

The role of communities in advancing the goals of the Movement for Global Mental Health

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Abstract

This special section of *Transcultural Psychiatry* explores the local-global spaces of engagement being opened up by the Movement for Global Mental Health, with particular emphasis on the need for expanded engagement with local communities. Currently the Movement places its main emphasis on scaling up mental health services and advocating for the rights of the mentally ill, framed within universalised western understandings of health, healing and personhood. The papers in this section emphasise the need for greater attention to the impacts of context, culture and local survival strategies on peoples' responses to adversity and illness, greater acknowledgement of the agency and resilience of vulnerable communities and increased attention to the way in which power inequalities and social injustices frame peoples' opportunities for mental health. In this Introduction, we highlight ways in which greater community involvement opens up possibilities for tackling each of these challenges. Drawing on community health psychology, we outline our conceptualisation of "community mental health competence" defined as the ability of community members to work collectively to facilitate more effective prevention, care, treatment and advocacy. We highlight the roles of multi-level dialogue, critical thinking and partnerships in facilitating both the "voice" of vulnerable communities as well as "receptive social environments" where powerful groups are willing to recognise communities' needs and assist them in working for improved well-being. Respectful local-global alliances have a key role to play in this process. The integration of local community struggles for mental health into an energetic global activist Movement opens up exciting possibilities for translating the Movement's calls for improved global mental health from rhetoric to reality.

Keywords

local-global, partnerships, social movements, psychiatry, Movement for Global Mental Health, community, resilience, community mental health competence

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What role can local communities play in improving global mental health? According to the World Health Organisation, globally, 32% of all years-lived-with-disability are due to neuropsychiatric conditions, most commonly unipolar depression (11.8%), alcohol use disorder (3.3%), schizophrenia (2.8%), bipolar depression (2.4%) and dementia (1.6%) (WHO, 2005a). Mental disorders are said to be highest in economically marginalised populations, especially the least educated, women and youth (Saxena, Thornicroft, Knapp, & Whiteford, 2007), with poverty, low education and food insecurity identified as key drivers (Lund et al., 2010; 2011). Yet mental health is neglected in country health budgets resulting in worrying “treatment gaps”. In low and middle income countries (LAMIC) between 75% and 90% of people with mental disorders are said not to receive medical treatment (Saxena et al., 2007; Patel, Boyce, Collins, Saxena, & Horton, 2011). Seventy percent of countries in Africa spend less than 1% of their health budgets on mental health (WHO, 2005b). Chad (population 9 million), for example, has one psychiatrist, and Afghanistan (population 25 million) has two (Saxena et al., 2007).

Against this background, a growing movement is advocating for increased mental health service delivery under the banner of the Movement for Global Mental Health (the Movement, www.globalmentalhealth.org). The Movement was formally launched in a landmark special edition of *The Lancet* (2007). This has come to be seen as the Movement’s rallying call, and is our frame of reference in this paper. This work has been expanded in a range of high profile scientific publications, including a further series in the *The Lancet* (2011) and papers in *Nature* (Collins et al., 2011), *JAMA* (Patel & Prince, 2010) and *PLoS Medicine* amongst others (see Petersen, Lund, & Stein, 2011 for reviews of some of this work).

Composed of an international coalition of actors and agencies, the Movement highlights high levels of untreated mental illness, calling for the large-scale scaling-up of services and medication, advocacy for the rights of the mentally ill, and research to support these efforts. To date, the Movement’s most vocal proponents have been clinicians working within biomedical models of disease. However social scientists have been welcomed to the Movement’s meetings and included as co-authors of key papers. The Movement’s calls make frequent reference to the social dimensions of mental ill-health. User group representatives have a high profile in its work, and its affiliates include organisations such as BasicNeeds, which has pioneered approaches to addressing mental illness through improving affected peoples’ livelihoods and opportunities for social inclusion (BasicNeeds, 2008). However there is a need for more systematic attention to the role social scientists might play in driving the global mental health agenda forward.

In this regard, the Health, Community and Development Group at the London School of Economics held a meeting to begin to map out a role for social scientists, with particular emphasis on the need for frameworks of analysis and action to clarify and expand the role of communities in advancing the Movement’s agenda (ISP, 2009). This section of *Transcultural Psychiatry* presents a selection of the

papers from this meeting. Whilst the Global Mental Health Movement's rhetoric and literature frequently refer to the need for greater community involvement, references to communities tend to be firmly located within the medical model of disease and recovery. Communities remain narrowly defined as patients and their families, and lay health workers linked to primary health care facilities. The lay health workers are viewed largely as handmaidens of biomedical expertise, with their role seen as that of helping in the scaling up of medically oriented mental health services (Kakuma et al., 2011). In this introductory essay, we will argue for a broader conceptualisation of this role, with communities viewed as experts in their own right, as crucial partners in dialogue with biomedicine, as well as agents in the promotion of what we call "community mental health competence", rather than simply assistants in implementing an externally imposed biomedical agenda.

Our starting point here is our perception of a disconnect between the *Lancet* special section's frequent references to the role of poverty, social inequalities and injustices as the causes of mental ill health (Lund et al., 2011; Patel, Collins et al., 2011), and their proposed solution – namely scaled-up services (with their primary emphasis on targeting physical disease at the individual level), and advocacy for the human rights of the mentally ill. We will argue that the Movement's view of the role of "mental health advocacy" as that of calling for the scale-up of psychiatric and psychological services and acknowledgement of the human rights of the sick, is similarly too narrow, as is their conceptualisation of "political will" in terms of the will merely to scale up services. In many situations, mental ill health is a symptom of "sick societies" as much as "sick individuals". The proposal of biological and psychological solutions to problems which also have social drivers draws attention away from the matched need to create social contexts that enable and support peoples' opportunities for improved mental health. An expansion of the role of grassroots communities is core to meeting this challenge.

The Movement's choice of biomedicine rather than social theory as its guiding star is arguably an astute political strategy, a necessary first step in establishing a broad-based global awareness of the issue – as a prelude to the development of a more complex social approach. As highlighted in *The Lancet* (2007) special edition, competing or unduly complex perspectives on a problem can detract from the clear and simple message most likely to convince governments and attract donors (Saraceno et al., 2007). Too early an emphasis on diversity and controversy could fragment the Movement before it has established a broad-based foundation. Furthermore, a one-size-fits-all approach to diagnosis and treatment may be regarded as the most practical opening strategy given the perceived scale of the problem.

Emphasising parallels between mental disorders and physical illness may also be strategically useful given that at least rudimentary infrastructure for physical health services often exists even in the most challenging settings, providing a useful infrastructure for the bolt-on of mental health services. Furthermore the governments of many countries with high levels of mental ill health are unlikely to be sympathetic to a movement calling for radical social change. We fully acknowledge these

strategic points. The complex and multi-layered processes that deprive so many people of the opportunities for mental health are unlikely to be tackled by a movement with a single focus. We therefore present our perspective as a complementary rather than competing approach.

Local-global connectedness as a “problem space” for analysis and action

The concept of “local-global connectedness” is a useful analytical tool for highlighting the spaces of engagement between self-styled “global” actors and “local” communities¹ (Campbell, Cornish, & Skovdal, 2012). Local-global engagements refer to the flows of resources, knowledge and influence between global actors and the local communities targeted by their services and advocacy (Herod & Wright, 2002).

The extent to which local communities are passive recipients of external resources and influence, or able to use these to increase their control over their well-being, is hotly debated (Ansell, 2009; Seckinelgin, 2008; Swyngedouw, 2002). A large literature on the global response to HIV/AIDS (Hanefeld, 2010), a key source of inspiration for the Global Mental Health Movement (Patel, Collins et al., 2011), highlights how the uneasy interfacing of global and local systems of power and knowledge have often undermined efforts to manage the epidemic where interventions have failed to engage with the realities of target communities (Campbell & Cornish, 2010). Criticisms have been made of the prescriptive and top-down nature of the global funding architecture (Kelly & Birdsall, 2010), the subordination of local experiences of “health” to ill-fitting international models of behaviour change and service provision (Vaughan, 2010), the positioning of communities as passive recipients of services rather than agents of their own health (Aveling, 2012) and the poor fit between donor and indigenous styles of response (Cassidy, 2010). All of these have been said to undermine programmes of prevention, care and treatment, preventing them from achieving optimal success in particular settings.

Critics have long argued that the global health apparatus deflects attention away from problems arising from social inequalities by conceptualising them as technical issues solvable through neutral systems of biomedical expertise (Escobar, 1995). This ignores the extensive evidence (e.g., reviewed in the WHO’s “Social Determinants of Health” report, CSDH, 2008) that increased access to political recognition and economic power is necessary to improve the opportunities for health available to marginalised groups. Thus, for example, the Millennium Development Goals’ approach to maternal health has been criticised for deflecting attention from the impacts of the oppression of women on their health, opening up markets for medical services and pharmaceutical products with scant attention to the social factors that make it unlikely that many poor women will be able to access or benefit from these resources (Harcourt, 2009). Dominant responses to women’s depression (Stoppard, 2000) and to the high levels of alcoholism, violence and suicide by men (Haaken, 2010; Lynch & Kilmartin, 1999) have been criticised

for emphasising drug treatments and psychotherapy, with too little attention to the harmful effects of gendered social roles and relations on the well-being of both women and men. Evidence for the tendency of psychiatry and psychology to individualise social problems resonates with Foucault's criticisms of psychiatrists and psychologists as "servants of power", policing the boundaries of normality and abnormality in ways that preserve the status quo, rather than highlighting the way in which social inequalities undermine opportunities for health (Foucault, 2006/1965).

However, other critical social theorists highlight the conceptual poverty of frameworks that assume a unidirectional flow of power and influence from active global agents to passive local communities, or from powerful psychiatrists to powerless patients (Lewis & Mosse, 2006). They argue that this simplistic view of power ignores how poor communities are sometimes able to use external knowledge and resources in ways that advance their own interests (Massey, 1999; Mosse, 2005). It also draws attention away from the potential for dialogue and partnership between global and local actors, in which communities would be able to advance their health and social interests. Local-global engagements may sometimes become sites for the reinforcement of social inequalities when outside health professionals impose their frameworks and practices on communities. However, such engagements also can act as catalysts for new ways of knowing, being and seeing by both communities and outside professionals (Campbell, Scott et al., 2012).

In the interests of advancing this more optimistic approach, and a more nuanced view of power, we seek to promote debate about the potential for communities to work in more equal partnership with health professionals and advocates to advance global mental health as well as simply tackling mental illness. How might the Global Mental Health Movement construct a more inclusive understanding of the term "global" (Fernando, 2012, this issue), one which regards communities as agents as well as targets of mental health-enhancing change?

Papers in this special section

What light do the papers in this section of *Transcultural Psychiatry* throw on the possibilities and limitations of the local-global spaces of engagement currently envisaged in the Movement's calls? What light do they throw on the potential for enhanced community engagement in driving the call for improved global mental health forward? Summerfield (2012, this issue), the Movement's most stringent critic, contests the frequently made claim that globally one in four people will suffer a mental disorder in any year, saying this number is inflated by a tendency to pathologise normal responses to life's challenges. In his view, the mental health industry has expanded its influence by emphasising human vulnerability rather than resilience, with the everyday challenges of life (e.g., stress, relationship breakdown, social uncertainty) increasingly viewed as drivers of biological illness and disability. He challenges the Movement's dependence on diagnostic

categories and symptom checklists standardised on white American populations, which he argues have limited generalisability to groups in other countries and contexts. Furthermore, he argues that there is scant empirical evidence for the efficacy of many western treatment approaches and little evidence that the scaling up of services improves mental health in any context (see also Summerfield, 2008).

Summerfield contests the “foundational assumption” of western psychiatry, that mental disorder can be viewed outside of the contexts of society and culture, using quantitative methods based on western models of symptomatology and personhood, ignoring difference, diversity and cultural specificity. In his view, many so-called mental disorders (e.g., depression, post-traumatic stress disorder) are better viewed as complex socio-cultural responses to adversity, rooted in the meanings that individuals give to their experience, with reductionist medical diagnostic categories incapable of assessing “a whole person immersed in the dynamic complexity of a life and situation” (Summerfield, 2012, p. 520). In the settings of poverty and social inequalities that characterise the lives of millions, many so-called mental illnesses, particularly common mental disorders, may often be normal reactions to negative social circumstances (Summerfield, 2001). Summerfield argues that there is an urgent need for the Movement to develop an “ecologically valid” evidence base, working more closely with communities to develop definitions of illness and strategies for healing that resonate with local worldviews and realities, and build on indigenous strengths and support systems.

The influence of powerful social groups in framing global responses to mental ill health is a theme in several papers. Kienzler and Pederson (2012, this issue) highlight the politicised nature of humanitarian interventions in their discussion of the evolution of international responses to the distress of civilians in conflict situations in the Cold War and post-Cold War era’s. They trace the social processes through which the construction of post-traumatic stress disorder became exported from war veterans to civilian populations, and through which trauma care came to constitute part of the standard humanitarian package alongside food, shelter and medical care. They highlight the contradictory juxtaposition of terms “humanitarian” and “intervention”, the former referring to neutral and ethically motivated efforts to alleviate the suffering of survivors of adversity, and the latter to the unilateral interference of one group in the affairs of another. Humanitarian intervention is often driven by the military logic of powerful states, associated with violence, dependent on military support and exerting a key role in international politics.

The partisan nature of so-called “global” mental health actors is a theme in Fernando’s (2012, this issue) critique of the *The Lancet* (2007) series for its absence of an explicit discussion of the role of culture in mental health, a topic at the heart of a large anthropological literature (Kirmayer, 2006; Kleinman, 1980). Drawing on her work in collectivistic communities in Sri Lanka, she highlights the poverty of individualistic approaches that fail to position the mentally ill within their

families and communities, or to integrate understandings of the role of religious beliefs and culturally specific framings of mental states in treatment responses.

Given this absence of “other” perspectives, Fernando questions the Movement’s claim to be “global”. She argues that “HP-I-18” would be a more appropriate description, given the dominant role of 18 countries in setting the series’ (2007) agenda, many of which exert “High Power” in terms of global political and economic influence, and favour an “Individualistic” approach to health and healing, drawing largely on American diagnostic categories and de-contextualised quantitative research methodologies. She outlines ways the Movement might construct a more inclusive conceptualisation of the “global”, through research and interventions that put communities and culture at the heart of its efforts. She argues that research contributing to its evidence base should be required to yield tangible benefits for study communities, given that ecologically useful research findings are most likely to lead to effective mental health policies.

The role of patients’ cultures and livelihoods in framing their abilities to benefit from psychiatric services is at the heart a study by Read (a medical anthropologist and occupational therapist) (2012, this issue) which highlights the complexities of the Movement’s call for scaled-up access to psychotropic medication. In rural Ghana, drug treatment was often discontinued by patients with severe mental illness, with the support of their families, even when they recognised its efficacy in controlling symptoms such as hallucinations, aggression or sleep disturbances. This was often because unpleasant side effects (drowsiness, feeling weak) conflicted with local understandings of health in terms of strength and ability to work. In poor rural areas, where physical strength is crucial to community survival, the ability to carry water, chop wood, tend fields and carry children is a core dimension of health, often considered more important than e.g. the reduction of hallucinations.

The need for long-term medication, and the failure of antipsychotics to bring about a permanent cure, was often seen as evidence for spiritual causes of illness that were resistant to medical treatment (e.g., witchcraft). Read’s informants often viewed recurring mental illness as a symptom of dysfunctional social relationships rather than simply biological illness (Comaroff, 1980), requiring the intervention of traditional healers rather than, or alongside, medical ones.

Read’s interrogation of the Movement’s goals in the light of the realities of rural lives follows on from an earlier paper (Read, Adiibokah, & Nyame, 2009) in which she discusses the Movement’s calls for governments to protect the human rights of the mentally ill. In rural Ghana the common practice of “chaining the mad” is widely condemned by western activists. Whilst not denying the terrible suffering of the chained, she argues that poverty and limited access to services often leave families with no alternative to restraining potentially violent relatives. This makes sense in a cultural context where the community’s well-being is prioritised over individual rights. She also points out that in many countries with emerging economies and weak systems of governance little respect is shown for the rights of any citizens, mentally ill or not. Furthermore, Read argues that whilst calls for rights are vital, efforts to protect the rights of the mentally ill are most likely to

succeed alongside efforts to work in partnership with families, carers and local communities to develop alternative ways of managing dangerous behaviour and strengthening communities' abilities to implement these.

The need for collaboration with local communities in ways that recognise their agency and resilience is central to the discussion by Skovdal (a community health psychologist) (2012, this issue) of "the pathologisation of healthy children" implicit in the global response to AIDS-affected children. Driven by western associations of "normal" childhoods with innocence and play, researchers have been quick to position AIDS affected children as helpless victims at heightened risk of depression and deviance, and in need of mental health interventions. Arguing that AIDS-affected children tend to be "poor" rather than "mad" or "bad", and often able to exercise resourcefulness in tackling their daily adversity, Skovdal says children's well-being would be better served by policies and interventions that support their resilience and strengthen potential community support networks than by the increased availability of psychological therapies or drug treatments.

Citing Summerfield, Skovdal claims that the growing prevalence of psychiatric worldviews in poor communities teaches people that they are not expected to cope through their own resources and networks, potentially undermining local responses and coping strategies of communities. Skovdal would not seek to deny that some children have mental disorders in need of clinical intervention. However, in contrast to the quantitative symptom checklists that currently dominate research and practice in this area, he argues that many children would be better served by participatory research and interventions focused on understanding how they cope, and how their wider communities might best be supported to facilitate their coping. For many children community-based interventions are more useful than mental health services (Skovdal & Andreouli, 2011; Skovdal, Ogutu, Aoro, & Campbell, 2009).

However, as Petersen and colleagues (2012, this issue) show, community participation is not a magic bullet in the absence of wider efforts to create contexts which support effective grassroots mobilisation. They report on a South African intervention promoting community involvement in mental health service delivery. South Africa has a firm commitment to user participation in mental health policy and service (Kleintjies et al., 2010). They found that the participation of poor and uneducated community members in multi-stakeholder service meetings, self-help groups and community health worker programmes enhanced the cultural competence of service providers, improved local awareness of services and facilitated valuable peer support amongst people who were psychologically distressed. However, gender inequity and poverty limited local peoples' efforts to improve mental health. Thus, for example, local informants praised the support that a self-help group had given a woman whose husband and sons had stolen her cattle to pay for a second wife. The group persuaded her to accept the situation without protest, convincing her that "over-reaction" would place her and her other children's physical safety and economic survival at risk. In another example, a lay community health worker's (CHW) response to the repeated rape of a 13 year-old-girl by a man in her household was to furtively engineer the relocation

of the child (rather than the offender) to another relative's house, after the child's carer refused to take action given their economic dependence on the rapist. The CHW feared more direct intervention would place her own safety at risk in a context where there was no institutional recognition or support (from clinics or police) for her role. Thus, whilst Petersen and colleagues strongly support the involvement of local communities in tackling mental illness, including lay CHWs, they emphasise that in practice the bulk of this burden comes to be shouldered by marginalized women. While they may assist in ameliorating mental distress, they have limited power to address the social determinants of poor mental health, especially in the absence of greater formal institutional support, placing burdens on disempowered lay people to deal with problems with roots in circumstances beyond their control creates a burden that potentially places their own mental health and physical safety at risk.

Formalising a role for communities in advancing the goals of the Movement

How can the local-global engagements opened up by the Movement enable new and enhanced ways of knowing, being and seeing by communities and mental health professionals? The papers highlight some of the challenges facing the Movement in advancing its goals to be "global" and "health" (rather than illness) oriented. They emphasise the need for greater attention to the role of context and culture in framing how people experience and respond to threats to their well-being, greater recognition of the agency and resilience of individuals and communities, and the need to take more explicit account of the ways in which power inequalities undermine opportunities for health. It is in meeting these challenges that community participation has a role to play.

There are three justifications for community participation in health programmes (Campbell & Cornish, 2010). The first relates to the growing emphasis on "task shifting" by the Movement (Saxena et al., 2007) and in global health more generally (WHO, 2007). Lay volunteers, and low-level paid health workers, have a central role to play in delivering expanded services in resource-poor contexts with few trained personnel. Secondly, community participation increases the reach of services, with community members often best able to identify and support members of particularly vulnerable groups who are least able to access and use services. Thirdly, most importantly for our interests, community participation is essential for developing health-enabling community contexts that support the possibility of effective prevention, care, treatment and local advocacy. There is growing evidence for the direct and indirect health-enhancing impacts of positive local participation in informal or formal networks related to friendship, leisure, spiritual faith, community activism and so on, as well as health-oriented projects (Campbell, Skovdal, & Gregson, 2011; Campbell, Scott et al., 2012).

Directly, social participation can lead to benefits such as increased access to information about health problems and how best to avoid or respond to them,

better access to practical, emotional and material support for the ill and the confidence to cope with or challenge social stigma. Indirectly, social participation may be associated with various forms of empowerment (e.g., increased income generation opportunities, enhanced social recognition, opportunities for community activism), which may also increase opportunities for health, both at the individual and the collective levels (Blane et al., 1996; Gregson, in press). Social participation potentially advances the sense of coherence and positive social connectedness that Summerfield (this issue) views as central to mental health, and which are central to our conceptualisation of community mental health competence described below.

To date, efforts to promote community participation for improved mental health have been fraught with complexity. We have already referred to Petersen's account of the possibilities and limitations of the participation of disempowered women in mental health support groups and health volunteer programmes in South Africa. In a very different case study in India, which also has sound pro-community mental health policies, Jain and Jadhav (2009) highlight the absence of community participation in a community mental health programme, which involved nothing more than the transport of psychiatrists to remote areas to prescribe psycho-tropic drugs to queues of patients. Facing the embeddedness of mental illness in intractable socio-economic problems, and equipped with professional training that offered few ways to engage with local cultural idioms of suffering, interaction with community members took the form of psychiatrist monologues about drug compliance. Nearby Hindu and Muslim shrines were more responsive, offering patients a more accessible framework for understanding and responding to their distress.

Dialogue

The field of community psychology (Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2011; Jovchelovitch, 2007) emphasises the importance of dialogue between communities, researchers and service providers regarding how best to integrate insights from "local" and "global" perspectives in optimising opportunities for well-being (see also Apfel-Marglin & Marglin, 1990). Target communities are not blank slates that sit waiting passively for external experts to come and solve their problems. They are active social agents, often exercising extraordinary courage and ingenuity in staying alive in adverse social circumstances, with already well-established local worldviews and systems for tackling health problems, framed by cultural beliefs and practices that might have poor resonance with formal mental health services. Professionals are experts in the biomedical paradigm of health and healing. Communities are experts in their own cultural paradigms, and best qualified to assess how to integrate what biomedicine can offer into the daily realities of their lives and survival strategies.

It is vital that professional and community expertise are accorded equal status in such dialogue. The dialogue should approximate Habermas' (1989) idealised

notion of the “public sphere”, where equal respect and recognition is given to the views of all participants irrespective of their social status or institutional power. In unequal social settings, it is unrealistic to assume that marginalised group members will have the confidence to express their views forcefully to more powerful actors, and Fraser (1990) argues for the need for supporting “counter-public spheres”. These are social spaces in which disempowered people have opportunities to formulate and rehearse their views and arguments before discussing them with more powerful group members.

Mental health interventions are most likely to resonate with communities’ own understandings of their needs and interests when they rest on a research base which takes full account of local understandings and responses to mental illness, and where diagnostic categories and treatment plans recognise and engage with the agency, resilience and world views of target communities – with communities seen as partners with service providers rather than as passive beneficiaries of services. A recognition of the “culturally alien” status of psychiatry in many contexts, and the existence of “multiple models” of health and healing – as well as skills around how best to integrate these in the interests of their patients – needs to be integrated into the training of psychiatrists and other mental health workers (Jain & Jadhav, 2009, p. 78). The Movement has a key role to play in calling for the recognition of multiple models in building a more inclusive global approach to mental health.

Community mental health competence

Partnerships between professionals and communities are a core aspect of community mental health competence – the ability of community members to participate effectively in efforts to promote prevention, care, treatment and advocacy. We characterise health competent communities in terms of three core dimensions (Campbell & Jovchelovitch, 2000; Nhamo, Campbell, & Gregson, 2010). Firstly community members should have sound *knowledge* of how to recognise symptoms of stress and illness at an early stage, and how to access services and use them in ways that are not too dissonant with core cultural beliefs or local support networks. However knowledge is only one precondition for effective community response to health. This knowledge needs to be shared and debated in supported “social spaces” enabling the integration of often unfamiliar medical knowledge with local frames of reference.

Access to *safe social spaces*, the second dimension of health-competent communities, provides opportunities for people to engage in “critical thinking” (Freire, 1973) about the social and cultural drivers of distress and poor mental health, about obstacles to effective responses, and about how their impacts might be predicted and ameliorated. In ideal circumstances such discussions serve as a springboard for more politicised responses in which community members engage in collective action to challenge or resist negative or disempowering social relations, in alliance with outside groups, although this will not always be possible.

Dialogue amongst liked and trusted peers may occur spontaneously in the course of indigenous forms of social participation – in local faith-based organisations or women's groups, or in daily peer networks of various sorts. It may also be purposively facilitated by health programmes using methods such as “community conversations” (UNDP, 2004) or peer education (Campbell & MacPhail, 2002) with a carefully selected range of local groups representing different local interests. Community interventions have also used initiatives such as sport and microfinance as arenas for promoting critical thinking about health. Such approaches train local community health workers to facilitate discussions where local people air reservations about new health programmes, “translate” unfamiliar medical information about health problems or services into concepts and practices that make sense to them, and brainstorm locally appropriate responses to health problems.

Effective social spaces facilitate the development of three important aspects of health competent communities. These include:

- a sense of *local community ownership and responsibility* for good mental health through the participation of local people in promoting health and tackling illness alongside health services;
- the confident recognition of *local individual and group based skills* as contributing to such efforts;
- a sense of *local solidarity* around collective efforts to optimise mental health in adverse conditions, including “buy-in” from local community leaders and, where possible, from local people associated with different configurations of age, gender and other significant markers of local difference (communities are seldom homogenous).

The third feature of a health-competent community is that of *partnerships*. In a health competent community local people are aware of, and able to access, external organisations and agencies (including, for example, public health services, NGOs, charitable foundations, political groups) with the will and resources to support good mental health in the community. Bourdieu's work (1986) reminds us that a key driver of health inequalities is peoples' lack of access to social networks that can help them advance their interests (“social capital”). Marginalised communities cannot be expected to tackle significant health problems without significant outside support and recognition from groups with the political power and economic resources to assist them in achieving their goals. Elsewhere we have argued against the common tendency for community projects to focus too narrowly on building the knowledge, capacity and “voice” of local community groups, without parallel efforts to create “receptive social environments” in which more powerful groups are willing to listen to local peoples' needs and demands and assist them in achieving them (Campbell, Cornish, Gibbs, & Scott, 2010). In this regard the Global Mental Health Movement constitutes a key potential support partner for vulnerable communities.

It is here that community participation also ideally takes on a more politicised dimension. In highlighting the global AIDS struggle as a model for the Movement,

clinicians and researchers Patel, Collins and colleagues (2011) refer to the inspiration the Movement has drawn from the South African Treatment Action Campaign (TAC). The TAC is a global coalition of AIDS activists that has played a key role in mobilising international awareness of the suffering of people living with HIV/AIDS. The TAC formed an effective bridge between its rank-and-file local members in South Africa – the majority highly marginalised as poor, uneducated, young women with AIDS – and a range of national and global supporters (Friedman & Mottiar, 2004). Drawing on this support base, the TAC successfully challenged the power of pharmaceutical companies who had sought to limit poor peoples' access to life-saving AIDS drugs. It also built effective alliances with politicised women's groups, trade unions, radical networks of health workers amongst others – locally, nationally and internationally – to highlight how the well-being of people living with HIV/AIDS was undermined by social injustices including racism, women's oppression, unemployment, homophobia and other sources of social inequality (Robins & von Lires, 2004). The TAC indeed provides an inspiring model of how a global network can link with marginalised local communities in LAMIC settings to drive forward global support for health-enhancing change.

The challenge facing any 21st century global movement is that of “formulating cross-spatial strategies that do not silence the other, exclude the different, or assume the particular within a totalising vision” (Swyngedouw, 2002, p. 160). This involves recognition of the vital role that both local worldviews and practices need to play, alongside global ones, in co-constituting their conditions of engagement. The mobilisation of vulnerable local communities and user groups into a global mental health network could play a key role not only in scaling up psychiatric services, but also in ensuring that mental health research and services recognise and strengthen vulnerable communities' own worldviews, priorities and strengths. Most importantly, the integration of local community struggles for mental health into an energetic global activist network opens exciting possibilities for drawing local voices into wider calls for the recognition and empowerment of vulnerable and excluded groups – in a way that starts to translate the Movement's calls for improved global mental health from rhetoric to reality.

Note

1. The term “community” is a contested one, varying used to refer to people who live in a common geographical space, people with common interests or people with a shared social identity. Because public health interventions most commonly target their efforts at geographically defined communities, we use this place-based definition of community in our work.

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