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Community Psychology and Social Change: A Story from the field of Mental Health in Portugal

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Community Psychology and Social Change: A Story from the field of Mental Health in Portugal

Abstract

A contextual and ecological intervention approach for people experiencing mental illness was developed with a primary focus on the mobilization of natural resources, the expansion of social networks and supports, and to systematically promote opportunities for activity within the community. The mutual help movement provided a major contribution to enhance and strengthen the social role of those experiencing mental illness. This social change process was inspired by empowerment theory and the goal of recovery through social and community participation. Therefore we present a community-based intervention, based on the principles and values of Community Psychology, a program implemented during the last twenty years in the field of mental health that contributed to changes in the mental health system in Portugal. A community-based support system has been organized to provide social supports in terms of housing, education and employment by enhancing the use of natural contexts, such as schools and businesses, and the diverse social resources available to the general public.

Introduction

The challenge raised by the integration of people experiencing mental illness into the community receives valuable contributions from Community Psychology and related fields of study. Of those contributions we place emphasis on the contextualist approach (Kelly, 1987, 1990, 2006; Segal & Aviram, 1978; Aubrey & Myner, 1996), the social movement of community mental health (Mosher & Burti, 1989; Levine & Perkins, 1987, 2004), and mutual help (Madara, 1986; Rappaport, 1995). Two additional pillars of research that influence the work include empowerment theory (Rappaport, 1977, 1984; Zimmerman, 2000) and the recognition of Recovery reports of those with experiential knowledge of mental illness (Deegan, 2002; Chamberlin, 1997; Ahern & Fisher, 2001).

In this presentation we aim to describe some of the contributions of community psychology over a 20 year period of growth in this field, and consolidation of a non-governmental initiative created to promote change in the mental health system in Portugal. We begin with a brief story of the initial steps, and we seek to provide an overview of the progressive implementation of a community-based services program. We discuss how the specific contributions of community psychology were relevant for the formulation of strategic options, to provide context for the program (both the structures and activities), and the principles upon which the system was gradually completed. We recognize that this is an unfinished story, and the impacts of the changes observed still need to be investigated. Such investigation can help us understand more fully the

promotion of effective change on the mental health system of the country.

Throughout this paper, we refer to “users” as users of the mental health services. Some countries refer to them as “clients” or “consumers”.

Social and Political Change in the Mental Health System in Portugal

During the 80's, the mental health system in Portugal was structured around large-scale psychiatric hospitals or psychiatric wards integrated in general hospitals, and also large institutional facilities managed by religious congregations.

In 1987, through a small grant provided by the State Mental Health Department to a Psychiatric Hospital, a small group of professionals began home-visits to identify people in the community who received treatment in the Hospital and were discharged to the community of Olivais - Lisboa. In March 1987, group meetings were held 3 times a week in a room provided by the local authority of Olivais, for a group of four people with mental illness and their families. In October 1987, a group of twelve persons with mental illness, their families, a group of professionals and under-graduate students in psychology and other social sciences (political sciences; social work; art education), created a non-governmental organization named *Association for the Study and Psychosocial Integration* (AEIPS) to promote a community-based service system.

During the last two decades, through the work of this organization (Ornelas, 2002; Ornelas, Monteiro, Vargas-Moniz, Duarte, 2005) there was an effort to synthesize the contributions of Community Psychology with inputs from psychosocial initiatives

in order to renovate the mental health system in Portugal.

Applying a community model to treat people with mental illness, their families and support the professionals working with them, means defining their backgrounds, and to think about the specific roles each group plays in the development of a community mental health paradigm.

Overview of AEIPS

For people experiencing mental illness AEIPS¹ has served over 700 persons (70% men and 30% women). The vast majority diagnosed with schizophrenia (70%), and another group of people diagnosed with bi-polar disorder or other psychosis, and some people with a mixture of mental health illness, and a history of substance abuse.

The ages of the patients range from 18 to 57 and the average age is 33 years old. The average time that patients received medical psychiatric support is 8 to 10 years and the majority received in-ward treatment. The participants of the AEIPS have a history of long-term unemployment, or lack professional workplace experience, and low or incomplete educational attainment levels with the exception of some University degree students, depending on the age at on-set of the reported problems. The majority receives social income (social pension, early retirements, other social revenues), but not enough to survive independently. Most patients live with their families and lack the possibility of alternatives in terms of housing or other supports based on financial difficulties.

Reports of social isolation and stigma were found in a study reported in a trans-national research initiative by Rego and Vargas Moniz² (2007) with a group of people with mental illness (N=25). Globally the participants reported that, they did not feel discriminated against, however high rates of perceived self-stigma were narrated in everyday life interactions such as “I do not trust that I am able to study or work,” “I stop myself several times...”, or “I feel they avoid me!”, “... I was very discriminated against...”; “I haven’t made that many friends, after I was diagnosed...”

¹ Information available from the AEIPS annual reports

² Portuguese version of the INDIGO study developed in collaboration with the King’s College in London by G. Thornicroft and N. Sartorius

Family involvement. During these 20 years, the families were the major source of social and political support of this organization, as members of the statutory boards, and as political advocates for a community support system for their relatives. Personal reports of high levels of stress, isolation and stigma, and a lack of recognition are also reported by the family members “we live in a cycle of sadness, and prejudice, we need to find others with similar experiences...someone that accepts us...and we need to find hope...so that we may feel stronger and provide support to others” (Bruno-da-Costa & Manuel, 2005). Therefore there was the need to enhance their social and political capacity, and simultaneously their social supports and their wellness (Riebschleger, 1991, 2004).

Professional challenges. The challenge for professionals has been the application of the community psychology constructs, principles, and values in the context of a non-governmental community organization, namely the empowerment theory. Moreover, the very idea of empowerment had also to be applied to the professionals themselves so that they may feel strengthened, valued, and able to anchor their practice in a set of values that accommodate for increasing participation levels of the people with personal experience of mental illness in the management and evaluation of the services provided.

Community model. The consistency of a community model meant the need to focus the community intervention through persistent involvement and participation in regular community contexts including the families, specialized services when required, but also the array of services and supports available for the general population, and particularly the social services or supports for those experiencing some sort of vulnerability.

Socio-political context. During the 20 years of implementation there has been a negotiation process, both with the governmental health and social welfare bureaus and private funders and/ or supporters. Between 1990 and 1992, a commission was formed among governmental agencies where this organization was extensively interviewed during a set of hearings with a Trans-disciplinary group that built the foundation for a legal document that was adopted in 1998 (407/98).

In 1995, the Ministries of Health and Social Welfare officially recognized the importance of the need for mental health services and created a stable financial

agreement; prior to this supports were provided for the structures, but not for the operation of the service.

From simple beginnings twenty years ago, the organization now has four locations in the city of Lisboa. All operate with a combination of public grants (60%), and a combination of families' contributions and private corporations' donations (40%), serving 120 people with mental illness, their families, and a total of 30 support professionals, with a global budget of 1 million Euros. As a result of this investment, we have the structures, the knowledge, the experience, trained professionals, and the commitment of the people with mental illness and their families to consolidate this change process.

Portugal is in a privileged position to avoid the de-institutionalization phenomena observed in countries such as Italy, United Kingdom, and even in the United States, during the seventies and the eighties (Mosher & Burti, 1989; Levine & Perkins, 1987, 2004), that promoted public policies without a paradigm able to sustain the complexity of the social integration processes.

We still live in a country with two systems in the field of mental health. They include the large psychiatric institutions, which have a larger part of the financial resources and a community support system; it is still relevant to present theory and practice to prepare the post-hospital era (Ornelas, 2005).

Community Psychology Principles

Ecological approach. Based on the contextual and ecological approach (Levine & Perkins, 1987, 2004; Kelly, 2006), we were able to change the focus of the intervention from the diagnosis and deficit identification or confirmation to the observation of people with mental illness in context. Through this observation we learned about the need to acquire "situated knowledge is knowledge derived from appraisals of persons in specific locales, settings and situations in which they are participants..." (Kelly, 2006, p.189). We used this knowledge to understand how the community resources are used to expand the social networks, and keeps the person experiencing mental illness in a functional community setting.

Within this perspective, the main focus is the person's integration into the community through physical presence, enhanced access to community resources, personal care, and active participation with family, friends and other social groups and contexts (Segal & Aviram, 1978; Aubrey & Myner, 1996). It is not exclusively the participation in services and

resources specifically designed for people experiencing mental illness and their families.

Through the experience of implementing the principles and the practical guidance of community mental health we were able to validate basic human rights such as people, independently of any diagnosis or other vulnerability, should live in the community, even in crisis situations, maintaining access to the available resources (Mosher & Burti, 1989; Levine & Perkins, 1987, 2004). The community mental health movement advocates that if people have access to resources they may improve their lives, grow and strengthen themselves (Levine & Perkins, 1987, 2004). This thesis was confirmed with recovery reports about persistent engagement with support networks, mutual help groups, and involvement in diverse natural social contexts.

Social Integration. The idea of social integration results from advocating that people with mental illness have access to the same housing, professional, and social contexts as any other person; that people have the right and opportunity to choose the location where they will live, work, or study and socialize, including people who do not experience problems for mutual benefit. Therefore, services and supports need to be made available according to need and take into consideration that individual needs change over time (Deegan, 2002; Carling, 1995).

Mutual help. Another source of learning came from the mutual help movement. This has been a major contribution for the enhancement and strengthening of the social role of those with a personal experience of mental illness. It may be defined as the voluntary gathering of people who share common experiences or problems and offer continuous and permanent support (Madara, 1986).

Empowerment. This twenty year process has been built through the inspiration of the empowerment theory defined as the process by which individuals gain mastery over their lives (Rappaport, 1977, 1984; Zimmerman, 2000), or more recently as "the process by which individuals, communities and organizations gain mastery over their lives in the context of changing their social and political environments to improve equity and the quality of life". (Minkler & Wallerstein, 2005, p. 34). The major challenge has been the application of this paradigm to the three main actors in this process: a) the people with a personal experience of mental illness, b) their families, and c) the innovation of role of the professional facilitating the whole movement

(Ornelas, Vargas-Moniz and Albuquerque, 2003; Ornelas, 2002, 2005).

Recovery orientation. Recovery represents another major challenge, because it means the planning and implementation focused on what may be defined as a process, an attitude...a way of facing the daily challenges...establish a renewed sense of integrity and personal purpose beyond the illness (Deegan, 2002) or as "...regaining a sense of trust on oneself" (Chamberlin, 1997, p.9). Some perspectives on recovery recognize that it is possible through a process of personal strengthening, of control over the important decisions of one's lives, participating in the life of the communities, through relevant professional, educational or family social roles (Ahern & Fisher, 2001). All of these contributions have been crucial to understand the social and political potential of community psychology to anchor concrete social change processes.

The Community Program

A community-based support system was organized to provide housing services, educational and employment enhancement through the use of natural contexts. These contexts include access to regular schools, particularly Secondary Schools and Universities; access to companies in all economic sectors, as well as the diversity of social resources available for the general public.

a) Supported Housing Services

Inspired in the community mental health movement, in 1989 we created the first group-home in the community that provided a housing solution for four institutionalized people, three men and one woman with long-term hospitalization, but could not be discharged due to a lack of social supports. After three years the woman (when re-employed) decided to leave hospital care and live in the community. Currently the organization owns three different spaces in the city of Lisboa as housing alternatives for 21 persons who lack community supports, and all are used with many different profiles; for some it is permanent and for others it is a transitory experience, there are no time limitations, and in some situations they have worked as a crisis support and management context.

The group homes have been crucial over these years to demonstrate that deinstitutionalization was not a myth or simply a movement or a social policy that went wrong in many countries. We were able to have personal reports of satisfaction and achievement (Oliveira e Duarte, 2006; Homem, 2005), and

comparatively lower rates of hospitalizations. Building and generalizing supportive housing for a set of services and supports for people with mental illness, it is crucial to have investments in diverse housing options (Brown, Ridgway, Anthony & Rodgers, 1991) by providing group or individualized opportunities--including options for those who decide to live as partners. It is also relevant to structure housing support services, with specialized intervention professionals oriented towards the maintenance of the housing options in community contexts, even in crisis situations. The philosophy of these services is to permanently ensure efforts to keep people in contact with their relevant natural social and physical resources. The relevance of these supports may be corroborated by a monograph study by Oliveira & Duarte (2006), where the participants reported high rates of sense of community and stated that housing in community contexts contributed particularly for their personal recovery.

This study also concluded that the length of time in the community was positively correlated with a greater sense of community, and the effective use of community resources. The participants reported (Oliveira & Duarte, 2006) that the housing experience has specifically contributed for their emotional and physical wellness. Within those facilities there were opportunities for a continuous support practice in community contexts, access to peers and the development of group spirit, new friendships, access to job and education opportunities, a daily routine with concrete responsibilities, a sense of independence, and the possibility of interacting with diverse people.

Although we may consider a diversity of resources to be relevant for housing in the community, there needs to be flexibility to provide differentiated responses adaptable to individual need (Vargas-Moniz, 1999). From the research data available (e.g. Brown, Ridgway, Anthony & Rodgers, 1991), individualized housing solutions tend to increase satisfaction and effective integration into the community. Therefore the next steps on the investment in this support program should proceed in this direction.

b) The Employment Program

One of the most relevant services provided within the organization is the supported employment program defined as a system to keep people with the experience of mental illness in the open labor market. This paradigm (Brooke, Inge, Armstrong & Wehman, 1997) states that a larger number of people achieve success through their professional integration, and

this is based on the premise that all individuals, despite their differences, should have equal opportunities to reach the labor market, and actively participate in society. This seems a simple and linear concept, but it makes a large difference when implemented.

The professional areas of the 18 new opportunities created during the year 2007 (Table 1), for each of the location identified only one person has integrated.

TRAINING FIELD	COMPANY
Graphic Design	Delikatesen
Gardening	Horto Campo Grande
Computers helpdesk	MAPFRE Insurance
Administrative	CEFIPSI
Storage	FNAC Alverca
Administrative	FPCM
Human Resources	AUCHAN
Maintenance	Zoo
Beauty Adviser (1)	Marionnaud (1)
Administrative (2)	French Embassy (2)
Administrative	SAS
Orders for Clients	FNAC Chiado
Cashier and Logistics	FNAC Chiado
Car Washing	Precision
Administrative	Centro Comunitário
Accounts	General Electric
Administrative	Hospital Cuf Descobertas
Financial/ Fiscal	General Electric
Administrative	Hospital Cuf Junqueira

Table 1 – New Opportunities in 2007

Of the opportunities made available: 6 were successfully completed, and 4 resulted in a working contract, 11 transitioned into training for 2008 and 2 were less successful 1 for health reasons and the other decided to go back to school.

Besides the 18 new opportunities in 2007, the working group also provided support to 13 employed

participants, 8 of whom have been employed for over 3 years, and 5 signed new contracts during the year.

Supports for users. The supports provided include individualized meetings, support, and evaluation meetings within the company, group meeting at the AEIPS, and a monthly celebration dinner. On average each participant has 12 individual meetings (3 times a week) and weekly phone contacts. The support or evaluation meetings held in the workplace are for discussing problems or obstacles and are also used to sensitize employers and supervisors to accept difference and adopt anti-stigma procedures, and also aimed at progressively open the floor for a future contract. The weekly working group meetings have a plan, and are also aimed at supporting group members when they bring specific topics, or support needs. During 2007 the themes selected by the group, combined with demands or requirements related with the participation in partnerships and programs were peer supports, empowerment and recovery, the challenges of working as an integrated team, colleagues and supervisors, as well as conflict resolution. The rates of participation in these meetings are 64% of the working group members. The monthly celebration dinner is a highly appreciated activity by the members, because it is the recognition of the “small wins.”

Other activities of the working group also relevant to understand are the ecological contextualized approach and the empowerment strategies used within the program for the participation of the people with an experience of mental illness in the networks organized within the EU programs EQUAL, implying trips to meetings or other events in Paris, and Northern Ireland in 2007.

c) Supported Education Services

With similar principles and premises the supported education paradigm has focused attention to the relevance of academic success factors (Pomeroy & Pape, 1999), therefore opportunities to return to school became a relevant programmatic element of the service system. People with the experience of mental illness often had unfinished degrees; so the opportunity to return to school to complete such degrees or diplomas was transformed into an element for the process of building individual social support systems. These initiatives impact the increase of job options, and for personal and family satisfaction. Since 2000, the AEIPS program, supports in the educational area was provided for 350 people with an experience of mental illness. Among them 250 participants were integrated in continuing education

programs (e.g. computers, languages) and 100 people in regular curricula from basic degrees to secondary and universities³

d) The Users Empowerment and Mutual Help Movement

The Mutual Help Group is part of the empowerment process of the users, and according to Coimbra and Antunes (2005), the meetings are crucial as an opportunity for users to exchange about problems, experiences, deeds, thoughts and opinions; "...it is relevant for us to feel the affection and the good feelings of our peers"; "The strength, hope, and positive energy of a human environment"; "We learn to understand and respect others, and to recognize what is best for each of us".

Besides the Mutual Help Group, the organization facilitates the participation of people with mental illness in European and other international networks, and contributed to the progressive autonomy of the users/survivors' movements. The emergence of a Portuguese movement of people with the experience of mental illness as a part of this global movement has been happening, namely the participation of users in national and international events, the organization of meetings with representatives of several organizations, the publication of a newsletter, the contribution to international documents (e.g. The European Commission Green Paper on Mental Health⁴) and now the process of creating an Empowerment and Mutual Help Centre open to all those in need of peer support in the field of mental health. It is crucial that people with mental illness control these organizations so that the community model is a reality, a concrete example is the role played by the mutual help groups.

From collaborative research studies (Ornelas *et al.*, 2003; Breda, Ornelas, 2007), we were able to think about the results of the application of an empowerment philosophy. Users reported the need to have greater control and responsibility over their lives; increase their participation in decision making processes within the organization; to play significant roles in service providing, management and consultant roles in services run by professionals. Through these issues we may corroborate the concept

³ Data gathered from the Annual Reports (2000 to 2006)

⁴ For more information:

http://ec.europa.eu/health/ph_determinants/lifestyle/mental/greenpaper/mentalgpcontributionsen.htm#8

that increased participation and control among people experiencing mental health illness generates increased critical awareness, growth and *Recovery* (Ornelas *et al.*, 2002).

e) The Role of the Families

Over the past twenty years, family members have had the opportunity to participate in international initiatives, such as European Projects (eg. Prospect (2001-2004) an initiative supported by the European Program Leonardo da Vinci), national and international events and meetings (EUFAMI – European Federation of the Families of People with Mental Illness), organized a mutual help-group, and are also part of national family organizations.

In a *focus group* held during 2006, which included parents and siblings of people with mental illness to discuss the current mental health system, the participants reported the need to develop a group of families supporting the community integration of people with an experience of mental illness. This group would advocate for access to alternative supports to psychiatric hospitals and other forms of involuntary treatment, and to promote human rights within a holistic perspective about mental illness.

This group is also involved in a mutual-help dynamic with diversified groups and networks or platform for broader action for mutual benefit and political lobbying for community support systems. Bruno-da-Costa and Manuel (2005), the members of the Mutual Help report that in the groups the role of families is valued, "we may play a crucial role on the integration of our family member...but we are not able to help anybody if we are desperate or depressed...you cannot give what you haven't got"; "In the group we learn to be hopeful, that we are not alone, we transmit strength and even joy."; "We recognize that a mental illness situation has deep consequences in the family, it is a daily source of stress, because the illness never goes away"; "We are exposed to stigma and prejudice, therefore we must learn to take care of ourselves."

f) The Professionals in Community-based Programs

Community-based services should promote participation in regular social activities, the maintenance of a network of social ties and interactions, including the reciprocity of social supports, the opportunities for debate and critical reflection, as well as the strengthening of the sense of community and belonging that are maximized by the direct contact with corporations, schools and other

community contexts. The ability of the professionals to support this endeavor should be consistent with these challenges.

Multi-sector involvement. The implementation of a community model means expanding the intervention to wider social spheres; this implies the constant search for coalitions and alliances within the community to probe for answers to identify specific interests or the talents of users. To respond to the challenges and adjustments required as a result of the increasing user participation, there is the need to share power, provide opportunities for the active participation of users in terms of service organization and priorities definition, as well as access to training and information in continuing training programs.

Client involvement. Another innovative domain for professionals is the support for exclusive responsibility by users, such as mutual-help groups, peer-support systems, access to significant role models, providing support services, and representing the organizations. The direct influence in the definition of priorities, and privileging collaborative research methodologies, enhancing qualitative aspects of empowerment and recovery, are crucial for the improvement of community-based services and supports.

Advocacy. Professionals should also be advocates for the integration of people with mental illness in all sectors of society, corporations, schools, and facilitate the exercise of all their civic and political rights (*e.g.* political participation, access to legacies, having their bank accounts, life or health insurance, *etc.*). As change agents, the role of professionals is also to facilitate that services become more effective in terms of locating alternatives in the community, namely access to housing benefits or for the use of other community resources.

In order to complement the community-based multiple support system, we have to include the advance directives for crisis support and intervention, the development of mechanisms and flexible supports for emergency situations to prevent hospitalizations or discord with family and other relevant social ties.

Discussion and Recommendations

In 2006, inspired by the New Freedom Commission, (USA, 2003); the report from the Irish Commission titled "A vision for Change: Report of the Expert Group on Mental Health Policy (2004, Ireland) and other initiatives, the Portuguese Government created a National Commission for the Reform of the Mental Health Services. It was published in the official

journal⁵ that included the representation of the community-based initiatives. Within this Commission, we had the opportunity to organize public hearings for users, families and professionals, so that representatives from the three groups would have the opportunity to present their specific needs, opinions and suggestions for change, and organize specific documents to be formally forwarded to the Commission in order to contribute to concrete changes in the public policies in the field of mental health.

Further reflections on Community Psychology Principles

Empowerment. Considering that recovery oriented services (Onken, Dumont, Dornan, Ralph, 2002), tend to be more positive in terms of satisfaction, social participation, and effective integration of users it is recommended that among the service sectors there may be an opportunity for the debate and reflection aimed at this transition. The use of empowerment theory means that service delivery should be directly influenced by users, and that active participation may constitute the basis for the improvement of recovery outcomes.

Recovery and Stigma. In an exploratory study by Monteiro and Matias (2007), with people with mental illness (N=15), 87% considers him or herself in recovery and 13% not yet in recovery, those in recovery reported the need of support by others, the recovery process requires courage, and it does not emerge naturally, it has to be built within a supportive context, and that recovery being a unique and very personal experience is available to all. However, participants consider that they will not be the same after this experience.

Considering the role of stigma (Monteiro & Matias, 2007), 83% reported that stigma is damaging for recovery. Research in the field of stigma and mental illness tends to generate some controversy that requires further consideration.

Context is important. One of the major contributions of Community Psychology has been the emphasis that interventions should visualize individuals in context(s); therefore in the history of Community Mental Health, the main settings to promote participation and wellness have been housing alternatives, access to educational facilities and employment opportunities.

⁵ For more information see Despacho n°11411 May the 25th, 2006

Long-term view. It is possible that the long-term impact of the positive results in the three main areas (housing, employment and education) is strengthened by the effective and concrete control by users of services and resources. In a study by Ornelas, Moniz and Albuquerque (2003), about empowerment and rehabilitation of people with mental illness, the participants (N=50) reported that although personal talents were identified, the rate of participation in the decision processes within the AEIPS program was rather low. With these results there were several changes in the overall organization program in response to user feedback. The users now participate freely in the internal continuing education program; have at least one, but normally two representatives in all meetings and organization boards, have developed a center for empowerment and mutual help, and continued the mutual help group that has been in place for the last decade. This increase in user participation and involvement has led to a progressive betterment of results in terms of personal achievements and reported satisfaction.

Multiple systems engaged. This experience is an example of the importance of considering that mental health reform must include the general hospitals, the community health centers and the inter-sectoral public policies on housing employment and education all oriented towards recovery, and that is crucial to include evaluation systems by users. For the development of community-based services, there is still the need to develop financial supports for housing options, and access to resources for employment and education, as well as, the supports for the creation of Peer-Support and Mutual Help organizations exclusively lead by users.

Peer support. The relevance of peer-support may also be illustrated by the monograph study by Breda and Ornelas (2007) with a group of people with mental illness (N=55) reporting that the most relevant features of peer support were sharing information, leisure activities, emotional support and affection, and concrete supports in terms of studying or for the achievement at the work place. Another relevant result includes the reciprocity of peer support, the study found that 75% of participants considered themselves as peer-support providers and receivers, and only 8% considered themselves to be essentially receivers.

Capacity building. For the training of human resources to perform the change process, three priorities may be identified: *a)* Specific training in prevention and mental health promotion; *b)* training

on empowerment theory both process and results; *c)* training in planning, implementing and evaluating community based programs. In a survey by FNERDM⁶ (2007) about the training needs identified by the professionals involved in 15 organizations involved in community mental health programs (N=130) although issues concerning housing alternatives, individual supports and recovery; supported employment, and empowerment and community integration were identified as relevant domains, were not their first choices. The priorities identified were crisis management, psychosocial rehabilitation, anti-stigma interventions, and supports to families that are part of the classical community interventions in this field. Therefore, the innovation in the continuing education programs or formal curricula for community interventionists is relevant to support the services change towards empowerment and recovery approaches.

It is relevant to acknowledge that Portuguese Commission (2006), inspired on those of Ireland and the United States of America, included the concept of Recovery as an aim for the mental health reform; that users have the opportunity to have a permanent influence on services; that hospitalizations are in general hospitals or community health facilities; and that there is a strong need to increase the resources in term of housing as well as employment and educational support services and alternatives.

Lessons Learned

From our experience we were able to conclude that it is not enough to create community-based structures or services, we need a paradigm or model that is able to promote the development of new institutional or hospital-centered models, and that needs to be replicated in community interventions. Following this political experience and the empirical data available we have been building some guidelines to support the emergence of new public policies in the field of mental health.

There are three main lessons to retain about the validation or the quality criteria for the community mental health services. A community paradigm should observe three criteria, recognized to be essential to Community Psychology research and action that are *1)* the attention to Empowerment processes and results; *2)* the presence of individual,

⁶ Federação Nacional das Entidades de Reabilitação de Doentes Mentais/ National Federation of Entities in Mentally Ill Rehabilitation

organizational and community levels of participation; and 3) the accessibility to natural services and resources.

To take forward the idea and practice of deinstitutionalization is a moral imperative for community psychologists, and was the basis of the emergence of the community mental health movement. We need to further expand the idea of diversity with the inclusion of the people with an experience of mental illness. We should lead this process and revisit the values to consolidate future interventions.

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