intervention for such situations, with social workers being quickly informed and called on the scenes. The Civic Forum is also an occasion for a number of people in recovery to exercise their capacity to publicly express their opinions and be heard by local authorities and elected representatives (political domain of the GMPMH).
4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence, and abuse (Articles 15 and 16 of the CRPD): the third Civic Forum began with the testimonies of three mental health service users who were invited to speak about living in a 24-7 supervised housing facility, within family (as an adult with his parents), and living independently with social assistance. One of them told his story of having been handcuffed and denied the right to take a private shower in the psychiatric facility where he was brought several years before and kept for several days in the Emergency Room. *How can you take off your cloths to take a shower with handcuffs on?* he asked the audience. He was happy to say that he was about to leave the supervised housing where he lived for a low-income residence (socio-economic domain of the GMPMH). The audience sympathized and was happy for him, and that story was told in the local weekly newspaper and on the air of the special radio show that broadcasted, live, an hour of the Civic Forum (Folie Douce, 2013).
5. The right to live independently and be included in the community (Article 19 of the CRPD): living independently is not only cost-effective for society compared to institutionalizing people with mental health problems, it is a right. Nevertheless, to be included in the community, one has to live in a community that is welcoming. Transition from social marginalization to full citizenship represents a daunting challenge in public mental health

care. An approach that focuses primarily on individuals is not sufficient to ensure that they will be successful in accomplishing this transition. Instead, a public intervention is required that also addresses the inter-relationship between individuals and the larger communities (inter-personal domain of the GMPMH).

A Civic Forum and the ongoing activities of its organizing committee (LCMH) can promote human rights and empowerment, which are cross-cutting principles and approaches of the WHO Mental Health Action Plan. In May 2013, the 65th World Health Assembly adopted resolution WHA65.4 on the global burden of mental health disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. Member states are urged to develop and strengthen comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, and early detection, care, support, treatment, and recovery of persons with mental disorders (WHO, 2013). The LCMH can assume that role at the community level by promoting the CRDP and other human rights instruments, and by involving people in recovery in assessment, monitoring and in reporting in the Civic Forum. Such an active involvement is an important asset of effective anti-stigma strategies (Thornicroft and Tansella, 2008; Thornicroft, 2006).

The first step in implementing QualityRights projects at a local level is to establish “a core team of people who will be responsible for overseeing the project, providing guidance to the committee who will carry out the assessment, managing and coordinating the assessment, reporting the results and following up with action” (WHO, 2012). Since at least 2001, WHO has recommended that service users and their families be involved in the development of policies, programs, and services to ensure better fit with needs and better usage (World Health Organization, 2001). Yet, for this involvement to be genuine and beneficial, it is critical to ensure that the individuals in recovery who will be involved are empowered and supported to perform assessment, monitoring and research activities surrounding a local QualityRights project, and to report at the Civic Forum. To that end, we suggest that a CBPR design is most appropriate to empower those individuals, and at the same time, to evaluate the impact of this involvement and monitor the quality and human rights progress.

CBPR is an approach to research that involves persons of primary interest in all aspects of the process, from conceptualization to data collection through interpretation and sharing of findings. Involving people about whom the research is conducted as co-researchers is a fundamental tenant of CBPR, and speaks to CBPR’s roots in social justice and social change movements (Fine *et al.*, 2003). CBPR is well suited for exploring community- and individual-level socio-economic conditions, community health and disparities, and quality and human rights in care across racial and ethnic lines. With roots in feminist and postcolonial theory, CBPR is founded on the premise that knowledge is created in collaboration (Viswanathan *et al.*, 2004). In addition, co-learning, a strengths-based approach, and acknowledgement of privilege and power are hallmarks of CBPR (Wallerstein and Duran, 2006). What is the added value of CBPR from a mental health service user’s perspective?

For the development of a new measure of citizenship (Rowe *et al.*, 2012), a number of persons in recovery were trained to perform different research tasks, for example, in conducting focus groups and concept mapping sessions. In fact, they served as co-researchers throughout all phases of this project. They were not only “as good” as typical research assistants; they brought a unique contribution to the inquiry. A complementary focus group was organized among those Co-Research Team (CRT) members to reflect on this CBPR dynamic from their own point of view. They were asked to talk about their role in the project, what it meant for them, and what original contribution they thought they were making that other people without the lived experience of mental and behavioural disorders probably could not. Results are reported elsewhere, but a key finding relevant to this argument is that having and using their lived experience helps people to relate. The body language of CRT members was identified by them as key in making other participants more at ease, so these participants, too, were able to relate to each other with more fluidity. CRT members felt that they were valued members of the research team and in turn, other participants felt welcomed in discussing what it meant for them to be members of a community, to be citizens. This welcoming approach trickled down as CRT members made study participants feel welcome and respected.

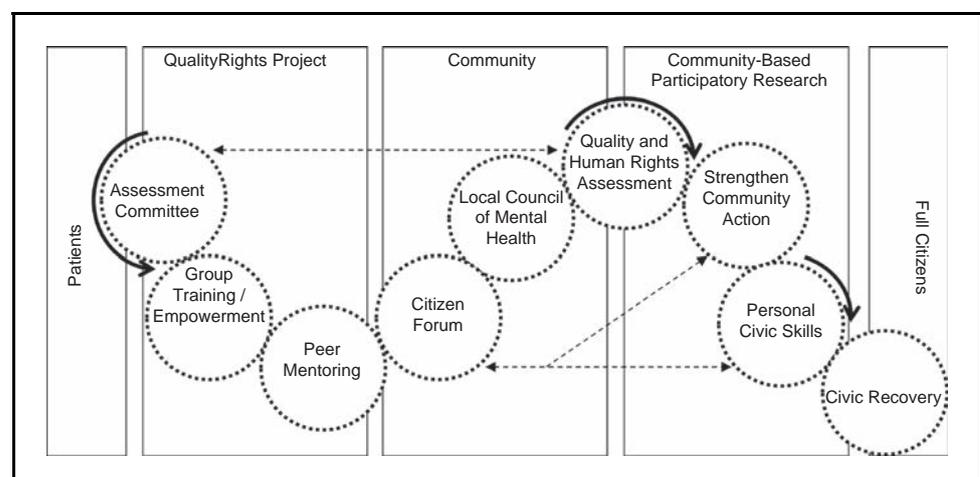
The topic of that particular research project was on social inclusion and citizenship, and the formal objectives of the project somehow percolated to become the individual goals of some CRT members who became more mindful of their own citizenship over time. They became role-models for their peers and then their role in their own neighbourhoods gradually mirrored their role in the project. Aside from having some specific responsibilities and tasks to perform, CRT members were just that – members of a team, a research team that became to them a small, yet meaningful community. To several, who had been away from the job market for extended periods, or who had at times occupied minimally valued job positions where they felt exploited, being a respected teammate provided an important experience for which they were grateful. CRT members were naturally communicating this kind of confidence to other study participants, encouraging them to also have an enhanced sense of belonging and citizenship. In a CBPR quality and human rights assessment committee, people in recovery could interact, develop, and reinforce their own social and political skills in addition to being trained, encouraged, and supported. This dynamic would ensure that they would be themselves agents of change, capable of exerting a positive influence within communities as contributing citizens (Figure 4).

The curved arrows of this figure symbolise the setting in motion, while the dotted lines of its nine components represent a dynamic gearing that keeps things going forward. This mechanism is not, however, linear, but rather sinuous. Recovery remains a very personal journey that can sometimes be littered by more or less prolonged latency phases. The progression towards full citizenship takes different paths from one individual to another, varying also as opportunities of fulfilment are offered, or not, to the person. At the beginning of this journey, participants are recruited as patients and as persons in recovery to take part in the QualityRights project. A local QualityRights CBPR project will include peer research assistants (CRT members) who will have a positive influence, especially during the group training. Individual support can also be provided by formal or informal peer-mentors and care providers. The research team is in itself an inclusive community that is reflexive with regards to its own functioning. The community can, too, become more aware of its role in the recovery process towards full citizenship. Full citizenship can be defined as a strong connection to the “five Rs” – rights, responsibilities, roles, resources, and relationships – available to people through public and social institutions and associational life (Rowe and Baranoski, 2000; Rowe and Pelletier, 2012).

Conclusion

When first published, it was suggested that the GMPMH could be used for identifying and keeping track of various activities unfolding at five possible levels of intervention: individual, organizational, community, state, and supranational. The idea was not necessarily to develop

Figure 4 From patients to full citizens through a Local QualityRights project



new interventions that would embrace all these levels at once. Rather, it was about paying careful attention to interactions, interfaces and overlaps among interventions in order to come to cover each level for a most comprehensive understanding of public mental health. No suggestion was made, however, about which body should or could perform such surveillance.

At the supranational level, with its Comprehensive mental health action plan (WHO, 2013) the WHO Secretariat will pursue its continuous, systematic collection, analysis and interpretation of mental health-related data needed for the planning, implementation, and evaluation of public mental health practice. Such surveillance can document the impact of an intervention, or track progress towards specified goals to allow priorities to be set and to inform public mental health policy and strategies. At the community level, it is a LCMH that should serve as a dedicated quality and human rights assessment body for a community-based QualityRights participatory research project. For example, it would be up to a LCMH to determine and agree upon the scope of the assessment; what type of facility or service will be assessed, will the focus be on one or two neighbourhoods, on one or two facilities, etc. As discussed, mental and behavioural disorders could be trained and supported to perform the assessment(s). This would empower a number of people, to start with, with a possible durable influence over the localities where they live, for these communities and neighbourhoods to become more aware, more respectful of human rights and conventions, and more inclusive.

The revision of the GMPMH through the WHO QualityRights project showed that that Model is flexible enough to be updated and articulated to the latest international conventions and human rights standards. We proposed some examples as how people with the lived experience of mental and behavioural disorders can act as main agents of transformation and in connection with communities through the Civic Forum. They should be included in any LCMH and the Civic Forum would seek to find collective answers to their needs, as they would express these needs, concerns, expectations and hopes. They would speak publicly for themselves. Yet, the composition of a LCMH and the focus of a Civic Forum may change from places to places and over time. More discussion would be useful for a better integration of these deliberative bodies to one another and to the communities from which they would emanate. In effect, governance is not just about government, but extends to its relationship with nongovernmental organizations and civil society. "A strong civil society, particularly organizations of people with mental disorders and psychosocial disabilities and families and carers, can help to create more effective and accountable policies, laws and services for mental health" (WHO, 2013, p. 9), and for enhanced citizenship for everyone in accordance to international conventions and human rights.

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