SALUD COLECTIVA. 2016;12(2):265-278. doi: 10.18294/sc.2016.1000

The challenge of inclusion in mental health: an analysis of a community center and its work with social bonds

El desafío de la inclusión en salud mental: análisis de un centro comunitario y su trabajo sobre los vínculos sociales

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ABSTRACT Social inclusion is a key component of transformations in mental health care, because it takes into account the benefits of community life for both those with mental illness and the other members of the community. In order to understand the scope of inclusion within mental health, 45 participants of a community center linked to a psychiatric hospital discharge program which explicitly seeks to provide social inclusion were interviewed. The possible changes in social relationships between users and other community members based in their sustained daily interactions in the community center were explored. Results suggest that the building of social bonds, as part of informal support networks, is one of the benefits of attending the community center. Positive changes in ideas regarding people with "mental illness" were also observed, although these ideas seemed to be more connected to the notion of integration than to social inclusion.

KEY WORDS Community Integration; Mental Health; Health Promotion; Argentina.

RESUMEN La transformación de la atención en salud mental supone tomar como eje de trabajo la inclusión social, considerando tanto los beneficios que la vida comunitaria trae para las personas con trastorno mental, como los que podría tener para las demás personas de la comunidad. Con el fin de analizar los alcances de la inclusión en salud mental, se entrevistó a 45 asistentes a un centro comunitario vinculado a un programa de externación de un hospital psiquiátrico, el cual busca explícitamente propiciar la inclusión social. Se indagó sobre las posibles transformaciones en las relaciones sociales entre personas externadas y otros miembros de la población, a partir de la interacción cotidiana y sostenida en dicho centro. Los resultados sugieren que uno de los beneficios que encuentran los asistentes es el establecimiento de vínculos, ligados al apoyo informal. A su vez, se observan transformaciones positivas en las ideas respecto a las personas con "enfermedad mental", aunque las mismas parecieran estar más del lado de la integración que de la inclusión social.

PALABRAS CLAVES Integración a la Comunidad; Salud Mental; Promoción de la Salud; Argentina.

SALUD COLECTIVA. 2016;12(2):265-278. doi: 10.18294/sc.2016.1000

INTRODUCTION

It is widely acknowledged that social relationships are crucial aspects in the lives of individuals suffering from severe mental illness.(1)[a] However, the institutions designed for the treatment of those illnesses – psychiatric hospitals – for a long time contributed to the relational impoverishment of the patients, by detaching them from their place of origin and isolating hospitalized patients from daily socialization areas, thus causing iatrogenic effects. On that basis, movements for mental health reform have focused on changing said situation taking as one of their main lines of action the improvement of the social bonds of people suffering from severe mental illnesses by recovering, expanding, and strengthening such bonds.(2)

The movements for care transformation in mental health, developed in the last seventy years throughout the world, resulted in a great variety of services, such as day and night hospitals, daycare centers, day clubs, community centers, and mental health community centers, just to mention a few of the many existing institutions. During that period, the conceptualization of the services mentioned above, and particularly, their purpose was modified. The new idea was that the aim of these institutions was mostly to focus on patients regaining civil rights rather than on rehabilitation.(3) This conceptual change meant that the services had to modify their focus – which was traditionally placed on the people suffering from severe mental illnesses – so as to center on the social relationships *between* these people and the rest of the members of their respective communities. To work from a relational approach means to recognize all the relevant actors of the process under study and to analyze the interactions among them.(4)

In this way, placing the focus on the relational aspect helped understand that the inclusion of individuals suffering from severe mental illnesses into daily life not only benefited them – as they could strengthen their social networks – but also, it enriched other members of the community at the same time. In addition, it enabled community members to expand their social networks and gave them the opportunity to experience and practice living with people who are different from them, as an essential part of life in society. However, despite being one of the purposes of the services, academic research has not fully accompanied these reforms, and the studies conducted, when oriented towards the members of the host communities, tended to focus on their acceptance of people suffering from severe mental illnesses and, to a much lesser extent, on the effects and transformations in themselves or in their social network.(5,6)

It is important to highlight that this change of focus in intervention is part of the debate arising from the notions of social integration and social inclusion in different areas, such as disability, education, and mental health. This debate has become confusing as both terms are often used as synonyms, despite being related to different paradigms. Social integration implies that a person who has been identified as having some difference with respect to a majority group – for example, a disability – can become in some way an active member of that social group, although the interaction structures among the members of the community have remained quite unchanged. Strictly speaking, integration proposes the opening of socializing spaces for the "different," given that it means:

> Participation by a (devalued) person or persons in social interactions and relationships with non-devalued citizens that are culturally normative both in quantity and quality, and that take place in normative activities and in valued, or at least normative, settings or context.(7 p.18)

In contrast, social inclusion considers that disability arises from the limitations and inequities produced by society due to being designed in a homogeneous way, based on a concept of "normality." That is the reason why the interventions for the treatment of these illnesses do not aim at the adaptation of those who are different, but at the modification of the environments, in which every person plays a defining role in making participation possible, as well as equal opportunities for the members of society.(8)

In this sense, the Convention on the Rights of Persons with Disabilities(9) questioned the concept of social integration, associating it with the rehabilitation model, which considered people with disabilities as subjects that needed rehabilitation in order to achieve a goal. The Convention proposed, instead, the concept of inclusion, based on the social model of disability, which considers that the disability occurs because society is not prepared to host people with different characteristics, and therefore, does not let them develop their full potential. In this sense, disability occurs *between* the individual and society. From this perspective, people with disabilities can contribute to society in the same way as any other person, emphasizing the value of each person and respect for the differences. The principles of the social model of disability are independent living, non-discrimination, and universal accessibility, from a human rights perspective.(10) Therefore, the problems of social inclusion are those severely affecting the quality of life of one part of the population, in a material and symbolic sense. These problems derive from the disadvantages arising from the exclusion of people with disabilities from the opportunities shared by others.(11)

In the mental health field, the change towards social inclusion has been hindered by the problems encountered by the services, and within them, by the workers in this field, to think in terms of relational categories. Even within the so-called community services, a usual characteristic is placing the focus on the "patients" and centering their attention on one of the elements of a field of intervention that, by definition, should be relational.

Within the field of knowledge production, in addition to the already low rate of systematization and evaluation concerning mental health services, it is also common that indicators and instituted ways of thinking tend to focus on the individual, that is to say, on "the patient." This turns out to be particularly problematic for community services, which have more difficulties in accounting for their professional work, given that their work tends to include, in various ways, other actors in addition to the "patients" themselves. At a regional level, it is important to mention the attempts to systematize the community experiences conducted by the Pan-American Health Association,(12) as well as the progress made in Brazil and Chile, countries in which the display of community services has been part of a reform process at a national level.(13,14) In the case of Argentina, this lack of information about community services creates significant vulnerability for them. This situation is a crucial element in the current situation of the country given that, within the context of the enforcement of the Argentine Mental Health Act,(15) a constant tug-of-war is taking place among multiple field actors, in which the scant systematic knowledge about community services becomes a vital element in the dispute over power. This is the reason why, over the last years, the interest of several actors over the work done by the community services has increased.(16)

From what was mentioned above, over the last eight years, a research line exploring the evaluation of mental health community services was developed. In this article, we present the results of a research study conducted between 2011 and 2014 within this research line, called "Evaluation of the changes produced by the discharge of psychiatric patients in their communities: insights from the community." The study analyzed the changes in attitude within the community in which former long-term patients from psychiatric hospitals started to live. The investigation was divided into two stages: the first stage focused on the neighbors of the group homes where the users of a discharge program(17,18) lived; and the second stage analyzed in detail the community center involved in the program, where discharged people assist as well as other members of the community, under the assumption that it is a privileged place for interaction, that is to say, a place of change

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for all the people that attend the center. This article presents the results of the second stage of the study, whose objective was to describe and analyze potential changes in the social relationships among people who were admitted to specialized psychiatric hospitals for long periods of time and other members of society. Changes in social relationships were based on their sustained daily interactions in a community center, which aimed to promote social inclusion in their community.

Characteristics of the community center

The community center in which the research study was conducted has been running for fifteen years and is part of the Rehabilitation and Assisted Discharge Program at the José A. Esteves District Hospital, a specialized psychiatric hospital for women located in the southern area of Greater Buenos Aires. This program has two components: one that is concerned with support during the discharge that is focused on the users, and the other that deals with health promotion oriented to all the community. The original objectives of this center were, on one hand, to create a space for interaction between the users of the program and the community through the development of cultural and educational activities, operating as a mechanism for social inclusion, and on the other hand, to be the premises of the program outside the psychiatric hospital.

The activities offered by the center are aimed at the whole community, including the users of the program, which means that the action and intervention goals are not only the users but all of the community, as well. According to the founding members of the program: “it is not about asking the community to support the users and to accept them, but to offer the community activities that may be of interest to them, from a health promotion perspective.” It is important to contextualize the opening of the community center in a period immediately preceding the social and economic crisis in Argentina in 2001, a crisis that, along with the suffering of the population, gave rise to the revival of spaces promoting socialization, sharing, and solidarity among people.

In this way, the community center offers not only activities that are concerned with the support provided during the discharge that is exclusively directed to the users of the program, such as individual and group sessions, and user and team meetings, but also activities aimed at the whole community: workshops, training courses, and cultural activities. Therefore, the community center is a shared space: the same classroom can be used for a meeting of the program users and then for a knitting workshop that is open to all the community. This causes the members of the community and users of the program to inevitably meet in the center, whether sharing the same activity or not. Sharing the space is a distinctive feature of this program in comparison with other mental health community programs in the country and, at the same time, it is one of the reasons why it is referred to as a “community” center and not as a “day” or “mental health” center.

The activities of the center are constantly promoted by several means in order to encourage community participation. Likewise, efforts are being made to encourage and mostly to support the participation of more vulnerable groups (such as individuals from addiction prevention centers, containment centers, and foster homes), as they tend to have more difficulties including themselves in socialization spaces. These people are usually referred to the center by a professional or by recommendation of other attendees. Finally, program users work along with the discharge support teams, who motivate them to participate in the different activities according to their interests. Since the year 2013, it is mandatory for newly discharged users to attend at least one workshop during the first two months following their discharge, after which period they can decide whether to continue attending or not. Furthermore, it should be noted that some of the program users also work in the center, doing administrative or cleaning tasks, or assisting the workshop teachers.

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The activities offered by the center include art workshops, bodywork, and sports workshops, training courses, socially-productive endeavors, and social and cultural activities. In the workshops, the work centers around two goals: one, related to the learning of the specific activity of the workshop (for example, painting) and the other, to the promotion of interaction and bonding among participants. In this sense, it is worth noting that the workshops are not therapeutic spaces, despite having such effect, and also, that the teachers are skilled people specialized in the specific contents of each workshop.

METHODOLOGY

The study had a mixed method design, since quantitative and qualitative data were produced and analyzed in order to ensure better understanding of the subject matter of research.(19) At the time when the research study was conducted, eighteen workshops were being held in the community center. The following inclusion criteria were applied for workshop selection: the workshops should include a stable group of participants, should be institution-specific, and intended for adults. Thus, the sample of the research study included nine workshops, with 153 participants. During the first week of August 2013, structured interviews were conducted, for which 45 people attending the center were summoned, and then willingly agreed to participate in the research study.

The interviews were conducted, individually, at the beginning of each workshop, with the first five people to arrive and who have attended the workshop for more than a month. Each interview lasted approximately 20 minutes and was recorded with notes taken by the interviewer, which were later transcribed.

Given that the interviews were conducted by members of the research team who did not work at the community center, they had no knowledge of whether the interviewed person was a discharge program user or not. Each interviewed person was informed about the objective of the research study and was asked to give his or her informed consent. With the purpose of maintaining confidentiality, the interviews were numbered according to the order in which they were held.

The interview consisted of 27 open-ended and closed-ended questions, grouped into four sections: socio-demographic data, relation between the interviewed people and the center, their perceptions concerning different problems, and their perceptions and relationships with people suffering from "mental illness." The term "mental illness" was used because, in the pilot testing of the interview that was implemented in the first stage of the research study, it was the easiest term to be understood by those who were not familiar with the mental health field. The interviewees answers were categorized independently by at least two members of the research team, later discussing the cases in which there had been no agreement regarding the categorization, in order to determine it.

RESULTS

The results of three of the four sections of the interview are presented in this work. The section regarding the "perceptions concerning different problems" was excluded, on the basis that its purpose was to compare the answers with the ones obtained from the work done with the neighbors – an aspect which is not covered in this article.

Socio-demographic data

Of the interviewed people, only 60% had attended the center for over a year. Of them, 73% were women. The age range of the interviewees was between 18 and 77 years, with only 9% of people aged over 65 years, that is to say, reaching retirement age. There were heterogeneous levels of education: 56% had completed their secondary studies or higher education and only 7% had incomplete primary studies or no schooling. Regarding their condition, 20% were married, 55% were single, 16% were divorced, and 9% were widowed. The household and family structures of the interviewed people showed that 7% lived in their nuclear household, 73% in an extended household, 13% in a one-person household, and 7% in a composite household.

Regarding their occupation, 33% of the interviewed people were active workers, half of whom were regular employees. The remaining interviewees occupations were: housewives (18%), students (13%), unemployed (16%), recipients of social security (11%), and retired (9%). Finally, with regard to the place of residence of the interviewees, 64% lived in the same municipality as the center and the rest came from eight different localities in order to attend the workshops.

Relationships in the community center

Some of the questions asked in the interview were about the relationship between the people and the center; that is to say, how they came to know the center, the reason why and the purpose of attending the center, what they gained from attending, and more specifically, to what extent attending helped them build social bonds.

With respect to how they came to know the center, a third of the interviewees were referred by a professional, whereas others were recommended by an acquaintance, or because they lived nearby. As for the reason why they attended the center, most of them stated to have done it for the workshop activity offered, for example, learning how to draw or learning a trade such as hairdressing. Another reason for attending was their search for something that may help them relieve some pain, usually linked to loneliness and social isolation:

> *Retirement seems terrific at first, then you feel empty. I started to search but, I didn't know where to begin. I chose these three workshops and I don't regret the time I spend in them.* (61 years old, female, workshop No.4)

> *To begin with, to be with people.* (35 years old, female, workshop No.9)

A third reason for attending the center was by referral of a professional or as a form of treatment:

> *Because the psychiatrist recommended it to me as therapy.* (61 years old, female, workshop No.2)

> *I need it, the doctors told me to do yoga.* (77 years old, female, workshop No.2)

Moreover, 84% of the interviewed people stated that they had built new bonds as a result of attending the community center. Almost half of these people met with the new acquaintances outside the community center framework.

With respect to what they liked about the center, most of the answers were grouped into three categories: social bonds, the activity itself, and social "integration." The category connected to social bonds was the one with the highest number of answers referring to the "people," including their workshop mates, teachers and other staff members of the center. The answers grouped under the social "integration" category made explicit reference to the presence of "patients" or "mentally ill people," for example:

> *There is respect. The workshops are very well organized, and their role is to help people suffering from mental illnesses.* (47 years old, male, workshop No.6)

> *They fit in naturally, nobody treats anybody differently because they are in a better or worse condition.* (61 years old, female, workshop No.4)

> *It's all about learning. Before you would see them depressed now they attend the workshop. It saddens me a little.* (61 years old, female, workshop No. 4)

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With regard to what motivated the people to keep attending the workshop, most of the answers were grouped into three categories: bonds, learning the specific workshop activity, and feeling good. Among the answers, it was noted that attending the center helped people go out of their homes and meet others, and promoted companionship. They also highlighted the treatment within the center, as well as the bonds built with the teachers. For example, some of the interviewed people said:

> *Here I found people I can talk to, I have friends.* (62 years old, female, workshop No.1)

> *It makes me happy, it is good for overcoming loneliness and isolation.* (67 years old, female, workshop No.4)

Furthermore, there were questions about the benefits that the interviewees thought they obtained from attending the center. Most of the answers were grouped into two categories: "well-being" and "socialization," although most people mentioned both of them at the same time. The "well-being" category was described in different ways, as follows:

> *To keep myself busy with other things, I had a lot of problems.* (42 years old, female, workshop No.8)

> *I was depressed because I lost a job of 16 years, but I realized I can do other things.* (42 years old, female, workshop No.8)

> *You feel good.* (67 years old, female, workshop No.2)

> *To clear your mind.* (35 years old, female, workshop No.3)

> *To see things in different ways.* (34 years old, female, workshop No.3)

As for the "socialization" category, the answers indicated that attending the center served them to meet people and create social bonds; also, to improve the way they socialized with other people, and they also mentioned cases involving people with mental illnesses. For example:

> *To be with all kinds of people. You help, and they help you. There are various kinds of people.* (54 years old, female, workshop No.3)

> *It helped me to socialize. I have a friend.* (42 years old, workshop No.1)

> *To be a bit in touch with people, I used to feel lonely otherwise.* (61 years old, female, workshop No.2)

Perceptions and relationships with people suffering from "mental illnesses"

Of the interviewed people, 80% answered that they knew someone who had been admitted to a psychiatric hospital, more than half of them had met that person at the community center. The latter were asked about what it was like to share the center activities with a former psychiatric patient. It is important to highlight that none of the answers had a negative connotation. In some cases, they referred to the former patients as equals, coming across answers such as:

> *Just the same as with anybody else.* (19 years old, male, workshop No.6)

> *Just like any other person.* (31 years old, female, workshop No.7)

Some other interviewees seemed to have learned from the bond built in the center:

> *It helped me to understand; I was judgmental at first, by knowing their story I learned what happened.* (20 years old, male, workshop No.6)

> [It is] *really nice, you learn a lot about life.* (45 years old, female, workshop No.7)

In other cases, they acknowledged the difference, linked to the concept of tolerance:

> *Good, you don't even realize, they adapt to the group.* (47 years old, female, workshop No.6)

> *I don't engage much, she connects with me.* (61 years old, female, workshop No.4)

> *Good, because it's like you accept them.* (54 years old, female, workshop No.3)

Most of the people who met a former mental patient at the center for the first time noted that the original idea they had of this kind of people changed as soon as they interacted; in all cases the answers were positive. Interestingly, many of the interviewees said that they did not use to accept them much before; however, this had changed:

> *It makes you feel more humane, you are more helpful when you know more.* (54 years old, female, workshop No.3)

> *You take them more into account. They can integrate into society with our support.* (47 years old, female, workshop No.6)

> *I didn't think I could relate, but it's possible.* (47 years old, female, workshop No.6)

> *It has helped me change the forms of interaction and to relate more naturally.* (31 years old, female, workshop No.7)

They were also asked about what they currently thought about people suffering from mental illnesses, and also, about what they thought about them before attending the center. Almost half of the interviewees mentioned a change in their way of thinking, these changes being mostly positive and negative only in one case. About the positive changes, it was found that becoming acquainted with those people taught them things:

> *I didn't really know them, now I care for them and I think I can help them.* (42 years old, female, workshop No.8)

> *I never thought about it before. I realized that it is important to listen to them.* (35 years old, female, workshop No.9)

In addition, thanks to knowing them, some preconceptions were changed:

> *They used to scare me, now they don't because I'm getting to know them quite well. It's nothing like I had imagined.* (19 years old, female, workshop No.8)

> *...now I don't judge them or cross the street when I see them; we all have our own painful experiences.* (61 years old, female, workshop No.4)

It should be noted that six of the interviewed people spoke about mental illness in the first person and, in all cases, they mentioned the suffering and loneliness involved in their illness, as well as the rejection they perceive from other people:

> *We are in constant struggle with our illness. I suffer a lot and I need to avoid that suffering for a while.* (57 years old, female, workshop No.2)

> *I think we are ignored and set aside. Most people don't like to deal with it. They don't like to be near suffering. I don't like it myself, but have to cope with my illness.* (35 years old, male, workshop No.4)

On the other hand, those who were interviewed were asked about what they thought they could do for a person suffering from a mental illness and what a person suffering from a mental illness could do for them. With regard to the first question, most of the answers were related to accompanying, helping, and listening to them:

> *Help them, take them out so they can feel the sun, breathe some fresh air, to show them that there are other things besides the suffering they had experienced.* (42 years old, female, workshop No.8)

> *To make them feel good, to caress them, to give them affection, something to do.* (38 years old, female, workshop No.2)

> *To understand them, to guide them.* (69 years old, female, workshop No.1)

Only a minority of the interviewed people mentioned that they needed to be treated as any other person:

> *To treat them as equals.* (35 years old, female, workshop No.4)

> *To treat them exactly in the same way as me.* (32 years old, male, workshop No.6)

In relation to what they thought a person suffering from a mental illness could do for them, it should be noted that the question surprised most of the interviewees. Half of them gave categorized answers such as helping, accompanying, and listening:

> *To accompany me, that is enough for me.* (57 years old, female, workshop No.2)

> *To be friends, so that they can show me life from a different (darker and sadder) perspective.* (20 years old, male, workshop No. 6)

> *To share things.* (54 years old, female, workshop No.4)

> *To listen to me and help each other, to give me support.* (27 years old, male, workshop No.5)

Other answers were about giving love and affection:

> *To give you affection.* (47 years old, male, workshop No.6)

> *The affective aspect.* (69 years old, female, workshop No.1)

> *You receive love.* (42 years old, female, workshop No.8)

Moreover, the two final answers of each interviewed person were compared, finding in almost half of them a similarity between what they thought they could do for a person suffering from a "mental illness" and what that person could do for them. For example, one of the interviewees answered the first question by saying, "*Listening to them is a little of what I have learned here, they need to talk and share,*" and the second answer was, *"what I learned was mutual";* the answer to the first question of another interviewed person was, *"to make them feel good, to caress them, to give them affection, something to do,"* and the second answer was *"the same."*

DISCUSSION

Some of the sociodemographic data of those who were interviewed could account for one of the reasons why the population uses the services provided by the community center and that is lack of support, and as a consequence, the search for socialization spaces. The data supporting this hypothesis are that 80% of the people were single, widowed, or divorced and that, although 80% of them lived with their families, only 7% lived within their nuclear family. Moreover, only 33% were active workers. That means that it is possible to observe some evidence showing that two of the main sources of social bonds, work and family, could be reduced among those who attend the center. As already mentioned in many studies,(20,21,22,23) social support is an essential source of well-being for people, and the absence of social support is correlated with different causes of morbidity and mortality. For instance, not having a life partner is related to stress, depression, and lower satisfaction with life,(24) and both unemployment and irregular employment are associated with anxiety and depression.(25,26) Furthermore, it was noted that the effects of social support depend partially on the person providing such support.(27) Family and employment characteristics of some of the interviewees could account for a reduction

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in social support provided by peers (for example, in terms of their role) and that could be one of the aspects reached when participating in the center activities, in the sense of joining a group of peers.

Moreover, and despite including a small sample size, it is interesting to read the data from a gender perspective. The men who attend the center are less related to work than women, although the percentage is low in both cases; in addition, the few individuals who lived in their nuclear households were all women. Although most of the interviewees, as well as the ones working at the community center, were women, it is important to say that, in comparison, men attending the center seem to be more vulnerable than women attendees. As already mentioned in gender studies, job-related failures affect men's self-esteem more seriously than women's, given that they question their gender identity.(28) In this sense, it is also important to reflect upon the programs and services, considering that many times they represent a more approachable option for women in material and symbolic terms, which represents an obstacle for male access.(29)

Furthermore, around 25% of the interviewed people said that the reason to start attending the center was the search for some help to relieve the pain linked to loneliness and social isolation, considered, in theory, as a typical suffering and pain of the time,(30) and that cannot be restricted and categorized as an "illness."(31) Many other interviewees explained that they had come to the center by the advice of a professional; therefore, it could be inferred that these professionals are considering this type of services for referrals, which would mean that activities that are not clearly related to therapeutic standards are being included within the treatment spectrum. This could be considered a possible change in treatment methods, and coincides with what has been mentioned for several decades at a discursive level in international documents regarding the types of mental health care(32); and recently, also in Argentina, since the enforcement of the already mentioned Argentine Mental Health Act.(15)

Although in most cases the initial reason for attending the center was not related to the creation of social bonds, it was, in fact, the reason why they kept going, and one of the elements as to why attending the center has been useful for them. In this sense, it could be mentioned that a service such as the community center, by promoting the creation of social bonds, helps people to come out of isolation and loneliness; a problem that, with its differences, is shared both by the people who are traditionally treated at psychiatric institutions as well as by those who despite not being treated or not needing a psychological or psychiatric "treatment," still feel lonely and isolated. Both cases include people who had suffered different types of isolation, and who need to come out of that situation by building social relationships, as part of their rehabilitation and well-being. It should be noted, as Grandesso postulates, that by counting with the support and encouragement of a group, people tend to suffer less from different daily situations.(33) Moreover, studies conducted with the participation of people suffering from severe mental illnesses showed that involvement in spaces with other people helped them improve their skills and lead a more independent life.(34)

Likewise, the fact that many of the people who attend the center maintain the social bonds they had built there even outside the center framework, reveals that an important feature of their intervention lies in promoting the creation of relationships that facilitate the informal support among people, a really significant feature given that one of the main aspects of this type of support, unlike formal support, is reciprocity.(35) It has been noted, that for people's well-being, to receive social support is as important as to give it,(22) considering that, in the particular case of people suffering from severe mental illnesses, helping others is a capacity that they are usually denied.(36) In this sense, results would show that a feature observed in people who socialize with severely mentally ill people, within the center context, is the notion of reciprocity of social bonds, and the idea that those people may be subject of and also a source of support, particularly, in tasks related to social and emotional support.

The fact that those who were interviewed may think of the people suffering from "mental illnesses" as individuals from whom they could also receive things can be seen as an improvement in doing away with the stigma of danger that had historically been attached to the understanding of "mental illness." However, it should be mentioned that, among those who spoke about "mental illnesses" in the first person, the ability to help others was not frequently recognized, which could account for the effects of the stigma on the subjectivity of those who suffer from it.

Furthermore, it is important to highlight that a large number of the people attending the center (80%) knew at least one person who had been admitted to a psychiatric hospital; of whom more than half had met that person at the community center, which shows that the center is vital for the interaction with people suffering from severe mental illnesses. This contributes to the debate regarding the effects of the organization of mental health programs and services, in the sense of analyzing the results of their exclusivity or diversity; in other words, their integration to other services, or their differentiation or specialization.(37) The results also suggest that, after interacting with people suffering from "mental illnesses," a positive change occurs in the perceptions of those who attend the center regarding the mentally ill. Along these lines, there are some research works that show direct contact with people suffering from a "mental illness" is one of the best ways to neutralize the presence of the stigma and social discrimination against them.(38) However, it should be considered that, since the discharge program involves a psychiatric hospital for women, the interactions occur mainly, although not exclusively, among women who were formerly admitted to the psychiatric hospital. Most of them being over 50 years old, a feature that may be related to a reduction in the concept of danger, which tends to be more associated with young males.

It is also important to note that, although the answers of those who were interviewed showed a decrease in prejudices and further development from the interactions with the "mentally ill patients," they seemed to be more on the side of social integration than on that of social inclusion. Although social inclusion is the working horizon where the actions of the community center are aimed towards, to achieve inclusion exceeds the intervention possibilities because, as social exclusion is a multidimensional process, it would take several actions and interventions, both planned and spontaneous, to achieve social inclusion. In this regard, thanks to the creation of social bonds, the community center has contributed to the mobilization of some individuals from a zone of exclusion to a zone of vulnerability,(39) given that, despite some precarization and fragility factors that are still present, they have managed to break down barriers of social isolation, and thus, to make an impact on an essential, yet not sufficient component, to achieve social inclusion: the reciprocity in social bonds.(40)

To conclude, it is important to mention that this research study is not, strictly speaking, relational research, given that it only addressed the perspective of the relationships of one of the actors in the scenario in question: the community. As mentioned above, the community is an actor that, paradoxically, is not often analyzed in community mental health or social inclusion programs and services, which, by taking into account such perspective, explore the insights of family members and professionals related to the users or patients.(41) This is probably due to the methodological difficulties arising from the operationalization of the concept of "community." Therefore, considering that the relational perspective implies an advance with respect to placing the focus exclusively on people suffering from "mental illnesses," it could be stated that there is a paradox in this model and that is the intention to maintain a dichotomous logic (e.g. between the community and the mentally ill). Nevertheless, the development of a relational perspective regarding mental health interventions would help facilitate a better understanding of how interventions can not only be beneficial to those who are traditionally considered to be their target population, but also to the communities where they live. This change in perspective would allow workers in this field to understand that their work is to create more diverse human groups and communities, and not just to "integrate" those who are different.

ACKNOWLEDGMENTS

The authors of this article would like to thank the Rehabilitation and Assisted Discharge Program at the José A. Esteves District Hospital for their help with the fieldwork and to Valeria Canales for her participation. The study was financed by the Universidad Nacional de Lanús, through research study No.33A103, titled "Evaluation of the changes produced by the discharge of psychiatric patients in their communities of residence: insights from the community."

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ENDNOTES

[a] There is a debate in the field of mental health about the concepts of severe mental illness, mental illness, psychological suffering, and mental suffering. This debate is beyond the scope of this article, and for this reason, it was decided to use the term "severe mental illness" since it is internationally accepted.

CITATION
Ardila-Gómez S, Hartfiel MI, Fernández MA, Ares Lavalle G, Borelli M, Stolkiner A. The challenge of inclusion in mental health: an analysis of a community center and its work with social bonds. Salud Colectiva. 2016;12(2):265-278. doi: 10.18294/sc.2016.1000.

Received: 6 Jul 2015 | Modified: 23 Jan 2016 | Approved: 24 Feb 2016

https://doi.org/10.18294/sc.2016.1000

The translation of this article is part of an inter-departmental and inter-institutional collaboration including the Undergraduate Program in Sworn Translation Studies (English< >Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús and the Health Disparities Research Laboratory at the University of Denver. This article was translated by Martina Fuchs under the guidance of Victoria Illas, reviewed by Amy Hudson and Kait Ross under the guidance of Julia Roncoroni, and prepared for publication by Aldana Micaela Schöenfeld under the guidance of Vanessa Di Cecco. The final version was approved by the article author(s).