Original Research Article

Psychological Reports
2024, Vol. 0(0) 1–22

DOI: 10.1177/00332941241248595
journals.sagepub.com/home/prx
Sage

Support Groups Versus Primary Mental Healthcare on Disability and Continuity of Care: Community Trial [Support Groups for Recovery]

Felipe Agudelo-Hernández
Universidad de Manizales, Manizales, Colombia

Ana Giraldo Alvarez
Universidad de Los Andes, Bogotá, Colombia

Rodrigo Rojas-Andrade
University of Santiago de Chile, Santiago de Chile, Chile

Abstract

Based on the need to implement strategies to reduce recovery gaps in mental health with the community as axes of recovery, the objective of the present study was to assess the impact on psychosocial disability and care continuity in individuals with suicidal behavior, of the clinical and community components of the Mental Health Gap Action Program (mhGAP), versus exclusive psychiatric care. For this, a controlled community trial carried out in 2023 was conducted, comprising intervention groups: Support Group (SG), mhGAP Group (mhGAPG) and a Control Group (CG). Self-report measurements were collected pretest and posttest, utilizing the Psychosocial Disability Scale and the Alberta Continuity of Care Scale. The study involved the participation of 94 individuals with a history of suicidal behavior, with 30 individuals in

Corresponding Author:
Felipe Agudelo-Hernández, Universidad de Manizales Facultad de Ciencias de la Salud, Centro Liborio, Manizales 170001, Colombia.
Email: afagudelo81703@umanizales.edu.co

Data Availability Statement included at the end of the article

the SG, 34 in the mhGAP group, and 30 in the CG. Categorical variables were summarized using frequency distribution tables. Descriptive statistics were used to examine participants' characteristics at the study outcome and estimate treatment compliance. The Mann–Whitney U Test examined differences in sociodemographic variable frequencies. The Jarque-Bera test confirmed a normal distribution for psychological variables, warranting the use of parametric tests. Differences in mean values across groups, each with two measurements per individual, were assessed using a type II repeated measures ANOVA. There were significant differences based on the intervention, with the effect being greater in the SG across all domains. Significant improvement was observed in all domains of the disability and continuity of care scale within the intervention groups. Both groups showed improvement, with better results for the SG. In conclusion, a methodology is proposed for implementing support groups based on core components, which effectively enhances psychosocial disability and the continuity of mental health care, especially in suicidal behavior.

Keywords
Self-help group, community networks, mental health, mental health systems/hospitals, suicide

Public Health Significance Statement

While the significance of community interventions and support groups for mental health recovery is outlined in global public policy, there is a paucity of studies that specifically address the impact of these interventions on mental health and the enhancement of healthcare services.

The findings of this study demonstrate the potential impact that support groups could have on psychosocial disability and continuity of care in mental health, surpassing the effects of solely professional mental healthcare.

Based on the results, a methodology is proposed to develop support groups based on the promotion of active agency, coping strategies, recognition, and management of emotions, problem-solving strategies, supportive interaction, trust, self-identity construction, and strengthening of social networks.

Introduction

In the Americas and the Caribbean region, psychosocial disability is identified as the primary cause of disability, accounting for 7.8% of the total disability burden,

specifically attributed to depression (Pan American Health Organization -PAHO-, 2021). A psychosocial disability is understood as a process that appears when the environment does not allow a person to participate in the same way as everyone else due to a mental health process or history (PAHO, 2021).

It has been observed that in low and middle-income countries, between 75% to 90% of individuals with mental disorders do not receive the necessary treatment, despite the existence of effective treatments (Organización Panamericana de la Salud, 2018). Likewise, it has been documented that countries allocating fewer resources for mental health tend to have higher spending on psychiatric hospitalizations. Conversely, countries with greater investment in community-based services exhibit fewer psychiatric hospitalizations (Jamison et al., 2018).

Individuals who have been discharged from mental health facilities exhibit higher suicide rates compared to the general community. As a result, efforts targeting suicide prevention should commence in emergency or hospitalization departments, extend into the immediate post-discharge period, and be sustained over a longer duration, with particular focus on community settings (Chung et al., 2017). The aforementioned approach encourages individuals with psychosocial disabilities to establish legal connections, while also acknowledging that social barriers and access to health services play a pivotal role in distinguishing between limitation and disability in an individual (Patel et al., 2018).

These barriers primarily pertain to mental health services. According to Díaz-Castro et al., several challenges in public health management concerning mental health have been identified in Latin American countries (Díaz-Castro et al., 2017). These challenges encompass limited research resources, fragmented functionality within mental health systems, the absence of a comprehensive national health system, inadequately formulated policies affecting service organization and delivery, and mismanagement of policies in the context of mental health services (Díaz-Castro et al., 2017). These challenges may vary and encompass health co-morbidities, housing instability, relationship breakdowns, disconnection from support networks, or difficulties in continuously navigating through multiple service systems (McIntyre et al., 2022).

The significance of the social environment and community-based care has grown in importance for individuals confronting mental health issues. However, this scenario brings forth various challenges at ethical, social, administrative, and even epistemological levels (Patel et al., 2018). Since 1990, particularly with the Declaration of Caracas, the focus of mental health care has shifted away from psychiatric clinics characterized by asylum-like settings. Instead, the aim has been to establish psychiatric wards within general hospitals, emphasizing a more integrated and community-oriented approach to mental health care. In addition to the integration of mental health into primary healthcare, the emphasis is placed on considering both the individual and the community as the core elements of the recovery process (World Health Organization-WHO- & Pan American Health Organization - PAHO-, 1990).

The latter concept is encapsulated in the expression “nothing about us without us.” This principle signifies that individuals who experience mental health problems assert

their empowerment and advocate for their active involvement in shaping care services and research within the field. Consequently, low-cost interventions, such as peer support groups, have been recognized as potentially beneficial, as they align with this philosophy of inclusive participation and can contribute significantly to the well-being of those involved (Nickels et al., 2016). In certain cases, it has been suggested as a strategy to alleviate the financial burden related to psychosocial disability (Agudelo-Hernández & Rojas-Andrade, 2023a; Kelly et al., 2019).

PAHO (2022) defines peer groups as groups comprised of individuals who convene regularly to support and assist each other in dealing with life challenges. MAGs, commonly known as Mutual Aid Groups, have been referred to by several designations, including mutual aid and mutual support groups. They are also encompassed within the broader terms of self-help groups, mutual aid groups, and peer support groups (Agudelo-Hernández & Rojas-Andrade, 2023).

The recovery approach places the aspirations of individuals with mental health disorders at the core of care objectives. In addition to the evident reduction in the manifestation of the disorder, the recovery approach strives for the restoration of cognitive abilities, as well as improvements in community and occupational performance. The recovery approach emphasizes an individual's endeavors to live a life that aligns with their personal values and aspirations, remaining true to the roles they wish to fulfill in various contexts.

However, evidence-based practices take an average of 17 years to be routinely incorporated into healthcare practice (Morris et al., 2011), and only half of Evidence-Based Interventions (EBIs) achieve widespread clinical utilization (Bauer et al., 2015). In the case of Colombia, community-based and comprehensive mental health care strategies do not present a different outlook (Agudelo-Hernández & Rojas-Andrade, 2023a). The National Institute of Mental Health (NIMH) recognized the need for research focused on increasing the implementation of effective and efficient programs (Fajardo Flores & Alger, 2019). This requires identifying aspects such as the core components of interventions.

Core components are fundamental elements within empirically validated treatments that serve as key reference points for comprehending, implementing, and evaluating an intervention. These core components may encompass techniques, contents, or discrete skills (Garland et al., 2008). Embracing a core component approach to evidence-based practice enhances decision-making processes when implementing health strategies or plans. For support groups, it has been determined that these components could include "active agency, coping strategies, recognition, and management of emotions, problem-solving strategies, supportive interaction, trust, self-identity construction, and strengthening of social networks". (Agudelo-Hernández & Rojas-Andrade, 2023a, p. 96).

Based on the above, best practices for the prevention and management of suicide recommend that individuals identified as at risk of suicide receive targeted treatment designed to mitigate associated risks, with services that ensure continuity in mental health care and facilitate the transition to community-based services (Jamison et al.,

2018; OPS, 2022). To accomplish these objectives, clinical teams must employ evidence-based practices in a continuous, longitudinal, and coordinated approach (Doupnik et al., 2020).

This coordination entails two-way communication between the clinical team responsible for referring individuals at risk of suicide for mental health care and the team that receives them for follow-up. This is why continuity of care serves as a central element in international public health systems that prioritize a community-based approach. Particularly in the field of mental health, continuity of care has emerged as a standard for interventions due to its pivotal role in ensuring the quality and effectiveness of mental health services (Field, 2009; Vandyk et al., 2016).

This variable is regarded as a process that entails systematic care, ensuring an uninterrupted flow of individuals between the different components of the service delivery system (Adair et al., 2005). This plays a critical role in achieving positive outcomes for individuals with severe and persistent mental illness, as evidenced by robust associations between this variable and sustained quality of life in multivariate models (Mitton et al., 2005).

The Present Study

In Colombia, the implementation of mental health services remains low, with approximately 70% of the country's departments having fewer than five services in operation out of the 11 services established in the National Mental Health Law (Agudelo-Hernández & Rojas-Andrade, 2023a). The least implemented services are those related to community-based care (Agudelo-Hernández & Rojas-Andrade, 2023a). In the department of La Guajira, mental health problems are exacerbated by additional factors, including migration, particularly from Venezuela, and a significant percentage of the indigenous population facing conditions of vulnerability, especially due to malnutrition and multidimensional poverty (Gutiérrez López et al., 2020).

Barriers to the implementation of mental health services are evident in most regions of the country. These include limited access to professionals responsible for rehabilitation, fragmented health services with actions focused on individual services, inadequate human resources, insufficient resources for community strategies, underreporting and lack of follow-up for individuals with mental problems or disorders, absence of service continuity, concentration of services in urban areas, and a lack of programs for social inclusion (Agudelo-Hernández & Rojas-Andrade, 2023a). These factors contribute to a rise in psychosocial disability and the subsequent years lost as a result (Jamison et al., 2018).

Community-based interventions represent a viable, cost-effective, and accessible option for various regions, primarily in low-income settings. The enhancement of individual and collective autonomy is promoted through strategies that prioritize community participation and the continuity of interventions in a specific context, as is the case with Mutual Aid Groups where individuals are encouraged to build networks

with others by leveraging the potential developed within a team, facilitating the formation of strong and lasting bonds.

Meanwhile, the mhGAP is a training and support program aimed at a wide audience, including community leaders, healthcare personnel, governments, and decision-makers, mainly focused on low- and middle-income countries (PAHO, 2022; PAHO, 2023). This program focuses on providing theoretical and practical training for the comprehensive management of people with mental and neurological disorders deemed a priority (Millán-González, 2014; PAHO, 2021; WHO, 2023). In addition to the clinical component of mhGAP, a community component has been developed with the goal of strengthening the environments in which people with mental disorders are expected to receive a welcoming and destigmatizing treatment (Millán-González, 2014; PAHO, 2021; WHO, 2023).

mhGAP is a program that prioritizes community-based interventions from an educational approach. However, it is considered that interventions integrating the individual with mental health issues into the community recovery process have a greater impact on maintaining health and well-being. This, in turn, is directly related to reducing psychosocial disability and ensuring continuity of care, key factors for adequate quality of life (Agudelo Hernández et al., 2024).

Therefore, this study begins with a comparison of the impact that Mutual Aid Groups (MAGs) and the application of the community mhGAP model have, compared to conventional care interventions, on individuals with severe mental disorders and suicide attempts. It focuses on two central indicators in severe mental health conditions: the continuity of care and psychosocial disability.

Based on the above-mentioned information, the present study aims The objective of this study is to assess the impact of two community-based mental health interventions on psychosocial disability and continuity of care in individuals with severe mental illness and suicidal behavior. The following hypothesis is proposed: Individuals who participate in support groups experience a greater reduction in psychosocial disability and a greater increase in continuity of care compared to those who only attend comprehensive care programs.

Method

A controlled community trial was conducted in the municipalities of Riohacha and Maicao during the year 2023, which comprised two intervention groups: Support Group (SG), mhGAP Group (mhGAPG), and a Control Group (CG). Self-reported measurements were collected before and after the intervention using the Psychosocial Disability Scale and the Alberta Continuity of Care Scale. The study involved the participation of 94 individuals diagnosed with severe mental disorders (bipolar disorder and schizophrenia) with a history of suicidal behavior. The support group consisted of 30 individuals, the mhGAP group of 34 individuals, and the control group of 30 individuals. The level of statistical significance adopted in this study was 0.05 for the p-value.

Sample

For the Support Groups (SG), the mhGAP Group (GmhGAP) and the Control Groups (CG), was assigned according to the people's choice. People in the CG continued to be monitored and received support from their traditional health services (psychiatry). Those who chose not to participate mentioned their preference for private specialized consultations (16 individuals) or continuing their care through the conventional healthcare system (14 individuals). In this group, risks were monitored every two weeks by social work and psychology professionals to activate appropriate care pathways as needed.

The inclusion criteria considered individuals with chronic mental disorders reported in the national surveillance system for suicidal behavior during the last semester of 2022 or the first semester of 2023. Additionally, being of legal age, being affiliated with the healthcare system (for those who were not affiliated, the affiliation process was carried out) in the department of La Guajira, and providing informed consent were also included as criteria. Figure 1 illustrates the process leading to the final sample.

Instruments

Psychosocial Disability Scale. To assess psychosocial disability, the study employed the Psychosocial Disability Scale, which was validated for the study population and endorsed by the Colombian Ministry of Health (2022). This scale comprises 75 questions with binary responses ("Yes" or "No"). A higher score indicates a greater level of psychosocial disability, with a maximum score of 175 (Agudelo-Hernández, Andrés Romero, & Quintero-Pulgar, 2023).

The scale assesses two domains: Adherence to Treatment, which identifies elements related to treatment, its continuity, and the person's understanding of it; and Disability at a personal and emotional level, which evaluates the ability to care for oneself, engage in significant activities, and the loss of emotional responsiveness capacity. In the domain of Disability in family functioning, the assessment acknowledges the family structure, including considerations of kinship, age, profession, and level of education. The evaluation involves entirely open-ended questions. In the Social Disability domain, the assessment focuses on significant interactions with others and examines the existence and quality of relationships within support networks. Lastly, in the Occupational Disability domain, inquiries are made regarding job satisfaction, relationships with colleagues and superiors, as well as work and occupational performance. Afterward, a summation of each item is conducted, enabling the stratification of psychosocial risk into low, moderate, high, and very high categories.

Alberta Continuity of Services Scale - Mental Health

The study utilized the Alberta Continuity of Services Scale - Mental Health (ACSS-MH) (Adair et al., 2005). The scale was translated into Spanish and validated within the

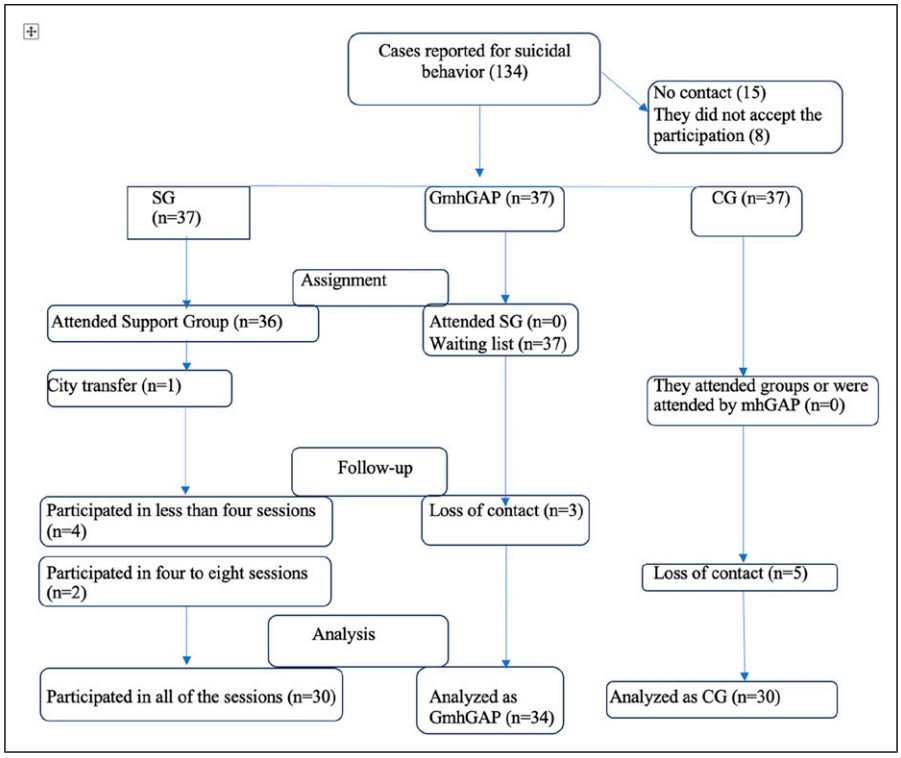

Figure 1. Flowchart to reach the sample. The authors.

Colombian population, demonstrating high reliability (Alpha = .93) while maintaining the original factorial structure (Agudelo-Hernández et al., 2023c).

This instrument is divided into two parts. Part A is designed for users and comprises 43 Likert-type items that explore the utilization of mental health services and the subjective experience regarding the care process. It includes three subscales: System fragmentation, relationship base, and responsive treatment.

Part B consists of 17 multiple-choice items with a single answer. It focuses on reporting the provision of services based on the records of the care process and is completed by healthcare personnel after analyzing the care processes. While no cut-off point has been established for Part B, Part A of the Scale is quantified, with a maximum score of 172. A higher score indicates better continuity of care services.

Intervention

Support Group

For the support groups, an eight-session program was designed to strengthen the core components identified in the literature (Agudelo-Hernández & Rojas-Andrade, 2023a). Among these components are problem-solving, hope, agency capacity, support networks, coping strategies, stress management, psychoeducation, and empowerment. Each component will be addressed in a weekly session lasting 90–120 minutes, conducted in community settings.

In addition to the core components of the groups, techniques for group cohesion based on Hombrados (2010) and strategies to address difficulties with the therapeutic alliance in the group, such as the Rupture Resolution Rating System (3RS) (Garceau et al., 2021), were taken into account. The content and theoretical support for each session is described in Table 1.

World Health Organization's Mental Health Gap Action Program

Based on the foundations of this program, it is believed that having a trained team at the primary level of care could generate impacts on mental health outcomes, other non-communicable diseases, and improve the response of systems to humanitarian crises (Keynejad et al., 2021). The professionals trained in mhGAP received their training from certified personnel in November 2022, within the framework of the present research (Agudelo-Hernández et al., 2024).

Procedure. Prior to the study, 10 teams were trained in the mhGAP 2.0 program. Each team was composed of a physician, psychologist, and nurse. Emphasis was placed on the modules related to suicide, depression, and essential clinical care practices. The instruments proposed by the mhGAP management committee were used to ensure the fidelity of the training. Likewise, a psychologist and a social worker with experience in group work in mental health were trained in the proposed components for the intervention. This intervention was based on the support group manual from the Ministry of Health of Colombia (2022) and the Pan American Health Organization (PAHO) (2022). However, the focus was on the core components associated with greater benefits of these strategies (Agudelo-Hernández & Rojas-Andrade, 2023a).

Through the Health Department of La Guajira, reports of suicidal behavior were requested. These reports are mandatory in Colombia and include sociodemographic data. The invitation was personally extended by the psychology staff, and for those who agreed to participate, the instruments were administered to them. At the group intervention level, to assess the integrity of the intervention, at the end of each session, participants were asked to rate the level of achievement of the objectives set at the beginning of the session through an online form using a scale from one (objective not achieved) to five (objective fully achieved). The mhGAP Group (GmhGAP) was

Table 1. Themes Addressed in the Support Groups.

Session	Component Definition	Theoretical Basis of Interventions
Active agency	The enhancement of capabilities or the translation of these capabilities into actions that arise from the engagement in the support group	Bernabéu-Álvarez et al. (2020), Petrini et al. (2020), Sample et al. (2018).
Coping strategies	The support group provides individuals with techniques that are learned or strengthened, enabling them to better cope with challenging personal situations.	Landstad et al. (2020), Longden et al. (2018), Sample et al. (2018).
Emotion recognition and management	This code pertains to the identification of personal difficulties through group dynamics. It includes all citations that explicitly or implicitly refer to the processes conducted within the group, facilitating the recognition of individual challenges related to mental health.	Ngai, Cheung, Ng, et al. (2021), Manning et al. (2020), Juarez-Ramirez et al. (2021).
Problem solving	Group contribution that occurs by identifying individual coping strategies in group dynamics that had not been considered before and that are important for recovery.	Bernabéu-Álvarez et al. (2020), Gona et al. (2020), Wijekoon et al. (2020), Carlén and Kylberg (2021).
Supportive interaction	It refers to relationships given in the group perceived as horizontal and generating trust between members. Active exploration of the same people of group actions for mental health with the intention of relating to other people.	Fernandez-Jesus et al. (2021), Trojan et al. (2014); Ngai, Cheung, Mo, et al. (2021)
Identity construction	This code includes all citations that make explicit or implicit mention of a process of identifying characteristics of one's own personality. Also, in the behavior or in the thoughts of the other people in the group. Identification of parental roles, such as father, mother, brother, etc., are included.	Ngai, Cheung, Mo et al. (2021), Wijekoon et al. (2020).

(continued)

Table 1. (continued)

Session	Component Definition	Theoretical Basis of Interventions
Trust	Perception of the dynamics of the group with the freedom to express an opinion or speak what is thought. Reception of particularities of each person without criticism or pointing out those that the person perceives as negative in himself.	Landstad, et al. (2020), Fernandez-Jesus et al. (2021), Ngai, Cheung, Mo et al. (2021), Activament Catalunya Associació (2021)
Social networks	It refers to relationships given in the group perceived as horizontal and generating trust between members. Recognition of the group as a tool that provides the person with constant availability for their difficulties, beyond specific meetings.	Patil and Kokate (2017), Kelly et al. (2019), Southall et al. (2019)

Adapted from (Agudelo-Hernández & Rojas-Andrade, 2023).

attended to by the mhGAP program from the primary level of care, as outlined in the guidelines of the Pan American Health Organization (Agudelo-Hernández et al., 2023; PAHO, 2021).

Those individuals who did not agree to participate in any study group were contacted weekly to monitor suicide risk and raise awareness regarding the activation of appropriate support pathways. If any individual from the control group wished to attend the mhGAP program, they could do so immediately. However, during the course of the research, no person from the control group expressed interest in attending the program.

Ethical Considerations. Participants signed informed consent forms. There were no reports of adverse treatment effects. Psychoeducation was provided to the families participating in the study, and with their prior consent, they were referred to the health secretariat if they presented any health issues. The included individuals comprehended, accepted, and provided informed consent, after which they were accompanied by the psychosocial team to complete an instrument containing demographic data, the Psychosocial Disability Scale, and the Alberta Scale of continuity of mental health services.

This study adheres to the ethical standards for research involving human subjects, as specified in resolution # 008430 of 1993 by the Ministry of Health and the Declaration of Helsinki of 2000. It is considered minimal-risk research and has been reviewed and endorsed by the CBE02_2022 document by the Bioethics Committee of the University of Manizales. The data of the present investigation are available and are attached in https://osf.io/c8f7b/?view_only=4b9ad1ee66e34fe795553490d911a0b8

Analysis Strategy

The data analysis was conducted using statistical software R version 4.3.2. Categorical variables were described using frequency distribution tables. Descriptive statistics were employed to analyze participants' characteristics at the beginning of the study and to estimate treatment compliance percentage. The results of the Jarque-Bera test indicated that the measurement data for the psychological variables follow a normal distribution (p-value in Jarque-Bera test >0.05); for only some of these variables (pre- and post-work disability and post-adherence), the p-value was <0.05, but normality was assumed due to the sample size. Consequently, parametric inferential tests were utilized.

The Mann–Whitney U Test was used to assess differences in the frequencies of sociodemographic variables. To identify differences in the mean values of the dimensions between the groups, and considering that each individual had two measurements, we chose to perform a type II repeated measures analysis of variance (ANOVA) test as the groups were not exactly balanced.

Results

The study participants had a mean age of 34 years, a median of 30 years, and an interquartile range of 20.75 years. Of the total, 61% were women, and the remaining percentage were men. Regarding occupation, 43% of individuals were unemployed, 31% had formal employment, 16% were engaged in various trades, and 10% were students. The results of the analysis at the beginning of the study show that there was statistical equivalence ($p < .001$) in the general characteristics of the participants from both groups, as observed in Table 2. Gender, age, and occupation were not statistically significant, so they were not included in the model.

The interventions significantly modified scores in all dimensions of the Caldas Scale and the Alberta Scale, compared to the control group. There were significant differences based on the intervention, with the effect being greater in the SG across all domains. Significant improvement was observed in all domains of the disability and continuity of care scale within the intervention groups (Table 3).

Discussion

Effective interventions aimed at reducing suicidal behavior place significant emphasis on addressing psychosocial disability. This comprehensive approach encompasses various essential components, including addressing financial needs, enhancing knowledge and information dissemination, promoting peer support, conducting group meetings, fostering therapeutic relationships, and, notably, facilitating smooth transitions from hospital settings to community-based services (20).

In this regard, the purpose of this research was to assess the impact The objective of this study is to assess the impact of two community-based mental health interventions on psychosocial disability and continuity of care in individuals with severe mental

Table 2. Participant Characteristics.

Variable	Participants in Support Group *n* = 30(%)	mhGAP-Attended Group *n* = 34(%)	Control Group *n* = 30(%)	U[a]
Sex:				.24
Female	80	73.53	76.67	
Male	20	26.47	23.33	
Age range:				.696
18–40	73.34	73.52	66.67	
40–74	26.66	26.47	33.33	
Marital status:				.42
Single, widowed, separated	56.67	41.17	46.67	
Married/Common-law	43.33	58.82	53.33	
Education				.089
Primary – No schooling	26.67	26.47	23.33	
High school	43.34	44.11	50	
Technical school	16.66	17.64	16.66	
College/University	13.32	11.78	10	
Employment status:				.098
Formal employment	26.67	26.47	23.33	
Unemployed	43.33	50	50	
Informal employment	30	23.53	26.67	
Diagnosis:				.220
Depressive disorder	50	52.94	53.32	
Anxiety disorder	23.33	20.58	20	
Bipolar disorder	10	14.70	13.34	
Thought disorder	10	8.82	6.66	
Cognitive or developmental disorder	6.67	2.94	6.66	

[a]Mann–Whitney U Test.

illness and suicidal behavior. The hypothesis is confirmed that individuals with mental disorders who are part of mental health support groups or primary health care strategies (mhGAP) experience a greater reduction in psychosocial disability compared to those who do not participate in any of these interventions. The hypothesis that individuals who participate in support groups experience a greater reduction in psychosocial disability and a higher increase in continuity of care compared to those who only attend comprehensive care programs is also confirmed.

Table 3. Results of Repeated Measures ANOVA for Comparing Intervention Groups.

Dimensions	Sum sq	Mean sq	F Value	*p*	CG[a] (Intercept)	SG[a]	mhGAP[a]
Caldas scale							
Adherence	189.6	94.81	21.32	<.001	10.53	−2.43	−1.74
Interpersonal disability	60.9	60.9	11.34	.0011	43.29	−6.38	−2.17
Family disability	181.2	90.62	4.445	.014	19.59	−2.43	−1.50
Social disability	144.5	72.27	17.25	<.001	12.32	−1.98	−0.20
Occupational disability	389.4	194.69	7.405	<.001	21.05	−3.60	−1.91
Caldas scale total	8534	4267	23.81	<.001	106.79	−16.83	−7.54
Alberta scale							
Fragmentation	6462	3231	53.19	<.001	44.71	13.98	3.28
Personal health relationship	1640	819.9	17.53	<.001	25.33	7.30	4.62
Effecctive response	1587	793.6	18.82	<.001	18.87	7.13	4.74
Alberta Scale total	24330	12165	41.68	<.001	88.93	28.41	12.65

[a]Repeated Measures ANOVA Test (degrees of freedom = 2.).
SG: Support Group; GmhGAP: Group attended by mhGAP; CG: Control Group. Sq: residual sum squares.

Effective implementation of strategies that strengthen the first level of care and community settings can significantly enhance individuals' quality of life (Agudelo-Hernández & Rojas-Andrade, 2023b). The implementation of the mhGAP strategy has encountered barriers, particularly in the follow-up step, as it has been primarily focused on training across 100 countries, rather than effectively putting the strategy into practice (Keynejad et al., 2021; PAHO, 2021).

Among the benefits of community-based interventions for mental health are reduced hospitalizations, lower levels of worry and depression, increased feelings of empowerment, positive effects on social support and social networks, improved functioning of individuals, and a decrease in caregiver burden (Cohen et al., 2012). Other studies have also indicated an improvement in self-regulation skills, positive emotional coping abilities, and positive behavioral coping strategies with community-based interventions (Sample et al., 2018).

Morales-Piña & Gutiérrez-Chavez (2019) conducted a systematic review where 100% of the articles indicated that psychosocial rehabilitation was effective in improving the functioning and social inclusion of individuals with severe mental disorders. This was evidenced by a reduction in relapses, improved treatment adherence, demonstrated clinical progress, and enabling individuals to participate in society in a timely and proactive manner (Morales-Piña & Gutiérrez-Chavez, 2019).

Previous research has demonstrated that environmental characteristics that strengthen social networks and support can improve mental health (Miles, 2015;

Russell et al., 2023). Other studies have also found that community participation in mental health interventions leads to better outcomes compared to other interventions (Agudelo-Hernández et al., 2024). Additionally, it increases awareness of mental illnesses within the general community and empowers local organizations to influence each other in addressing community mental health as well (Hardy, 2016).

Another finding of this research is the high perception of the presence of the core components of support groups by the participants, which could be suggested as elements related to the mechanism of change. Each component emphasizes the importance of support interaction, which involves the exchange of feelings and mutual support, along with sharing experiential knowledge among group members. This positive influence on treatment adherence is particularly notable (Ngai, Cheung, Ng, et al., 2021).

Several components align with the guidelines proposed by Pearce et al. (2016), where they identify core elements for self-management support in non-communicable problems and disorders. These elements include understandable language, information on available resources, life skills training, psychological strategies training, social support, and advice on adopting healthy lifestyles. The correlation between these components and the positive outcomes in mental health learning and skill-building reinforces their significance in the intervention. These mentioned components, along with those used in the present research, coincide with common elements associated with benefits in mental health strategies developed in middle- and low-income countries (Murray et al., 2014).

The benefits reported by the participants in the groups align with the principles of global community strategies (Cohen et al., 2012). Achieving long-term recoveries requires programs to address the multiple challenges, such as clinical, social, and economic factors, faced by individuals with mental disorders (BasicNeeds, 2022). In this context, a four-year follow-up of a cohort of individuals with severe mental disorders revealed that participation in community strategies emerged as an independent predictor of improvement in social functioning. This improvement was evident in activities such as voting, attending festivals, and engaging in work-related activities (Chatterjee et al., 2003). The above-mentioned is in line with the findings of the present study, which shows an improvement in psychosocial disability among individuals who participated in these strategies.

As limitations, it is important to note the necessity for further investigation into other variables associated with suicidal behavior and psychosocial disability, particularly exploring barriers to participation and the overall impact on living conditions. Although the Alberta Scale and the Psychosocial Disability Scale investigate individual aspects beyond symptoms, future studies with qualitative approaches that investigate the experiences of each person are recommended, and that also include categories such as stigma, social inclusion and participation from community.

Similarly, an intersectional approach to suicidal behavior and psychosocial disability, which also includes aspects of the health system, is necessary (Ghasemi et al., 2021). Future research should provide more detailed descriptions of the protocols used

for community participation, intervention implementation, and evaluation to facilitate the translation of interventions to other communities. This will enable direct comparisons of effectiveness across geographical boundaries.

Conclusions

The present study proposes a methodology for implementing Community-Based Rehabilitation through support groups that develop core components in their methodology, aiming to improve psychosocial disability and continuity of mental health care. This calls for further work on domains such as service fragmentation and other variables related to living conditions, such as employment, education, and labor inclusion. Support groups are a promising strategy for addressing these challenges.

In Latin American countries, while this mental health approach has been acknowledged and outlined in public policies and programs, it is crucial to move beyond mere intention and initiate its practical implementation. This involves transitioning from evidence-based practices to the application of these approaches within specific social contexts where people navigate their daily lives. Such actions are demonstrated to be a facilitating pathway towards transforming communities into more inclusive environments, fostering equitable mental health. They highlight the importance of health services as a fundamental element in this transformative process.

Acknowledgments

To Has Bustos and Mar Hurtado, belonging to the CBR team of the University of Manizales, and Juan David Rodríguez.

Author Contributions

FAH: Conceptualization, planning leadership, formal analysis, research process, validation, data presentation, writing and editing. AGA: Conceptualization, data curation, formal analysis, research process, validation, data presentation, writing and editing. RRA: Conceptualization, formal analysis, methodology, software, validation, data presentation, writing and editing.

Declaration of Conflicting Interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: The opinions and concepts expressed in this manuscript are the sole responsibility of the authors.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Ethical Statement

Ethics Approval

This study complies with the research ethics guidelines for human subjects as outlined in Resolution No. 008430 of 1993 by the Ministry of Health and the Helsinki Declaration of 2000. It is a minimal-risk research study and it was reviewed and approved through the CBE02_2022 resolution by the Bioethics Committee of the University of Manizales.

Consent for Publication

The publication of the data provided in this manuscript is authorized.

ORCID iD

Felipe Agudelo-Hernández https://orcid.org/0000-0002-8356-8878

Data Availability Statement

The data of the present investigation are available and are attached in https://osf.io/c8f7b/?view_only=4b9ad1ee66e34fe795553490d911a0b8

References

Activament Catalunya Associació. (2021). *Guía para los grupos de ayuda mutua de salud mental en primera persona*. https://www.activament.org/es/2021/guia-GAM/

Adair, C. E., McDougall, G. M., Mitton, C. R., Joyce, A. S., Wild, T. C., Gordon, A., Costigan, N., Kowalsky, L., Pasmeny, G., & Beckie, A. (2005). Continuity of care and health outcomes among persons with severe mental illness. *Psychiatric Services*, *56*(9), 1061–1069. https://doi.org/10.1176/appi.ps.56.9.1061

Agudelo-Hernández, F., Andrés Romero, E., & Quintero-Pulgar, Y. (2023b). Diseño y validez de un instrumento para determinar discapacidad psicosocial asociada a trastornos mentales. *Revista Iberoamericana de Diagnóstico y Evaluación – e Avaliação Psicológica*, *69*(3), 161–171. https://doi.org/10.21865/RIDEP69.3.14

Agudelo Hernández, F., Guapacha-Montoya, M., & Rojas Andrade, R. M. (2024). Mutual aid groups for loneliness, psychosocial disability, and continuity of care. *Community Mental Health Journal*, *60*(9), 1–12. https://doi.org/10.1007/s10597-023-01216-9

Agudelo-Hernández, F., & Rojas-Andrade, R. (2023a). Design and validation of a scale of core components of community interventions in mental health. *The International Journal of Health Planning and Management*, *39*(1), 36–47. https://doi.org/10.1002/hpm.3711

Agudelo-Hernández, F., & Rojas-Andrade, R. (2023b). Mental health services in Colombia: A national implementation study. *International Journal of Social Determinants of Health and Health Services*, *53*(4), 424–433. https://doi.org/10.1177/27551938231156023

Agudelo-Hernández, F., Salazar-Vieira, L.M., & Plata-Casas, L.I. (2024). Mental Health Friendly Territories: Strategy for the implementation of the Mental Health Policy in Colombia. *World Medical & Health Policy*, *16*(2), 1–20. https://doi.org/10.1002/wmh3.611

Agudelo-Hernández, F., Vélez-Botero, H., & Rojas-Andrade, R. (2023c). Traducción y adaptación de la escala de continuidad de servicios de salud mental de Alberta en un Contexto Latinoamericano. *Revista Chilena de Neuro-Psiquiatria*, *62*(3), 1–9. https://www.sonepsyn.cl/uploads/61-3-2.pdf

BasicNeeds BasicRighs. (2022). *Mental health. Together we can do more*. https://www.basicneeds.org/ghana

Bauer, M. S., Damschroder, L., Hagedorn, H., Smith, J., & Kilbourne, A. M. (2015). An introduction to implementation science for the non-specialist. *BMC psychology*, *3*(1), 32. https://doi.org/10.1186/s40359-015-0089-9

Bernabéu-Álvarez, C., Faus-Sanoguera, M., Lima-Serrano, M., & Lima-Rodríguez, J. S. (2020). Revisión sistemática: influencia de los Grupos de Ayuda Mutua sobre cuidadores familiares. *Enfermería Global*, *19*(2), 560–590. https://doi.org/10.6018/eglobal.392181

Carlén, K., & Kylberg, E. (2021). An intervention of sustainable weight change: Influence of self-help group and expectations. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *24*(4), 1498–1503. https://doi.org/10.1111/hex.13290

Chatterjee, S., Patel, V., Chatterjee, A., & Weiss, H. A. (2003). Evaluation of a community-based rehabilitation model for chronic schizophrenia in rural India. *The British Journal of Psychiatry: The Journal of Mental Science*, *182*(1), 57–62. https://doi.org/10.1192/bjp.182.1.57

Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. *JAMA Psychiatry*, *74*(7), 694–702. https://doi.org/10.1001/jamapsychiatry.2017.1044

Cohen, A., Raja, S., Underhill, C., Yaro, B. P., Dokurugu, A. Y., De Silva, M., & Patel, V. (2012). Sitting with others: Mental health self-help groups in northern Ghana. *International Journal of Mental Health Systems*, *6*(1), 1. https://doi.org/10.1186/1752-4458-6-1

Díaz-Castro, L., Arredondo, A., Pelcastre-Villafuerte, B. E., & Hufty, M. (2017). Governance and mental health: Contributions for public policy approach. *Revista de Saúde Pública*, *51*(1), 4. https://doi.org/10.1590/S1518-8787.2017051006991

Doupnik, S. K., Rudd, B., Schmutte, T., Worsley, D., Bowden, C. F., McCarthy, E., Eggan, E., Bridge, J. A., & Marcus, S. C. (2020). Association of suicide prevention interventions with subsequent suicide attempts, linkage to follow-up care, and depression symptoms for acute care settings: A systematic review and meta-analysis. *JAMA Psychiatry*, *77*(10), 1021–1030. https://doi.org/10.1001/jamapsychiatry.2020.1586

Fajardo Flores, C. J., & Alger, J. (2019). Investigación de la implementación: características y oportunidades para su práctica. *Revista Medica Hondurena*, *87*(2), 85–89. https://doi.org/10.5377/rmh.v87i2.11917

Fernandez-Jesus, M., Mao, G., Ntontis, E., Cocking, C., McTague, M., Schwarz, A., Semlyen, J. Y., & Drury, M. (2021). Than a COVID-19 response: Sustaining mutual aid groups during and beyond the pandemic. *Frontiers in Psychology*, *20*(12), 716202. https://doi.org/10.3389/fpsyg.2021.716202

Field, A. (2009). *Discovering statistics using SPSS: Sex, drugs and rock and roll*. Sage Publications.

Garceau, C., Chyurlia, L., Baldwin, D., Boritz, T., Hewitt, P. L., Kealy, D., Söchting, I., Mikail, S. F., & Tasca, G. A. (2021). Applying the Rupture Resolution Rating System (3RS) to group therapy: An evidence-based case study. *Group Dynamics: Theory, Research, and Practice*, *25*(1), 89–105. https://doi.org/10.1037/gdn0000137

Garland, A. F., Hawley, K. M., Brookman-Frazee, L., & Hurlburt, M. S. (2008). Identifying common elements of evidence-based psychosocial treatments for children's disruptive behavior problems. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(5), 505–514. https://doi.org/10.1097/CHI.0b013e31816765c2

Ghasemi, E., Majdzadeh, R., Rajabi, F., Vedadhir, A., Negarandeh, R., Jamshidi, E., Takian, A., & Faraji, Z. (2021). Applying intersectionality in designing and implementing health interventions: A scoping review. *BMC Public Health*, *21*(1), 1407. https://doi.org/10.1186/s12889-021-11449-6

Gona, J., Newton, C., Hartley, S., & Bunning, K. (2020). Development of self-help groups for caregivers of children with disabilities in Kilifi, Kenya: Process evaluation. *African Journal of Disability*, *9*(1), 650–659. https://doi.org/10.4102/ajod.v9i0.650

Gutiérrez López, J. A., Cortés Wilches, N., & Montaña Londoño, C. J. (2020). La Pobreza Multidimensional y su relación con el espacio: Caso de estudio para Colombia. *Revista Visión Contable*, *21*(1), 78–100. https://doi.org/10.24142/rvc.n21a4

Hardy, L. J., Hughes, A., Hulen, E., Figueroa, A., Evans, C., & Begay, R. C. (2016). Hiring the experts: Best practices for community-engaged research. *Qualitative Research: Quaternary Research*, *16*(5), 592–600. https://doi.org/10.1177/1468794115579474

Hombrados, M. (2010). Grupos de apoyo y autoayuda para cuidadores de personas dependientes. In En Martínez M. *C En Dinámicas e Intervención Grupal*, 67–68.

Jamison, D., Nugent, H., Gelband, S., Horton, P., Jha, R., Laxminarayan, & Mock, C. (2018). Prioridades para el control de enfermedades: Compendio de la 3 a edición. https://openknowledge.worldbank.org/handle/10986/29392

Juárez-Ramírez, C., Treviño-Siller, S., Ruelas-González, M. G., Théodore, F. Y., & Pelcastre-Villafuerte, B. E. (2021). Los Grupos de Ayuda Mutua como posible estrategia de apoyo emocional para personas indígenas que padecen diabetes. *Salud Pública de México*. *63*(1) 12–20. https://doi.org/10.21149/11580, https://saludpublica.mx/index.php/spm/article/view/11580

Kelly, J. F., Hoffman, L., Vilsaint, C., Weiss, R., Nierenberg, A., & Hoeppner, B. (2019). Peer support for mood disorder: Characteristics and benefits from attending the Depression and Bipolar Support Alliance mutual-help organization. *Journal of Affective Disorders*, *255*(1), 127–135. https://doi.org/10.1016/j.jad.2019.05.039

Keynejad, R., Spagnolo, J., & Thornicroft, G. (2021). WHO mental health gap action programme (mhGAP) intervention guide: Updated systematic review on evidence and impact. *Evidence-Based Mental Health*, *24*(3), 124–130. https://doi.org/10.1136/ebmental-2021-300254

Landstad, B. J., Hedlund, M., & Kendall, E. (2020). Practicing in a person-centred environment - self-help groups in psycho-social rehabilitation. *Disability & Rehabilitation*, *44*(7), 1067–1076. https://doi.org/10.1080/09638288.2020.1789897

Longden, E., Read, J. Y., & Dillon, J. (2018) Assessing the impact and effectiveness of hearing voices network self-help groups. *Community Mental Health Journal*. *54*(2),184-188. https://doi.org/10.1007/s10597-017-0148-1, https://pubmed.ncbi.nlm.nih.gov/28638952/

Manning, V., Kelly, J., & Baker, A. L. (2020). The role of peer support and mutual aid in reducing harm from alcohol, drugs and tobacco in 2020. *Addictive Behaviors*, *109*(1), 106480. https://doi.org/10.1016/j.addbeh.2020.106480

McIntyre, H., Reeves, V., Loughhead, M., Hayes, L., & Procter, N. (2022). Communication pathways from the emergency department to community mental health services: A systematic review. *International Journal of Mental Health Nursing*, *31*(6), 1282–1299. https://doi.org/10.1111/inm.13024

Miles, M. S. (2015). Across the miles: Process and impacts of collaboration with a rural community advisory board in HIV research. *Progress in Community Health Partnerships*, *9*(1), 41–48.

Millán-González, R. (2014). La implementación del abordaje colaborativo en Costa Rica: hacia una integración entre la psiquiatría y la atención primaria. *Acta Medica Costarricense*, *56*(4), 150–157. https://www.scielo.sa.cr/scielo.php?script=sci_arttext&pid=S0001-60022014000400003

Ministerio de Salud y Protección Social. (2022). Orientaciones para el fortalecimiento de la Rehabilitación Basada en la Comunidad-RBC en Salud Mental. https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/orientaciones-fortalecimiento-rbc-sm.pdf

Mitton, C. R., Adair, C. E., McDougall, G. M., & Marcoux, G. (2005). Continuity of care and health care costs among persons with severe mental illness. *Psychiatric Services*, *56*(9), 1070–1076. https://doi.org/10.1176/appi.ps.56.9.1070

Morales-Piña, M.G, & Gutiérrez-Chavez, S.M. (2019). Efectividad de la rehabilitación psicosocial en el funcionamiento y reinserción social en pacientes con trastornos mentales graves. *Universidad Norbert Weiner*. https://repositorio.uwiener.edu.pe/handle/20.500.13053/3074

Morris, Z. S., Wooding, S., & Grant, J. (2011). The answer is 17 years, what is the question: Understanding time lags in translational research. *Journal of the Royal Society of Medicine*, *104*(12), 510–520. https://doi.org/10.1258/jrsm.2011.110180

Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., Weiss, W. M., & Bolton, P. (2014). A common elements treatment approach for adult mental health problems in low- and middle-income countries. *Cognitive and Behavioral Practice*, *21*(2), 111–123. https://doi.org/10.1016/j.cbpra.2013.06.005

Ngai, S. S., Cheung, C. K., Mo, J., Chau, S. Y., Yu, E., Wang, L. Y., & Tang, H. Y. (2021b). Mediating effects of emotional support reception and provision on the relationship between group interaction and psychological well-being: A study of young patients. *International Journal of Environmental Research and Public Health*, *18*(22), 12110. https://doi.org/10.3390/ijerph182212110

Ngai, S. S., Cheung, C. K., Ng, Y. H., Shang, L., Tang, H. Y., Ngai, H. L., & Wong, K. H. C. (2021a). Time effects of supportive interaction and facilitator input variety on treatment

adherence of young people with chronic health conditions: A dynamic mechanism in mutual aid groups. *International Journal of Environmental Research and Public Health*, *18*(6), 3061. https://doi.org/10.3390/ijerph18063061

Nickels, S. V., Flamenco Arvaiza, N. A. Y., & Rojas Valle, M. S. (2016). A qualitative exploration of a family self-help mental health program in El Salvador. *International Journal of Mental Health Systems*, *10*(2), 26. https://doi.org/10.1186/s13033-016-0058-6

Organización Panamericana de la Salud. (2018). *Organización Panamericana de la Salud. La carga de los trastornos mentales en la Región de las Américas*. OPS. https://iris.paho.org/bitstream/handle/10665.2/49578/9789275320280_spa.pdf?sequence=9

Organización Panamericana de la Salud. (2022). *Servicios de salud mental de apoyo entre pares: promover los enfoques centrados en las personas y basados en los derechos (Orientaciones y módulos técnicos sobre los servicios comunitarios de salud mental: promover los enfoques centrados en las personas y basados en los derechos)*. OPS. https://doi.org/10.37774/9789275325995

PAHO. (2021). *Herramientas del mhGAP para usar en la comunidad: versión de prueba sobre el terreno*. OPS.

PAHO. (2022). *Servicios de salud mental de apoyo entre pares: promover los enfoques centrados en las personas y basados en los derechos*. OPS. https://doi.org/10.37774/9789275325995

Pan American Health Organization. (2023). *Una nueva agenda para la salud mental en las Américas. Informe de la Comisión de Alto Nivel sobre Salud Mental y COVID-19 de la Organización Panamericana de la Salud*. OPS. https://doi.org/10.37774/9789275327265

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., & UnÜtzer, J. (2018). The Lancet Commission on global mental health and sustainable development. *Lancet*, *392*(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Patil, S. Y., & Kokate, K. (2017). Identifying factors governing attitude of rural women towards Self-Help Groups using principal component analysis. *Journal of Rural Studies*, *55*(1), 157–167. https://doi.org/10.1016/j.jrurstud.2017.08.003

Pearce, G., Parke, H., Pinnock, H., Epiphaniou, E., Bourne, C., Sheikh, A., & Taylor, S. J. C. (2016). The PRISMS taxonomy of self-management support: Derivation of a novel taxonomy and initial testing of its utility. *Journal of Health Services Research and Policy*, *21*(2), 73–82. https://doi.org/10.1177/1355819615602725

Petrini, F., Graziani, E., Caputo, M. A., & Meringolo, P. (2020). Continuum between relational and therapeutic models of self-help in mental health: A qualitative approach. *American Journal of Community Psychology*, *65*(3-4), 290–304. https://doi.org/10.1002/ajcp.12399

Russell, K., Rosenbaum, S., Varela, S., Stanton, R., & Barnett, F. (2023). Fostering community engagement, participation and empowerment for mental health of adults living in rural communities: A systematic review. *Rural and Remote Health*, *23*(1), 7438. https://doi.org/10.22605/RRH7438

Sample, L. L., Cooley, B. N., & Ten Bensel, T. (2018). Beyond circles of support: "Fearless"-An open peer-to-peer mutual support group for sex offense registrants and their family members. *International Journal of Offender Therapy and Comparative Criminology*, *62*(13), 4257–4277. https://doi.org/10.1177/0306624X18758895

Southall, K., Jennings, M. B., Gagné, J. P., & Young, J. (2019). Reported benefits of peer support group involvement by adults with hearing loss. *International Journal of Audiology*, *58*(1), 29–36. https://doi.org/10.1080/14992027.2018.1519604

Trojan, A., Nickel, S., & Kofahl, C. (2014) Implementing 'self-help friendliness' in German hospitals: A longitudinal study. *Health Promotion International*, *31*(2), 303–313. https://doi.org/10.1093/heapro/dau103, https://pubmed.ncbi.nlm.nih.gov/25500993/

Vandyk, A. D., VanDenkerkhof, E. G., Graham, I. D., & Harrison, M. B. (2016). Using the Alberta continuity of services observer-rated scale to measure continuity of care in a psychiatric population. *Journal of Nursing Measurement*, *24*(1), 131–146. https://doi.org/10.1891/1061-3749.24.1.131

WHO. (2023). *Mental Health Gap Action Programme (mhGAP) guideline for mental, neurological and substance use disorders*. World Health Organization.

WHO & PAHO. (1990). *Declaración de Caracas*. https://www.paho.org/hq/dmdocuments/2008/Declaracion_de_Caracas.pdf

Wijekoon, S., Wilson, W., Gowan, N., Ferreira, L., Phadke, C., Udler, E. Y., & Bontempo, T. (2020) Experiences of occupational performance in survivors of stroke attending peer support groups. *Canadian Journal of Occupational Therapy. Revue Canadienne D'ergotherapie*, *87*(3), 173–181. https://doi.org/10.1177/0008417420905707, https://pubmed.ncbi.nlm.nih.gov/32115988/

Author Biographies

Felipe Agudelo-Hernández, MD, Child and adolescent psychiatrist, PhD in Social Sciences, Childhood and Youth. He is an advisor for the implementation of the mental health public policy in Colombia and the community-based rehabilitation strategy for the capital cities of Iberic-America. Aside from mental health services, his research interest is in mental health mutual aid groups and other community recovery efforts, especially for severe mental disorders and suicidal behavior. He has led national risk management strategies for adolescents and children at risk of suicide, with an intercultural approach. He is a clinical professor of pediatrics at the University of Manizales and a specialization in pediatrics at the University of Caldas. Email: afagudelo81703@umanizales.edu.co.

Ana Belén Giraldo Alvarez, Epidemiologist, psychiatry resident. She has worked on telehealth processes. As research interests she points to health services, intercultural mental health, and public health. Email: giraldoanabelen@gmail.com, Universidad de los Andes.

Rodrigo Rojas-Andrade, MEd, Psy.M., Ph.D., is Associate Professor at the School of Psychology, University of Santiago de Chile. Research Director of the Latin American Commission for the Global Implementation Society. His research interests are designing and implementing public community mental health programs in diverse settings.