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Community model of mental health: an analysis of its implementation in two psychosocial rehabilitation devices in mental health

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Introduction

In Chile, mental health problems have increased in recent years,[1–4] despite As a result, the existing gap in terms of timely diagnosis and treatment alerts us to improve the provision of these services. Approximately 80% of Chileans with psychiatric diseases do not present a diagnosis, while diagnosed people do not always receive specialized intervention.[5] Likewise, care approaches present difficulties in adjusting to an ecologically situated intervention, attending to social determinants associated with mental health problems. Furthermore, people with mental health disorders are sometimes not treated as citizens who have rights, as well as a voice and resources to make decisions about their processes.[6] Diagnosed with these disorders, history documents that in the country they received asylum treatment, with widely studied and published consequences. Current evidence shows that factors such as stigma, social marginalization, loss of support networks, limited autonomy for decision-making, failure to protect the full exercise of citizens' rights, have interfered in the psychosocial rehabilitation and recovery processes.[7]

Accordingly, various initiatives in the country have sought to reverse the asilar model and traditional stigma and exclusion of people with mental disorders. Experiences from the framework of community psychiatry in the late fifties and early sixties are the first attempts to advance this line helping to build a community mental health model.[8] The community mental health model recognizes and intends to address the needs of this population with a comprehensive approach recognizing the impact that has mental illness severe and persistent in the person, his family and environment as well as considering how this environment contributes to rehabilitation and inclusion providing conditions conducive to the full exercise of rights and welfare socioemotional.[9] In line with the challenges posed by mental health model community, the National Mental Health Plan 2017-2025 seeks to implement improvements in mental health. Proposes a reorganization of integrated services to the general health system ordered levels, with specialized resources, diversified, decentralized and regionalised. It recognizes the need for complex connections with non-health structures for the comprehensive and satisfactory care for people with mental disorders by MINSAL.

Although this plan promotes the community mental health model in the different devices that collaborate in its implementation, it has been documented that difficulties persist in Chile that hinder the implementation of community approaches in the field of psychosocial intervention and rehabilitation.[10–12] In order to inquire about the implementation of psychosocial rehabilitation programs that operate under the framework of the community mental health model and to study whether these effectively incorporate its approaches and operationalizations, this research seeks to characterize the implementation of the community mental health care model of two psychosocial rehabilitation programs in southern Chile.

Mental health community in Chile, trajectories and tensions

In Chile the first efforts to incorporate a community model to address mental health disorders, correspond to the early 60` through experiences led by doctors: Luis Weinstein, Juan Marconi and Martin Cordero in the public health system area community psychiatry. The first two in Santiago and the last in Temuco, all arrested almost completely with the advent of the military dictatorship in 1973.[8] These initiatives address the relevance of environmentally contextual conditions of people who had mental health problems, and the need to actively involve families, community organizations and the state itself was recognized. They were made possible by a social climate and academic openness, with spaces for innovation implemented from the institutions own. During the military dictatorship in Chile, since 1973, these community experiences stopped, pulling back on psychiatriccare practices prevailed as full institutionalization in psychiatrichospitals. At the end of this period, care was focused on four psychiatric hospitals nationwide, in conditions of overcrowding, mistreatment, insufficient care, and few possibilities for rehabilitation and social inclusion. Outpatient care was absolutely insufficient in this period for the population's requirements.[13]

The mental health unit created in the first Ministry of Health post dictatorship seencargó to initiate processes of change, on par with the impetus given by the Organization Pan American Health Organization to the psychiatric deinstitutionalization in Latin America in Caracas Conference (Pan American Health Organization, 1990). In 1993, he formulated the National Plan Mental Health First organized a network of national Mental Health, gradually increasing the budget guidelines systematized guidelines and standards, incorporating massively psychologists to primary health care (PHC). He provided ongoing support and training professionals APS, formation of user

groups and families were encouraged, establishing rights protection regulations, massive deinstitutionalization of people from psychiatric hospitals (mainly households and protected residences), plus efforts were made to establish quality policies and intersectoral work by MINSAL. Innovative practices that nurture the next mental health plan by MINSAL were introduced.

The second plan, applied in 2000, already integrated the lines of action proposed by the World Health Organization in 2001 in its report on health in the world.[14] Among the most prominent were the implementation of specialized services in community mental health, incorporation of mental health care into general health care, as well as work development and link with the intersector. The programs that were implemented in the context of the second national plan, incorporated the biopsychosocial approach, based on prevention and early intervention that allowed progress in improvements in mental health care, including the participation of user and family organizations.[14] The Observatory of Human Rights of Persons with Disabilities Mental 2014 generates a decumplimiento diagnosis rights established in this convention in Chile, for which analyzes legislation, concluding that its contrary to the principles of the International Convention fort he Rights of Persons with disabilities (hereinafter CRPD) and its specific provisions. According to general principles of the CRPD, full participation and inclusion and effective in society and respect for difference and acceptance of persons with disabilities as part of human diversity and the human condition they are part of the commitment made by part of the state. The National Mental Health Plan 2017-2025 attempts to respond to the challenges derived from this analysis, such as the mental health needs of the population arising from a detailed study of the current mental health situation in Chile by MINSAL.

According to what was proposed by Marconi[15] in a process perspective, unlike other countries (Canada, United States, France, Italy and Spain), Chile has not had a sustained and coherent policy for the implementation of mental health community, but the succession of creative and regressive events throughout history is appreciated. A central aspect to understand this situation is the fact that the new institutions advanced at the official level, failing to support the creation of sufficient and adequate community institutions for the wide spectrum of mental health pathology.[15] Although this is a diagnosis for what happened up to the 1990s, and progress has undoubtedly been advanced, there is also consensus on the persistence of problems. Specifically, in the integration of public institutions and the articulation with community networks of proximity,[2–4] as well as difficulties to really incorporate the community in the prevention and recovery of people affected by mental health disorders.

Evolution of the community model of mental health care

In order to achieve what is proposed by the National Mental Health Plan 2017-2022, it is proposed to continue advancing in the implementation of the community model of mental health care. Understanding that the community is associated with thed various intervention practices that account for the different links that are established between actors and social networks that are part of the daily life of a neighborhood.[16] Madariaga[17] points out that community mental health model identifies an ontological and epistemological shift compared to traditional views of health, particularly mental health. Part of a strong critical biomedical model, challenging the search for new theoretical and methodological tools. In this quest opens a path for an intense dialogue between natural sciences and biomedicine various disciplines of social sciences.[16] Approaches involved in building the focus of mental health community share the attempt to apply the biopsychosocial perspective to disease and health.[18] Health and mental health, are set in the dynamic interplay of social relations at a given moment and in a given society. Product of multiple determinations. Are moments of synthesis of biological processes (natural bases conditions) and cultural processes (the field of symbolic representations and meaning of the conditions).[17] From this approach, the object of study of health disciplines constitute problems (not just diseases), representations (not only medical diagnostics) and action strategies (not just treatments) presented in the course reproduction of social life.[19]

Community mental health model feeds on a set of approaches that expand the theoretical repertoire of health sciences, contributing to overcoming the biomedical reductionism and providing methods for deconstructing the process of health, illness and care in terms of totality. These theoretical sources are: field theory of health, socio-historical approach, collective health, systemic perspective, social ecology, constructionism, three-phase model, etc..[18] ANDl model focuses on the individual as a citizen with a set of fundamental rights, so you are encouraged to shift in practice in mental health spending from the perspective of protection of the individual patient to another to support a leading subject with resources and autonomy.[20]

Psychosocial rehabilitation in the community mental health model

Psychosocial rehabilitation is originain diverse and varied development professionals throughout history[21] and the Fourth Conference of Switzer where psychosocial rehabilitation was defined as a process that seeks to improve the quality of life of these people, helping them take responsibility of their own lives and act as actively as community by Aldaz & Vasquez possible. Rehabilitation would succeed if an inclusion of subjects occurs at social and community level. Whereas they can be integrated into its natural community citizens exercising their rights, participating in a social environment in the same way as the rest of the people living in it. This involves the use of community resources accessed by most people to meet their needs at various levels.[21] However, psychosocial rehabilitation has wanted to go a step further by incorporating the prospect of recovery (Recovery) in the practices of psychosocial rehabilitation in mental health teams.[22] Recovery emerges as a social movement of users of mental health services,[23] stressing that the side effects have had people with mental health problems go beyond the disease and point to the way this is seen socially, ie the impact of the stigma that people with mental illness have undergone both inside and outside the institutions.[24]

Thus Both psychosocial rehabilitation and recovery should contribute to the social and community inclusion of people who have mental illness by Martinez. To do the programs work or collaborate on these purposes must contribute quality resources, or must work together to enable or empower other services required to meet the needs of people. In addition, they must promote the complementarity of these resources that are present or latent in people served, their families and community membership. These efforts must integrate the development or strengthening of skills to ensure the progressive autonomy of persons involved in the rehabilitation regarding intervenors teams that have had to relate (Avello, Enesteplano, lo comunitario pone el focoen la cotidianeidad de las personas, espaciodondeocurresuvida y donde

se puedenes tablecer relaciones que permiten transformar suentorno.[25] Se fortalece así la idea de un modelo de salud mental comunitaria que extrae el sufrimiento mental del sistema institucional de la atención de la enfermedad devolviéndole a su contexto natural, la comunidad.[26]

Psychosocial rehabilitation in the community mental health model: international and Chilean experiences

Rehabilitation is understood as a set of strategies for coping with the difficulties in performing daily life of people with mental health problems of a severity and intensity that limit the development of their daily life and their personal goals by Hernandez. Among the values that guide the rehabilitation, considered central autonomy, participation, standardization and accountability. These values are particularly relevant from the perspective of recovery, which emphasizes control of the vital project itself and building a sense and meaning of life, providing opportunities for empowerment by Hernandez, which allows people make use of their rights and demand inclusive public policies.[27] Different international organizations have established that psychosocial rehabilitation should occupy a primary place among the priorities of public health systems by MINSAL. This has been established by new public policies on mental health by MINSAL, which have highlighted the development of psychosocial rehabilitation.

In terms of innovative experiences in psychosocial rehabilitation, international experiences that have sought to improve the quality of life and promote social inclusion stand out. One of the important experiences to highlight is La Fageda (Garrotxa, Gerona), a business-type project developed to achieve the labor and social insertion of people with mental disabilities and/or severe mental disorders. In La Fageda it is possible to develop a model of social integration that seeks to provide meaningful work adapted to the characteristics of each individual, which has allowed the recovery of identity and self-esteem of people with disabilities who work there every day making dairy products.[28] Another important experience to highlight is the Clubhouse, a support system developed for people with mental illness. This experience was born in the 1940s in the United States and is currently present in Europe and Latin America. According to the experience of Mosaic Clubhouse (London), the main task developed has been to empower people with mental health problems using the management and administration of the center itself and the recovery of its members has been given through mutual support.[29]

Europe highlights the work developed in Trieste, Italy, listed as a pioneering experience of community mental health care.[30] Since 1987, Trieste is one of the most advanced experiences in Italy and in Europe for deinstitutionalization and implementation of community mental health services, becoming an international reference point for these issues. Today with over thirty years of experience, he develops activities and community services in its territory and provides methodological support to several countries in all continents.[31] We can also find some innovative practices in Latin America, as in the case of Community Mental Health Movement Bom Jardim (Fortaleza, Brasil), This Brazilian movement is part of a policy against psychiatric hospitalization, established in 2001, which sought to avoid psychiatric hospitalization and stimulate return home, as well as social participation in the prevention and care of mental disorders.[32] The Bom Jardim Care Center uses community therapy to address mental disorders (schizophrenia, psychosis and severe depression) by providing multidisciplinary care and using methods that make collective and innovative therapy aiming at reducing drug-focused treatment.[32]

Noteworthy in Chile two experiences, which, in the context of the community mental health model, show interesting contributions. One of them is the Villa Solidarity Alsino, which constitutes a mental health program that is part of the Mental Health Network of the South Metropolitan Health Service Area East and health of Municipal Corporation of Florida. Born in order to respond to the needs of young people who have dual diagnosis (psychiatric comorbidity and substance), from a community perspective. The program explicitly valuing freedom of the person who presents difficulties, understood as a citizen who requires conditions for social inclusion by Silva. The Villa Solidaria Alsino, has quantified the impact on the subjects of care, noting that 85% of the users admitted have managed to be inserted with the maximum level of autonomy possible in their social environment, about 85% or more of the users under control have managed to remain stabilized in their psychopathology and 50% or more of the users under control in the program have joined various social groups by Silva.

Another experience is that developed in the Peñalolén Therapeutic Community. This entity is articulated with the Eastern Metropolitan Service through a service provision agreement, which has facilitated access to rehabilitation. From 1990 to 2014, more than 500 people have accessed psychosocial rehabilitation, of which 95% have not required psychiatric hospitalization.[33] The achievements are based on the methodology used aimed at the development of therapeutic activities in the community that facilitate social exchange, as well as the development of assemblies, conversation groups and the implementation of strategies for labor integration.[33,34] These experiences show that it is possible to advance in the rehabilitation, social inclusion and autonomy of the people being cared for, through a capacity for innovation that allows articulating from a positive vision of people who present mental health problems, their recognition as citizens with the articulation of institutional and community networks to give a favorable response to their rights and needs.

Although these experiences show us that advancing in the implementation of the community mental health model is necessary and possible, in the country, there is a heterogeneous implementation in the field of rehabilitation. This has had an impact on the quality and projection of the intervention carried out by the various programs in Chile.[35] In the Chilean experience, there are two complementary lines psychosocial rehabilitation within the mental health plan, the first is the incorporation of services intended for people who have diagnosis of harmful use or dependence on alcohol and / or other drugs, with a biopsychosocial commitment moderate to severe, with or without psychiatric comorbidity by MINSAL and, second, the inclusion of person who by the severity of mental disorder have mental disabilities by MINSAL that limit the development of their daily life and personal goals by Hernandez. In both lines, you can see that psychosocial rehabilitation is a dimension of mental health intervention operating as a key factor in the effectiveness of the process of deinstitutionalization.

Local context in which it develops the study

Osorno Province, located in the region of Los Lagos (south of the country area), covers an area of 9223.7 km^2, counting the year 2018 with a projected population of 230,247 inhabitants by DSSO. According to studies of prevalence of psychiatric disorders in Chilean population,[36,37] it is determined that 22% (reference value, prevalence in adult population 22.2% in child and adolescent population 22.5%) of registered opulationvalidated by the National Health Fund (FONASA) in the province of Osorno present a mental health problem

over a period of 12 months, which is equivalent to 46,146 people. The Mental Health Thematic Network in the province has presented important changes in the design of the network from 2014 to date, which has implied the successive incorporation of new mental health devices and with it the implementation of these. Given the growth of this network of mental health services, and the need to generate local evidence, it is worth wondering in a highly centralized country, how in devices further away from the usual spaces of innovation the community model of mental health care is implemented.

To answer the research question this study focused on two mental health facilities, one in the field of rehabilitation of addictions and another in the field of rehabilitation of chronic psychiatric disorders. The objectives were established as a general objective: to characterize the implementation of the Community model of mental health care into two mental health facilities in the province of Osorno. Specifically from the perspective of the members of both teams intervention: (a) characterize the understanding that both teams have about the community model of mental health care, (b) to characterize understandings of psychosocial rehabilitation (c) characterize how teams materialize the psychosocial rehabilitation model from a community perspective ed) to identify facilitators and hindering present in the realization of psychosocial rehabilitation in the field of mental health.

Methods

Design

The methodological perspective used in this study was qualitative, descriptive[25] and the investigation strategy used responds to a multiple case study.[38,39]

Participants

This research defined as the study population two mental health programs in the province of Osorno aimed at providing psychosocial rehabilitation to people with a pathology of psychiatric origin and/or disability. The inclusion criteria that were established for the selection of the devices were the following: being part of the mental health network of the province of Osorno, incorporating psychosocial rehabilitation services in the intervention process, presenting a minimum trajectory of 10 years performing Psychosocial Rehabilitation, have at least one member of the team with permanence since the creation of the center and present provincial and regional recognition from Public Institutions for the development of good practices The sample was composed of the AMORE Recovery Center, this center is managed by A social organization called Agrupación de Monitores de Rehabilitación en Salud Mental, the center is located in the Rahue Alto sector of the Osorno commune. Until 2016 the team consisted of five people (the director of the goldsmith center, agricultural expert technician, English-French translator / ceramicist, anthropologist and technician in special education). During 2017, the human resource of a professional nutritionist and kitchen monitor was added and in 2018 a professional social worker was integrated. Of a total of eight people who make up the team, seven accounts with a 44-hour shift. and a person with a day of 22 hrs. The members of the team with the longest experience are agricultural technician, English-French translator/ceramicist and goldsmith who have over fourteen years of experience in the field of mental health rehabilitation. Of this team, five people had availability to participate in the research (agricultural expert technician, English-French translator/potter, goldsmith and technician in special education).

Also part of the sample is the Peulla Therapeutic Community, a device dependent on the Osorno Health Service and maintains an agreement with the National Service for the Prevention and Rehabilitation of Drug and Alcohol Consumption (SENDA), it is located in the eastern sector of the commune of Osorno. Until 2016 the team was made up of the director of the center (social worker), two social workers (88 hrs. Per week), two psychologists (88 hrs. Per week), nurse (44 hrs. Per week), general practitioner (8 hrs. weekly), psychiatrist (1.5 hours weekly), rehabilitation therapist (44 hours weekly), two monitors (44 hours weekly), administrative (44 hours weekly) and two secretaries (88 hours weekly). During the year 2017, a human resource was hired as a nurse (44 hours per week) and an occupational therapist (44 hours per week). This device operates in an outpatient and residential mode, where the team distributes its working hours according to the technical guidelines of the SENDA with advice from the Health Service. The members who have more than fourteen years of experience in the area of addiction rehabilitation are Director of the center and rehabilitation therapist and with more than six years of experience one of the social work professionals and a monitor. Other team members have experience of less than three years. From this team, nine people agreed to participate in the research (director, a psychologist, a social worker, a nurse, a general practitioner, a rehabilitation therapist, secretaries, and a monitor).

Techniques

Group semi-structured interview[38] it was used as data collection technique, guided by a pattern of previously defined topics regarding the implementation of the Community model of mental health care. This pattern of topics seeks to meet the objectives of the study, and was tested and debugged from a pilot study. Each group interview lasted three hours and thirty minutes and was conducted mainly in areas of workplace professionals. Mode data recording audio recording was further supplemented by conducting field notes and memos summary for each of the interviews conducted. It is important to mention that, to develop the topic guideline and the group interview guideline as a data production technique, piloting was carried out with a technical team of similar characteristics in the Los Ríos region (neighboring region).

Process

For the development of this research, formal authorization was obtained from the Director of the Osorno Health Service, then the teams were contacted explaining the procedure, safeguarding their acceptance through the signing of informed consents. The data provided by the participants was confidential and for exclusive use for the purposes of this research. Regarding the information, it was validated by cross-checking with the participants. The results of the study were shared with both teams.

Analysis plan

The transcribed information was examined according to the technique of content analysis in its directed approach procedure is to identify initial coding categories using existing theories or previous research,[40] which were guided by four categories associated the research objectives, creating a codebook.[41] The ATLAS Ti used the program in its version 7.0, linking citations to the previously defined codes. The texts that could not be categorized with the initial coding scheme was allocated to an emerging code. Due to the high number of codes (143), it was necessary to create sub-categories (19) generated main categories (04). The reliability criteria used for the construction

phase of the interview pattern were the following: (a) consultation with experts and (b) piloting with a technical team of similar characteristics in the Los Ríos region; For the results phase, two other techniques were used: (c) the cross-check with the participants and (d) the triangulation of researchers[42,43] and, (e) the data analysis was triangulated by two researchers.

Ethical safeguards

The research process was guided by ethical criteria, considered the approval of the Healthcare Ethics Committee of the Health Service involved, participating health devices pledged their participation informed consent was applied, participants in the study agreed to be informants and, in turn, knew their rights and their responsibilities in the investigation. In addition, data confidentiality (anonymity on the identity of the participants and privacy of information that is revealed by them) was guaranteed. Theteamsmet.

Results

The results were organized to respond to the proposed objectives. In the first place, the understanding of both teams of the community model of mental health care and psychosocial rehabilitation is approached, then how the teams specify the model of psychosocial rehabilitation from the community perspective in their practice, to finally identify facilitators and obstacles in the realization of psychosocial rehabilitation in the field of mental health.

Understanding the community model of mental health care

In the analysis of this dimension, the teams point out that the community model is understood as coordinated and multidisciplinary work, which must be crossed by logic of trust and security among the team members, for proper case management. The focus is on the well-being of the person in rehabilitation and involves articulating the use of resources present in the community, rescuing human contact as an action that generates states of health and well-being. The following quote reflects the emphasis expressed in both teams interviewed: *"Community mental health promotes the use of resources and skills that are in the community and makes them available to people who have mental health problems" (team 1, person 2).*

Conditions are proposed to make the community mental health model effective, mainly of a structural nature, which are related to the rights of people with mental health disorders and mental disabilities. They also share the need to make these rights visible, so that they are known, recognized and validated by the social and community environment. Both teams, show that the transition from a biomedical model to a community care model requires "changes" practices of health professionals and teams to tune with the guidelines of the current mental health plan. As observed in practice, refer incompatibilities between the spirit of the community mental health model, objectives and requirements associated with performance indicators established by the Ministry of Health. Thissituationisexpressed in thefollowingquote:

"They usually talk to you about community mental health, about getting closer to the territory, to the neighborhood, but another message is also provided that says that you have to comply with hours of direct care in the center to be able to provide care to a number x of people, who demand care for example as a psychologist, then in what minutes do you complete these forms of work… "(Team 1, person 2).

It should also be mentioned that both teams show in their approaches that respect for people's rights and the humanistic vision that translates the community mental health model must first be developed in the daily subject-person-team interaction of the program. Then, the rights of people and their inclusion must be carried out in the provision of opportunities at all levels of civic life: work, health, housing, etc.

Understanding psychosocial rehabilitation

In the analysis of this dimension teams define psychosocial rehabilitation emphasizing the objective it pursues, highlighting the values and criteria that guide this process as well as identifying barriers to social inclusion of people with whom you work in psychosocial rehabilitation. In this perspective, psychosocial rehabilitation is understood as an integral process, long-winded that seeks social inclusion through work in complementary spheres of life of the person: the subject himself, family, work and social environment, so as to allow the individual skill development from doing itself. In psychosocial rehabilitation, according to the teams, it is central that the person gives meaning to your life, resignifique experiences through the assessment of their own skills in various contexts of participation (work, social participation, among others). The following excerpt reflect sthe points made:

"What we do is accompany the path of change, it is their struggle, not only to get out of addiction, but to understand all parts of their life, that they understand that they have skills to face other ways of being and being in life, to find meaning in the desire to want to live "(Team 2, person 1).

There is consensus that in order to promote psychosocial rehabilitation, there must be a shared value framework among the team members, which must be specified in the relationships they sustain. These values must translate a shared vision of the subjects in rehabilitation, they must be understood as people with rights, which deserve validation and consideration. Relational values point to empathy, a sense of transcendence and respect. This means that the subjects in rehabilitation are, in their condition as people and citizens, creditors of an empathic relationship, which allows building a context of opportunities to achieve validation, development and redefinition, if necessary, of the life project. Criteria are proposed that guide psychosocial rehabilitation and that are shared by both teams, that is; the recognition of the value of the experience of the team members, the response focused on the needs of the people who start the rehabilitation process, strategies that are sustained over time and the development of an intervention consistent with the characteristics of the local reality.

Therefore, psychosocial rehabilitation is oriented from a humanistic perspective recognizing the centrality of the subject in rehabilitation (with specific needs and characteristics) located in a familiar reality and particularly community. From there then that psychosocial intervention must be woven into daily life by "doing" of the subject in order to develop and strengthen skills that will allow them to be and "doing" better world. This involves creating conditions in the environment that enable new and better opportunities to this subject. Both teams indicate that in the process the team, as every person who composes, must go "dialogue", "adapted", "learning" in the relationship with the person who is in rehabilitation, as well as the context in which it is I insert.So matching teams identify barriers to cross psychosocial rehabilitation work involving work on "social".

These barriers are mainly stigma, prejudice and inequality affecting people who care

"I work on equal opportunities, that they learned it, then when they find employment or if you are already half an hour and fired, they consider it by prejudice and stigma. The state already said that they should have equal opportunities, without considering that some of these people can not work more than two hours, or may not have 15 minutes of attention, which can not come every day at eight o'clock "(team 1, persona 3).

Concreteness of the model rehabilitaciónpsicosocial from a community perspective

In the analysis of this dimension, the teams identify criteria to carry out the psychosocial rehabilitation model from a community perspective and account for the technical aspects used, the communication styles and relationship styles that they establish with the users, which have made it possible to develop this model. The teams agree on criteria for the realization of the rehabilitation model, which are; the co-construction of practice based on experience, that is to say "what has resulted" over time, which is consolidated as a learning that is shared with the rest of the team. The transdisciplinarity of the functions performed, highlighting the team look more than the disciplinary particularities. It is emphasized that the work should be aimed at achieving the maximum potential that the subjects can achieve, both at the contextual level (personal, family, social environment) and the "doing" (work, education, social participation). It is proposed that the practices should be developed in relation to the needs of the users, placing emphasis on generating family and community support networks. At the technical level, teams raised above all the need to maintain consistency in what everyone does with respect to a certain way of doing things is the cumulative learning achieved in practice by the members oldest of the team.

"For people who make up [to the intervention team], slowly going exerting pressure unexpressed to integrate our way of seeing the user, is not something to verbalize but it is shown with examples, it is in talks is in the days when we have team meeting where arises how to act against certain situations. We have one specific act that can not be transgressing, it is intended that there is a single glance. If we allow a different language installed, we are going to disarm what we have developed "(Team 1, person 2).

In addition, the need to maintain a permanent review of their own personal development, of the resonances that occur in the help relationship established with the users, is shared. This means being alert to work on personal aspects if necessary. *"You are realizing that there are things in life, situations that are echoing you, and that you had not looked because deep down you did not know how to look. And in learning to look, it means realizing that those things were not right and therefore you have to start solving them, otherwise, to generate an effect when you look at the other "(Team 2, person 7).*

Both teams are characterized by presenting a flexible organizational structure to respond to the demands of the context and establish a hierarchical administrative structure that is functional to the work being carried out. The therapeutic team is multidisciplinary, also incorporating monitors to the work developed. All members of the team participate in coordinating the rehabilitation plan, both in its preparation, development and redefinitions. In practice, they assume that by the nature of the work they do. They must be "always available", even outside working hours to resolve crisis situations of people in the rehabilitation process. It is assumed that the team must constitute an integrated whole, so the way in which they interact is fundamental. Direct communication, feedback and, if necessary, confrontation (saying things directly) are encouraged. Informed and consensual decisions must be made for the benefit of the user and their family or close social environment. A member of team two expresses:

"At first it is a bit shocking, that they tell you things so clearly, but over time you realize that it is necessary because of the position you have to have in front of the user, that is, you have to be consistent in each of your actions, because there are going to be users who will be observing, and you cannot lose credibility, as you can be responsible for them losing interest in continuing in rehabilitation" (Team 2, person 2).

Both teams share the ways of relating to users, establish bonds of trust with people in the process of rehabilitation, participating from the experience of the other, accompanying and relating horizontally. In addition, the definition of specific strategies for relationship with the family (therapeutic contract, admission interview) and responsibilities are assumed to face the demands of the users towards other public institutions. Two aspects are crucial to have sheltered about the nature of the work done. Relevant experience and skills that each member of the team to face a complex job that requires persistence and forms of relationships that make the difference to advance the process. The practices must be based on consistency between what is said and done, and between what is presented as computer people attended. But it also should be a model to show other teams that public policy should collaborate in the process that professionals can make a difference with their actions on the lives of people in rehabilitation:

"Show the other centers can, as long as there will, means taking a little more work, but we always made the best of enjoyments" (team 2 person 4).

Facilitators and hindering present in the realization of psychosocial rehabilitation in the field of mental health

Identifies internal facilitators teams to realize psychosocial rehabilitation in the field of mental health. The first is related to the opening of those teams to learn from the other members, particularly those who have more experience. So also it is identified as a facilitator aspect permanently have a critical look at what is done and systems for generating this constant evaluation of the work and the relationships maintained. At this level it is judged that facilitates the work have defined channels and direct communication between people: therapist / monitor-subject.So it is also recognized as facilitators have social networks that allow a more stable bond with the families of users and the users themselves, in other contexts other than that of the program.The ongoing exchange of equipment to improve the model is implemented, it is also noted as a facilitator. This exchange aims to have an understanding and shared ownership to ensure consistency in the work done. Thefollowingquote can appreciatethis:

"We are also in permanent training, because our errors are daily, we every other day are with errors of disagreement, or that we act badly in front of a user or we argue with each other publicly, that is,

in the week we have at least five points, or seven, or ten of errors so we have to evaluate ourselves "(team 1, person 2).

The Hindering appear in the external environment or the overall structure in which the program is inserted. The first thing indicated is the lack of consistency between what the mental health model poses as requirements to work, and what ultimately is requested administrative. For example, it is used as an indicator the amount of attention in box, but what is the model encourages coordination with other relevant actors to treatment that are out of the program.

It is also identified as an obstacle, the insufficient resources to implement a comprehensive rehabilitation, having to prioritize areas, and leaving others not addressed, for example: work with family members at home and interventions in context. An issue that clearly contravenes the community mental health model. Along the same lines, it is suggested that the increase in resources is not associated with improving the quality of work, but rather with increasing coverage. However, these teams have managed to adapt and from that position they criticize the actions of other teams with which they share responsibilities in treatment and rehabilitation, perceiving a low response to the lack of resources to carry out therapeutic interventions.

"At the beginning it was difficult, I came from a job in primary care where I and my box were, I attended every 40 minutes, 30 minutes and I had to see the user again in about a month and personally in a month I forgot who It was, I read my report and it was like what we are in and I felt that under this scenario I could not ask the user for more. So it was to attack the symptoms, but not the disease "(team 1, person 8).

Another aspect that is recognized as an obstacle corresponds to the work carried out by other health facilities with which they coordinate actions. Both teams share strong criticisms about the prevalence of the biomedical model. In this regard, it is discussed that this model prevails in those who intervene in mental health and psychiatry, since they have been trained under this model and that in some way it has managed to permeate and influence the new generations of health professionals. This situation has an impact on the practices that both teams maintain are stressed by the approach of the other teams that intervene in health care. Lack of knowledge and appropriation of community health model, according to the indications respondents equipment impacts the way they approach the person in rehabilitation, prevailing in psychiatric diagnostic equipment that reinforce stigma and define a relationship between health personnel and people seen holding a relationship impeding the vision of another as equal rights and autonomy. This scheme is also presented in professionals from other public services (education, work, housing), generating significant gaps to implement a comprehensive model of mental health. The health professionals who are part of these two teams recognize that the training itself has limitations, both due to not having training in mental health and in the community. In this regard, one of the members of team two, points out.

"I felt a little disappointed in the training that we were given as nursing students in the face of this issue of addictions, it really was a brushstroke, so it is like rediscovering another aspect of the profession, in academic training the profession is directed to a more focus. biomedical, even when it comes to psychiatry, we have a very short internship and there is really very little that one achieves as a student. And joining the area of mental health is almost going back to studying everything again and re-understanding a new world, especially with a community approach "(Team2, person 2).

The self-care practices present in the teams are also identified as a facilitator, a shared responsibility is proposed, transdisciplinary work, there is a homogeneous distribution of workloads, but also the need is raised that all team members should be involved in the process of rehabilitation of each user in order to establish responsibility in "the team" and not in a therapist or monitor.

Discussion and Conclusion

The results show that both programs share the same understanding of psychosocial rehabilitation, where they are understood as an integral process with objectives that aim towards social inclusion,[25] fully focused on the needs and requirements of people, giving value to the skills and abilities that unfold in the various contexts of participation.[44] Therefore, the focus is on the person who have mental disabilities or addiction and their family, social and community context. Which is in full symptom incorporating a rehabilitation perspective in line recovery[24,25,45] as a fundamental part of the implementation of the Community model of mental health care. In both teams there is a vision of rehabilitation as a process that seeks the transformation not only of the user, but fundamentally of the social, community and institutional context (particularly those who execute public policy) as well as the space closest to the life of east (family and community space). This will allow recognizing the person in rehabilitation as a subject of law who must have access to opportunities for their real social inclusion.

The teams show agreement in declaring humanistic values that guide their work, which implies a vision of the subject in rehabilitation as the center of the entire process, with capacities, abilities and rights. From this vision derives the need to establish a relational context that mobilizes resources, both in the subject and in the context of life. Consequently, the work is based on a quality help relationship, which implies, above all, relationships within the team consistent with this task, hence ensuring the presence of a team with high human and professional quality is raised as a fundamental requirement to fulfill the purposes of the work carried out. This approach is consistent with what is proposed in psychoeducation as a condition of the helping relationship.[46] There are also indications in the line of social learning when the importance of modeling in the relationships that the team members maintain among themselves and what they propose from the example to people in rehabilitation.[47]

Both teams implement two major levels of intervention, one focused on daily life, aimed at solving needs that allow subjects to advance positively in their process, through the development of skills and competencies, facilitating the resolution of difficulties that favor a better articulation of the life Proyect. And the other level is focused on the context of life and on the network of services that are required for people to access resources that promote recovery and social inclusion.[48] In this way, the integration of two complementary models of intervention is appreciated, such as the psychoeducational[49] and the community.[25] It is identified that the greatest efforts are focused on the first level of intervention, while the second, although it is understood as fundamental, is faced with various tensions for its implementation.

Facilitators for the implementation of the community mental health model are identified, located within both teams. In both cases,

aspects that favor adequate therapeutic management are rescued: coordinated, multidisciplinary work, focused on the well-being of the person, with articulation of community resources and enhancing the human encounter, both between those who make up the teams and with the people themselves in the process of rehabilitation. They identify that the training of new team members, through induction and training processes, are central aspects to guarantee coherence in the implementation of the model. In both teams, the contribution made by the people with the longest tenure in the program is valued since they transmit learning based on experience that has been validated over time. A facilitator in the induction process (initial training) has been the modeling of work behavior by the more experienced members; however, through the efforts of the teams, they identify a set of difficulties to fully implement the community model mental health. As has been indicated in other studies[50–53] the scarce coherence of intersectoral policies, in this case in mental health and mental disability prevent a comprehens'ive and integrated approach to the challenges of psychosocial rehabilitation in the field of mental health.

The absence of systemic coherence, an aspect already highlighted in national studies in other fields of psychosocial rehabilitation,[54,55] distracts teams in action more individualized despite the understanding they have of the nearest rehabilitation the comunitario.Se model considers that despite the difficulties have managed to overcome these obstacles creatively and strongly criticize the teams that do not. In addition, both teams must face in their work to the strong roots of the biomedical model in other equipment general health and mental health, plus social constructions based on stigmas. This highlights the strong need for public policy from mental health will emphasize continuous training that allows to incorporate new approaches to professional work, as well as the educational challenge must take both pre universities and graduate levels. As identified other research, innovation does not become exclusively the establishment of a new policy, but must assume the complex web of factors that influence whether an innovation is incorporated.[56,57]

In conclusion, the data obtained allow us to appreciate that in both cases the implementation of a community mental health model in the area of psychosocial rehabilitation has been a construction assumed endogenously by the teams, but today it faces the tensions of intersectoral policies that are not consistent with the model. Hence, teams, highly demanded by the very challenges of a demanding help relationship due to the nature of the problems faced by the people served, are stressed by performance assessment systems (translated into quantitative indicators) that are out of tune with the nature of community work, while they must devise a system of institutional and community collaboration for which they do not always have resources.[58–77]

It is recognized that both teams have been making important efforts to specify a community model of psychosocial rehabilitation, identifying important advances. The main resource they have deployed has been to safeguard a shared construction of the intervention, taking care of the coherence between the declared humanist values and the daily work in the aid relationship. Continuous learning, permanent evaluation of the work and coordinated work are at the core of these advances. Finally, the main contribution of this study is identified as the rescue of the experience of these two teams regarding the incorporation and implementation of the community mental health model in the specific field of rehabilitation, obtaining from their points of view, the advances, limitations and challenges faced by the full implementation of the model. This makes us recognize the complexity in the implementation of a public policy that seeks to innovate in the field of mental health, while we must also understand its implementation as a multi-level construction. In this case, the internal resources that have made it possible to advance positively are evident, but there are also operating conditions in the health system itself, such as in intersectoral policy that are acting as an obstacle and limitation in the operationalization of the model. Research being located in two specific cases in a given province, the challenge is presented to extend the inquirí to other cases elsewhere in the country. As well as strengthen the methodological development of these practices with an address located, more permanent in time with community education, ie a strategic approach such as that offered community psychology. However, the data obtained in the study show results that are in line with other areas of psychosocial rehabilitation in the country.

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Confclits of interest

The author declares institutional affiliation with the Directorate of the Osorno Health Service.

References

1. Vicente B, Saldivia S, Pihán R. Prevalencias y brechas hoy; salud mental mañana. *Revista Acta Bioethica.* 2000;22(1):51–61.
2. Encina E, Minoletti A. Hacia una estrategia de participación En y para la salud mental: escuela de Monitores en salud mental comunitaria La pintan. *Revista Chilena de Salud Pública*. 2016;20(2):91–100.
3. Crempien C, de la Parra G, Grez M, et al. Características sociodemográficas y clínicas de pacientes diagnosticados con depresión en Centros Comunitarios de Salud Mental (COSAM) de Santiago, Chile. *Revista Chilena de Neuropsiquiatría*. 2017;55(1):26–35.
4. Minoletti A, Soto G, Sepúlveda R, et al. Capacidad de respuesta de la atención primaria en salud mental en Chile: una contribución a Alma-Ata. *RevPanam de Salud Pública*. 2018;42:1–8.
5. Siebert F. La salud mental es el área de la medicina que produce mayor pérdida de productividad para el país. *Dircom-UChile.* 2016.
6. Figueroa F. Voces de usuarios y sobrevivientes de la Psiquiatría contenidas en la convención sobre Los derechos de las personas con discapacidad: Un nuevo paradigma abre camino en chile. *Revista Latinoamericana en Discapacidad, Sociedad y Derechos Humano*. 2017;1(1):123–142.
7. Grandón Fernández P, Bustos Navarrete C, Cova Solar F, et al. Evaluación de la restrictividad de dispositivos residenciales para personas con un diagnóstico psiquiátrico en el modelo de Salud Mental Comunitaria en Chile. *Revista UniversitasPsychologica*. 2015;14(4):15–25.
8. Torres R. *Experiencias de Psiquiatría Comunitaria en Chile*. Facultad de Ciencias Médicas USACH. 2001.
9. Minoletti A, Sepúlveda R, Gómez M, et al. Análisis de la gobernanza en la implementación del modelo comunitario de salud mental en Chile. *Rev Panam Salud Publica*. 2018;42(13).
10. Avello D, Roman A, Zambrano A. Intervención sociocomunitaria en programas de rehabilitación psicosocial: Un estudio de casos en dos equipos del sur de Chile. *Revista Psicoperspectivas. Individuo y Sociedad*. 2017;16(1):19–30.
11. Avello D, Zambrano A, Román A. Responsabilidad penal adolescente en Chile: propuestas para implementar la intervención psicosocial en Secciones Juveniles. *Revista Criminalidad*. 2018;60(3):205–219.

12. Daher M, Jaramillo A, Rosati A. Agentes de intervención en programas psicosociales: Tipos de Apoyo y efectos según nivel de vulnerabilidad. *Psicoperspectivas*. 2018;17(1):1–5.

13. Alvarado R, Minoletti A. *FONIS SA08I20033: Evaluación de las redes de atención para personas con primer episodio de esquizofrenia, en Chile*. Santiago de Chile. 2010.

14. Minoletti A, Zaccaria A. Plan Nacional de Salud Mental en Chile: 10 años de experiencia. *Revista Panamericana de Salud*. 2005;18(4–5):346–358.

15. Marconi J. La Reforma Psiquiátrica en Chile: Precedencia Histórica de los Problemas del Alcohol (1942-2000). *Revista Médica Social*. 1999;40(2):33–40.

16. Carrasco J, uing T. Lo biomédico, lo clínico y lo comunitario: Interfaces en la producción de subjetividad. *Revista Psicoperspectivas*. 2014;(13)2:98–108.

17. Madariaga C. La Salud Mental como un objetivo del desarrollo social. Director R. Alvarado, *Avanzar hacia la ciudadanía plena y el disfrute de derechos. Experiencias de trabajo comunitario en Salud Mental.* Conferencia llevada a cabo Jornadas Chilenas de Salud Mental, Santiago, Chile. 2014.

18. Madariaga C. Psiquiatría Comunitaria. *Apuntes para una conceptualización. Documento de estudio del Módulo II del Diplomado en Salud Mental Comunitaria de la Esc*. de Salud Pública, Facultad de Medicina U. de Chile. Santiago de Chile. 2002.

19. Samaja J. *Epistemología de la Salud.* Buenos Aires, Argentina: Editorial Lugar. 2004.

20. Minoletti A. *La delgada línea roja: Equipos de Salud Mental: ¿defensores o cómplices de las violaciones a los derechos humanos de las personas con discapacidad mental?* Conferencia en el Taller Internacional del Diplomado de Salud Mental Comunitaria, Escuela de Salud Pública, Fac. Medicina, U. de Chile. Powerpoint, Santiago de Chile. 2014.

21. Sandoval C. *Rehabilitación psicosocial: Reconsideraciones conceptuales y perspectivas actuales*. *Revista Cúpula*. 2010;*25*(1–2):8–26.

22. Mascayano F, Montenegro C. El "modelo de la recuperación" y la reforma de la atención en salud mental: evidencias, diferencias y elementos para una agenda latinoamericana. *Revista Argentina de Psiquiatría.* 2017;2:460–467.

23. Slade M. Personal Recovery and Mental Illness. *A guide for mental health professionals*. Cambridge University Press. 2009.

24. Davidson L, González A. La recuperación centrada en la persona y sus implicaciones en salud mental. *Revista de la Asociación Española de Neuropsiquiatría*. 2017;37(131):189–205.

25. Canales M. El Enfoque Comunitario. El Desafío de Incorporar a la Comunidad en las Intervenciones Sociales de Víctor Martínez. *Interamerican Journal of Psychology*. 2007;41(2):251–253.

26. Saforcada E, Castella J, y Alfaro J. *Salud Comunitaria desde la perspectiva de sus protagonistas: la comunidad*. Buenos Aires, Argentina: Editorial Nuevos tiempos. 2015.

27. Irarrázaval M, Prieto F, Armijo J. Prevención e Intervenciones tempranas en Salud Mental: Una perspectiva internacional. *RevistaActabioethica*. 2016;22(1):37–50.

28. Segarra J. La Fageda: Otra empresa posible. *Revista Universia Business*. 2011;30:110–119.

29. Iridium S. Clubhouse: una puerta abierta a la inclusión. *Revista Encuentro*. 2012;2:6–8.

30. Rotelli R. *Vivir Sin manicomios: La experiencia de Trieste*. Buenos Aires: Editorial Topia. 2015.

31. Dell'Acqua P. *Desde el manicomio hacia los servicios de salud mental en el territorio*. Programa Innovación para el desarrollo y la cooperación sur-sur IDEASS. 2012.

32. Osaba M. *Salud-Brasil: Una comunidad para curar dolores del alma*. Inter pressservice agencia de noticias. 2019.

33. Sandoval C, Mujica A, Pereira V, et al. Logros y desafíos de La Comunidad Terapéutica de Peñalolén: 25 años de cuidados comunitarios en Salud Mental**.**Director R. Alvarado, *Avanzar hacia la ciudadanía plena y el disfrute de derechos. Experiencias de trabajo comunitario en Salud Mental.* Conferencia llevada a cabo Jornadas Chilenas de Salud Mental, Santiago, Chile. 2014.

34. Díaz F, Erazo J, Sandoval C. Actuales Políticas Públicas para la Desinstitucionalización y Rehabilitación de Personas Psicóticas en Chile. Experiencia de la Comunidad Terapéutica de Peñalolén. *Revista de Psicología*. 2008;7(1):9–37.

35. Vicente B, Kohn R, Rioseco P, et al. Lifetime and 12-Month Prevalence of DSM-III-R Disorders in the Chile Psychiatric Prevalence Study. *Am J Psychiatry*. 2006;163:1362–1370.

36. De La Barra F, Vicente B, Saldivia S, et al. Estudio de epidemiología psiquiátricaen niños y adolescentes en Chile: Estado actual. *Revista Médica Clínica Las Condes.* 2012;23(5):510–645.

37. Baader T, Rojas C, Molina J, et a. Diagnóstico de la prevalencia de trastornos de la salud mental en estudiantes universitarios y los factores de riesgo emocionales asociados. *Revista chilena de neuro-psiquiatría*. 2014;52(3):167–176.

38. Hernández R, Fernández C, Baptista P. *Metodología de la investigación.* 5a.ed. México DF: Mc Graw Hill Educación. 2010.

39. Stake R. *The Art of case study research*. Thousand Oaks: sage. 1994.

40. Hsieh H, Shannon S. Three approaches to qualitative content analysis. *Qualitative Health Research*. 2005;15(9):1277–1288.

41. MacQueen K, McLellan E, Kay K, et al. Codebook development for team-based qualitative analysis. *Field Methods.* 1998;10(2):31–36.

42. Okuda M, Gómez-Restrepo C. Métodos en investigación cualitativa: triangulación. *Revista Colombiana de Psiquiatría*. 2005;24(1):118–124.

43. Valles M. *Técnicas cualitativas de investigación social: Reflexión metodológica y práctica profesional*. Madrid, España: Editorial Síntesis. 1999. p. 1–416.

44. Hernández B, Varela S. Psicología Social Aplicada e Intervención Psicosocial. Santa Cruz de Tenerife, España: Editorial Resma. 2001.

45. Farkas M. Restablecimiento (Recovery) y Rehabilitación. *La consideración actual de la recuperación: Lo que es y lo que significa para los servicios de atención*. Madrid: Grupo Web CRL de Ventas. 2007.

46. Dionne J, Altamirano C. Los desafíos de un verdadero sistema de justicia juvenil: una visión psicoeducativa. *Revista Universitas Psychologica.* 2012;11(4):1055–1064.

47. Lacunza A. Las intervenciones en habilidades sociales: revisión y análisis desde una mirada salugénica. *Picodebate Cultura Psicología y Sociedad.* 2012;12:63–84.

48. Blanco A, Rodríguez J. *Intervención Psicosocial*. Madrid, España: Editorial Pearson Educación. 2007.

49. Vizcarra M, Dionne J. *El Desafío de la intervención psicosocial en Chile: Aportes desde la psicoeducación*. Santiago, Chile: Editorial Ensayos & Estudios Ril. 2008.

50. Leiva L, George M, Squicciarini A, et al. Intervención preventiva de salud mental escolar en adolescentes: desafíos para un programa

público en comunidades educativas. *Revista UniversitasPsychologica.* 2015;14(4):15–27.

51. Grandón P, Saldivia S, Cova F, et al. Análisis psicométrico y adaptación de la escala de actitudes comunitarias hacia la enfermedad mental (CAMI) en una muestra chilena. *UniversitasPsychologica*. 2016;15(2):153–162.
52. Retamal P, Markkula N, Peña S. Salud mental en Chile y Finlandia: desafíos y lecciones. *Revista médica de Chile.* 2016;144(7):926–929.
53. Castillo T. Subjetividad y autonomía: significados y narrativas sobre la discontinuación de fármacos psiquiátricos. *Revista Salud Colectiva*. 2018;14(3):513–529.
54. Andradre C, García M, Zambrano A. Modelo Operativo de gestión de redes sociales para el sistema penal adolescente, Chile. *Revista Latinoamericana de Ciencias Sociales, Niñez y Juventud.* 2016;14 (1):247–260.
55. Asún D, y Unger J. *Una visión regional de la institucionalización de la psicología (social) comunitaria en Chile*. En A Zambrano G et al., editors. Psicología comunitaria en Chile: Evolución, perspectivas y proyecciones. Santiago, Chile: RIL Editores. 2007. 2007;2013–226.
56. Rogers E. *Diffusion of Innovations*. 5th edn. New York: Free Press. 2003.
57. LeBlanc L, Robert M. La innovación psicosocial: planificar su implementación y difusión para prevenir la delincuencia juvenil. *UniversitasPsychologica.* 2012;11(4):1125–1134.
58. Confederación Salud Mental España. Viaje a Trieste, la cuna de la atención comunitaria en salud mental. *Revista Encuentro*. 2017;*3*:7.
59. Desviat M, Moreno A. *Principios y objetivos de la salud mental comunitaria. Asociación Española de Neuropsiquiatría, Acciones de salud mental en la comunidad*. Ponencia al XXV Congreso de Salud Mental Asociación Española de Neuropsiquiatría, Madrid, España. 2012.
60. *Dirección Servicio de Salud Osorno, Departamento de Estadística y Gestión de la Información*. (2019). INE - Actualización Población 2002-2012 y Proyecciones 2013–2020.
61. Evaristo P. La reforma psiquiátrica hoy día en Trieste e Italia. *Revista de la Asociación Española de Neuropsiquiatría*. 2011;31(2):345–351.
62. Gendreau G. *Jeunes en difficulté et interventionpsychoéducative [Jóvenes en dificultades e intervención psicoeducativa]*. Montréal: Sciences et Culture. 2001.
63. iHernández M. Rehabilitación Psicosocial perspectiva actual y directrices en reforma psiquiátrica. *Revista Estudios de Psicología*. 2011;16(3):295–303.
64. Hernández M. La rehabilitación psicosocial entre la desinstitucionalización y la recuperación. *Revista Asoc Esp Neuropsiq*. 2017;37(131):171–187.
65. Langer A, Schmidt C, Aguilar J, et al. Mindfulness y promoción de la salud mental en adolescentes: efectos de una intervención en el contexto educativo. *Revista médica de Chile*. 2017;145(4):476-482.
66. Martínez G. Métodos de investigación cualitativa. *Revista Silogismo*. 2011;8:1–34.
67. Martínez V. *El enfoque comunitario: El desafío de incorporar a las comunidades en las intervenciones sociales*. Santiago, Chile: Universidad de Chile. 2006.
68. Martínez V. *La inclusión sociocomunitaria: Modelo de inclusión sociocomunitaria*. 2016.
69. Ministerio de Saludde Chile. *Políticas y Plan Nacional de Salud Mental*. Santiago: Ministerio de Salud; 1993.
70. Ministerio de Salud de Chile. *Plan Nacional de Salud Mental y Psiquiatría, Santiago*. 2000.
71. Ministerio de Salud de Chile de Chile. Departamento de Salud Mental. *Norma Técnica Rehabilitación Psicosocial Para Personas Mayores de 15 años con Trastorno Psiquiátricos Severos y discapacidad*. 2006.
72. Ministerio de Salud de Chile. *Decreto N°4. Reglamento de centros de tratamiento y rehabilitación de personas con consumo perjudicial o dependencia a alcohol y/o drogas. Publicado en el Diario Oficial de 13.01.10*. 2009.
73. Ministerio de Salud de Chile. *Subsecretaría de Salud Pública. Plan Nacional de Salud Mental 2017 – 2025*. Santiago de Chile. 2017.
74. Ministerio de Salud de Chile. Subsecretaria de Redes Asistenciales. *Modelo de Gestión de la Red Temática de Salud Mental*. Santiago de Chile. 2018.
75. Minoletti A, Rojas G, Sepúlveda R. Capítulo: Notas sobre la Historia de las Políticas y Reformas de Salud Mental en Chile. 2010.
76. Observatorio de Derechos Humanos de las Personas con Discapacidad Mental de Chile. *Derechos Humanos de las Personas con Discapacidad Mental: Diagnóstico de la Situación en Chile*. Santiago, Chile. 2014.
77. Universidad de Chile, Facultad de Medicina, Escuela de Salud Pública. *Sistema de Salud Mental de Chile: Segundo InformeWHO-AIMS. Santiago, Chile*. 2014.