The experience of people with psychosocial disabilities of living independently and being included in the community in war-affected settings: A review of the literature

Hanna Kienzler [a,*], Suzan Mitwalli [b], Meryem Cicek [a,c]

[a] *Department of Global Health and Social Medicine, King's College London, Bush House (NE) 3.15, 40 Aldwych, London WC2B 4BG, UK*
[b] *Institute of Community and Public Health, Birzeit University, Birzeit, occupied Palestinian territory (oPt)*
[c] *School of Public Health, Imperial College; Medical School Building, St Mary's Hospital, Norfolk Place, London W2 1PG, UK*

A B S T R A C T

This article explores the experience of people with psychosocial disabilities with independent living and community inclusion in war-affected settings. While the UN CRPD obliges states to protect the rights of persons with psychosocial disabilities to community living (Article 19) in contexts of war (Article 11), information is lacking about people's lived experience. We reviewed studies published between 1980 and 2020, exploring concepts central to the CRPD's Article 19. Sixteen articles met the inclusion criteria. Findings indicate that support for persons with psychosocial disabilities is lacking while also being insufficiently described; little information is available about types of mental health and psychosocial support services; and data are almost absent about access to community services available for the general population. To ensure independent living and community integration in contexts of war, we emphasize the need for comprehensive and intersectional approaches that are locally relevant, participatory, and based on human rights.

1. Introduction

This article explores how people with psychosocial disabilities experience independent living and community integration and participation in contexts of war. The aim is to highlight key avenues for community-based support, interventions, and policy development to improve the quality of life of those affected. Quality of life is defined by the World Health Organisation (WHO) as "individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns." It is a subjective evaluation and incorporates "the persons' physical health, psychological state, level of independence, social relationships, personal beliefs and their relationships to salient features of the environment" (WHO, 1998, p.11).

It is widely recognised that community inclusion and participation are vital for people to experience a good quality of life (Millner et al., 2019). Community participation refers to ways in which people get involved in formal and informal networks connected to friendships, volunteering and work, social groups and preferred leisure activities, spiritual faith, and community activism (Campbell & Burgess, 2012).

Benefits of community participation have been associated with better mental health and quality of life in relation to perceptions of belonging, social empowerment, independence and self-determination, and expansion of social networks and community activism (Aubry, Flynn, Virley, & Neri, 2013; Millner et al., 2019; Pearce & Smith, 2003). Conversely, research has indicated that weak social ties, resulting from social disadvantage, inequity, and discrimination are associated with adverse impacts on people's mental health (Braveman et al., 2011; Hinchliffe et al., 2018). In contexts of war, community bonds are often weakened as violence and socioeconomic hardship disrupt people's lives and social relations. Furthermore, communities appear to struggle with the breakdown of social services, the disruption of local economies, the exodus of the workforce, high unemployment rates and poverty (Miller & Rasmussen, 2010; Pedersen, Tremblay, Errázuriz, & Gamarra, 2008; Pérez-Sales, Férnandez-Liria, Baingana, & Ventevogel, 2011).

Adverse, traumatic experiences and weakening of community bonds among war-affected populations have been associated with a higher prevalence of both common and severe mental disorders compared to populations living in relative stability (Demyttenaere et al., 2004; de Jong, Komproe, & Van Ommeren, 2003; Tol et al., 2011). Yet the scale of

the problem is not fully known. Most research focuses on determining the prevalence rates of PTSD and common mental disorders, such as depression and anxiety, while little epidemiological research has been conducted that captures the prevalence rates for severe psychosocial disabilities such as schizophrenia, bipolar disorders and intellectual disabilities in contexts of war (Collins et al., 2011). Even less information is available about how people with psychosocial disabilities live and participate in war-affected communities and how this, in turn, affects their quality of life (Priddy, 2019). Nevertheless, there are some findings that indicate how persons with pre-existing psychosocial disabilities are particularly discriminated against and may be subjected to targeted killings and torture, including sexual violence, and used as human shields (Hart, Crock, McCallum, & Saul, 2014; Levy & Levac, 2018; Priddy, 2019). Evidence also suggests that psychosocial support and medical treatment are particularly scarce for these individuals. They are often disregarded or excluded from relief efforts, with widened treatment gaps due to inadequate infrastructure, human resources and financial investment (Coldiron, Llosa, Roederer, Casas, & Moro, 2013; Llosa et al., 2014).

Furthermore, some research has highlighted that responses to broader human rights-based needs that would allow people with psychosocial disabilities to participate in all spheres of society are largely absent or inadequate in war-affected settings (Priddy, 2019). This is so, despite the fact that international laws exist that aim to safeguard the rights of persons with disabilities, including those suffering from psychosocial disabilities. These include international humanitarian law (IHL) and international human rights law (IHRL), and more recently, the United Nations Convention on the Rights of Persons with Disabilities (CRPD). While the IHL provides the primary framework regulating the conduct of hostilities in war-affected settings, the IHRL and the CRPD can provide additional context of guidance as to the interpretation of these rules (Priddy, 2019). Priddy explains, "All of the norms pertaining to the conduct of hostilities will apply equally to all civilians, including those with disabilities, in accordance with the IHL prohibition on adverse distinction, as well as the IHRL prohibition on discrimination based on impairment" (p. 58).

While the addition of the CRPD to the body of international human rights instruments has not resulted in any new human rights, it clarifies the duties of States to explicitly enhance the rights of people with disabilities in all life aspects (Byrne, White, & McDonald, 2018; Harpur, 2012; Szmukler, Daw, & Callard, 2014; Wynne-Bannister & Venkatapuram, 2020). In other words, "it identifies where modifications need to be made and where protection (read support) needs to be put in place for persons with disabilities to be able to access the human rights that they have continuously violated" (Wynne-Bannister & Venkatapuram, 2020, 4). According to the CRPD, State Parties are required to enshrine their obligations toward people with (psychosocial) disabilities in national law and provide remedies to individuals for breaches. Thus, the CRPD becomes legally binding as soon as it is incorporated into domestic law. In situations where this is not the case, the CRPD Committee recurs to dialogue with states to identify problems of implementation and to find solutions to bringing their laws and practice into conformity with the Convention.

The CRPD is explicitly applicable in contexts of war and armed conflict. Article 11, entitled "Situations of risk and humanitarian emergencies" states specifically:

> States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters (UN CRPD, 2006).

The Convention has a broad definition of disability that includes "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (Article 1). The CRPD adopts a social model that "concentrates the disability experience not in individual deficiency, but in the socially constructed environment and the barriers that impede participation" (Lord, Suozzi, & Taylor, 2010, p.564; see also Harpur, 2012; Bannister & Venkatapuram, 2020). A central aspect of the "socially constructed environment" is the community in which people live, socialise, learn, work, play, worship and age. The CRPD recognises this explicitly in Article 19, "Living independently and being included in the community":

> States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community (UN CRPD, 2006).

To this end, States are required to provide people with disabilities, including psychosocial disabilities, with (a) the opportunity to choose their place of residence and where and with whom they live on an equal basis with others; (b) a wide range of in-home and other community support services to prevent isolation or segregation from the community; and (c) community services and facilities for the general population on an equal basis to persons with disabilities in a way that are responsive to their respective needs. This right is to be ensured no matter how severe the disability or how intensive the support needs (Hammarberg, 2012; Lewis & Richardson, 2020).

The implementation of human rights-based approaches designed to improve the lives of persons with psychosocial disabilities remains difficult, particularly in contexts of war and violence. Pérez-Sales et al. (2011) caution that "it must be taken into account that simply having a policy plan, or a facility, does not automatically mean funding is available or that implementation occurs" (347). Moreover, it has been found that where disability is specifically addressed in relief efforts it primarily focuses on physical and sensory disability "to the exclusion of persons with psychosocial and intellectual impairments" (Priddy, 2019, 16). Consequently, little dedicated attention is paid to persons with psychosocial disabilities and information is lacking about their lived experience and what it means for them and their families to live and participate in the community (Kamundia, 2013; Priddy, 2019). Without information to that effect, States are unable to fulfil their legal duty to ensure effective protection and safety, address rights-based needs, and offer services that meet their requirements (UN Committee on the Protection of the Rights of All Migrant Workers and Members of their Families (CMW) 2017).

Our article sets out to provide insight, from different disciplinary perspectives, into what is currently known within the academic discourse about the ways in which people with psychosocial disabilities participate in war-affected communities. Specifically, we reviewed the literature to explore concepts central to Article 19 of the CRPD by asking (1) what "community", "independence" and "support" mean for persons with psychosocial disabilities, their caregivers, and health providers; (2) how barriers and resources impact on the ability of people with psychosocial disabilities and their families to access support; and (3) what specialised and non-specialised services are available to support and enable community living. While our review is tightly linked to Article 19 of the CRPD, we also aimed to gain insight into the recent history of community living and participation of persons with psychosocial disabilities in war-affected settings. Consequently, we explore academic literature prior to 2008, when the CRPD first entered into force. We cast the net wider to include literature published since the 1980s. Our justification for the time frame is that while deinstitutionalisation and a shift to community living, as a policy, emerged in the 1960s, it only became widely adopted in Western countries in the 1980s coinciding

with large-scale closures of psychiatric hospitals (The King's Fund, 2015). Internationally, the implementation varied greatly occurring even later in low and middle-income countries (LMIC) where governments continue to spend most of their mental health budget on psychiatric hospitals (Patel, 2007; WHO, 2020). In war-affected settings, deinstitutionalisation and community integration of persons with psychosocial disabilities has been even slower due to violence, insecurity and diminishing resources (Kirmayer, Kienzler, Afana & Pedersen, 2010; Priddy, 2019). At the same time, research efforts into the lived experience of persons with psychosocial disabilities are compromised because of limited infrastructure, concerns for researchers' safety, and a shortage of local and international researchers willing to enter conflict settings (Campbell, 2017; Tamimi et al., 2021).

In the following, we provide an overview of our literature search and present the results to highlight ways in which people with psychosocial disabilities are supported to live independently and be included in the community while coping with violence and uncertainty during and in the aftermath of war. In the discussion, we develop a framework rooted in participatory and human rights approaches that brings together concepts of "pragmatic complexity" (Ansell & Geyer, 2017) with mental health in all policies in order to highlight key avenues for community-based policy development, interventions, and support.

2. Methodology

We conducted an in-depth literature review on how people with psychosocial disabilities live and participate in war-affected communities and set out to explore CRPD Article 19 relevant concepts. Specifically, we sought to examine emerging evidence of an underexplored topic in order to clarify key concepts in the literature (e.g., community, independence, support), identify key characteristics related to these concepts as well as the ways they are experienced by people with psychosocial disabilities in their everyday lives (Munn et al., 2018). We followed a rigorous approach divided into five essential steps.[1]

2.1. Identifying the research question

The research questions emerged from a large Wellcome Trust funded research project that aimed to understand the relevance of the CRPD and particularly its Article 19 in settings of war and to provide in-depth insight into what it means for persons with psychosocial disabilities to live in the war-affected communities. We conducted a preliminary literature search and found little about such experiences, and no literature that featured the CRPD and its Article 19. Therefore, we decided to conduct a more systematic literature review to uncover and understand (1) what "community", "independence" and "support" mean in war-affected communities; (2) how barriers and resources impact on the ability of persons with psychosocial disabilities to access support and to live in their communities; and (3) what specialised and non-specialised services are available to persons with psychosocial disabilities.

2.2. Identifying relevant studies

Guided by the Joanna Briggs Institute (2015) instructions manual, we initially conducted a broad unstructured search to generally explore the literature and help us decide on the keywords and search strategy for the structured search. For the structured round, we searched the scientific literature published from 01 January 1980 until 10 March 2020, while only including peer-reviewed articles written in English. Given that no previously conducted review on what it means for persons with psychosocial disabilities to live and participate in the community in war-affected settings exists, we decided to include a wide variety of studies

---

[1] Our approach was inspired by Arksey and O'Malley (2005) and the Joanna Briggs Institute (Peters et al., 2015)

ranging from quantitative to qualitative and mixed-methods studies, expert opinion pieces, case reports, document and/or policy analysis, and community-based studies.

We conducted a comprehensive search for publications in the following databases: Ovid (PsychINFO, Medline, Global Health, and Embase) and PubMed. To ensure that our search produced relevant results in relation to our research questions, we used a wide range of keywords; 'independent living', 'community support', 'barriers', 'lived experience', 'mental health system', 'community-based mental health', 'policy', 'regulations', and 'legislations' combining them differently using AND with the rest of the keywords: 'mental health', 'psychological', 'psychosocial', 'learning disabilities', 'war', and 'armed conflict', and their synonyms. An example of the search strategy used on the PubMed database is shown in Appendix 1. This search strategy was used across all five databases.

For each search combination, we went through titles and abstracts of the references and documented the number of relevant articles out of the total hits, and then transferred the selected articles to a shared EndNote library. We also manually searched the following journals for any relevant literature to answer our research question: Arab Journal of Psychiatry, Eastern Mediterranean Health Journal, Avicenna, Journal of Local and Global Health Science, Journal of Local and Global Health Perspectives, QScience Connect, and Qatar Medical Journal. We identified three articles through this search, and three other articles through the reference lists of some of the included journal articles.

2.3. Selecting studies

Among the identified literature ($n = 313$), we re-screened titles, abstracts, and in some cases, entire articles based on our inclusion and exclusion criteria. We included peer-reviewed articles written in English which explored community inclusion and independent living of persons with psychosocial disabilities in war-affected settings. We excluded studies not written in English and conducted in non-conflict-affected countries and among persons with physical disabilities (unless mental health problems were highlighted as comorbidities) as well as those reporting solely on prevalence rates or treatment development, efficacy and outcomes. Fig. 1 illustrates the selection process. Two reviewers
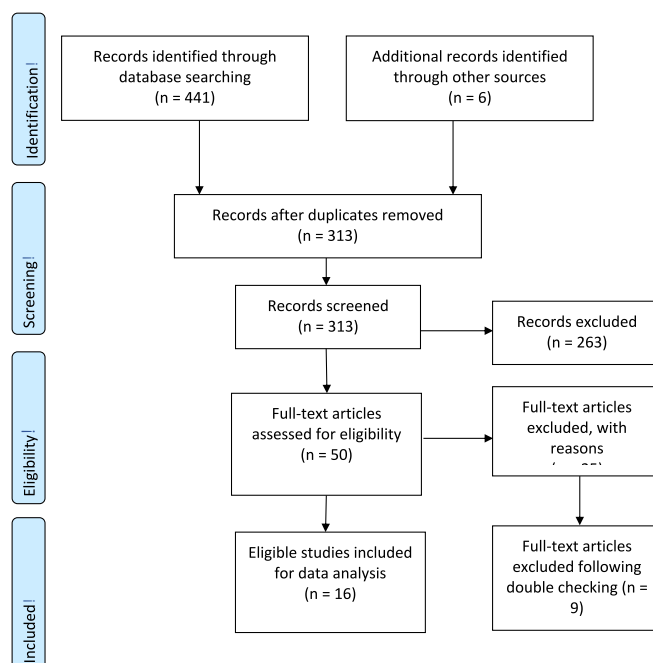
Figure 1: PRISMA Inclusion Flowchart

Fig. 1. PRISMA inclusion flowchart near here.

conducted the screening independently and discrepancies were resolved after discussion.

2.4. Charting the data

We developed a data charting sheet to collect the data from the included studies. We extracted the following information for each article based on this sheet: source type, full reference of the article, authors, and author background information (profession, discipline, geographical location, and university), objectives and focus, methodology, and main results based on our research questions. The data collection consisted of two rounds of independent readings by two of the authors. The authors exchanged the analysis sheets for double checking and compared notes to ensure reliability of the collected data.

2.5. Collating, summarizing, and reporting the results

To analyse our data, we followed a thematic network analysis approach developed by Attride-Sterling (2001) consisting of six steps: (1) we first coded the data charting sheets through a combined deductive and inductive approach. (2) The resulting codes were then combined into categories following which we generated and refined themes. (3) Thereupon, the themes were arranged into a thematic network which was then (4) described and explored and (5) summarised in order to derive at (6) interpretative patterns.

To capture the process in a transparent manner, we created an Excel sheet and labelled it "quote bank". In this quote bank, we produced a separate sheet for each theme. Under each theme, we arranged its respective categories vertically and listed related individual codes under each category. We inserted corresponding quotes related to each code and sub-code from the data charting sheets. We then decided on the structure of the results section in accordance with the thematic analysis and our overall research question.

2.6. Limitations

A key limitation of our literature review is that it includes only peer-reviewed journal articles. Additional information could have been gained from books and book chapters as well as policy documents and reports. Moreover, it could be argued that there is relevant literature from non-conflict related settings (e.g., development contexts or refugee studies) that could have been insightful for our review. Another key limitation is that our review is not reproducible mainly due to significant changes made to PubMed's algorithm after we concluded the search (see Puente, Ramón, Agirre, Morán, & Peco, 2020). Further limitations are that we did not ask a librarian to help us with our search, that we did not engage in a consultation exercise that could have added an important element of co-production to our review, and that only studies in English were included which could lead to the assumption that there is a relative paucity of research or interest in other countries (Steinert, 2020).

3. Results

Our literature search captured a total of 441 articles, of which we excluded duplicate articles ($n = 134$). The screening of 313 identified articles left 50 articles for full review. We reviewed these articles based on our inclusion criteria and research questions. We further excluded 25 publications for the following reasons: books or book chapters, studies conducted in non-conflict-affected countries, focus solely on persons with physical disabilities, studies about treatment outcomes, focus on dementia, and those not related to our research questions. We concluded with 25 articles for data collection. Following the data charting step, we excluded a further nine articles. This led us to include 16 articles for analysis (see Fig. 1).

The analysed articles revealed that community inclusion and independent living are experienced variously in different war-affected

settings. The countries in which these experiences are described in the literature include Cambodia, East Timor, Ireland, Israel, Jordan, Kosovo, Lebanon, the occupied Palestinian territory (oPt) (West Bank and Gaza Strip), Peru, Rwanda, Sierra Leone, and the Solomon Islands. They include LMIC and only two high-income countries (HIC), Ireland and Israel. Strikingly, the earliest paper published on this topic was in 1999, reflecting the relative infancy of this field and the underdeveloped scope of investigating the experiences of people with psychosocial disabilities living in the community in conflict-affected settings. In Table 1, we provide a detailed summary of all the articles by focusing on location and study population, study objective, study design, commentary on CRPD and Article 19, community living, and support facilities.

Study designs that elicit the experiences of persons with psychosocial disabilities are varied, including qualitative ($n = 10$), quantitative (n = 3), and mixed-method (n = 3) approaches. Seven articles are based on empirical research, four rely on expert opinions and the remaining involve document analyses. Five articles were published before, while 11 articles were published after the CRPD was ratified. Accordingly, only the latter may provide direct insight into the application of the CRPD and Article 19 while the former provide information about Article 19 relevant content and concepts. In the following, we demonstrate how the articles engage with the CRPD and its Article 19; barriers and support structures that impact the ability of persons with psychosocial disabilities to live and participate in the community; support services and facilities available to persons with psychosocial disabilities. We also highlight if and how Article 19-relevant concepts, such as community, support and independence, are defined and further discussed.

3.1. CRPD article 19: living independently and being included in the community

Among the 11 articles published after the CRPD was ratified, only one article mentions the CRPD and its Article 19. Notably, the study location is Ireland, a HIC post-conflict setting where mental disability rights and mental health interventions are comparatively well-supported and financed (García Iriarte, O'Brien, McConkey, Wolfe, & O'Doherty, 2014). The authors note that the CRPD can be viewed as a useful framework for investigating the rights of persons with intellectual disabilities considering that they lack control over their lives and have limited opportunities for decision-making with regards to money management, living options, relationships, and employment. It is concluded that this is "a worrying scenario for people with intellectual disability as it seems that the service systems they are currently experiencing are often not facilitating them to exercise their rights under the CRPD" (573). With regards to Article 19, the authors highlight the notion of independence arguing that persons with intellectual disabilities experience challenges when demanding to live independently and with people of their choice. Notably, the article does not explicitly discuss the CRPD or its Article 19 in relation to armed conflict and connected psychosocial disabilities.

3.2. Community inclusion

3.2.1. The concept of community

None of the articles define "community" – the most central concept of Article 19. Nevertheless, they agree that war and conflict can destroy the basis of community life by spreading fear and insecurity, building up tension between different groups, fragmenting the social fabric of society, shattering trust between people, and destroying people's livelihoods and economic opportunities (Shaked, Renert, Mahuda, & Strous, 2004; Somasundaram, van de Put, Eisenbruch, & de Jong, 1999; Stough, Ducy, & Kang, 2017; Zwi, Blignault, Bunde-Birouste, Ritchie, & Silove, 2011). The experience of community disintegration is described as a risk factor for undermining psychosocial health leading to an increase in psychosocial disabilities (Shawahin & Çiftçi, 2012; Stough et al., 2017; Zwi et al., 2011). Shawahin and Çiftçi (2012) note that "the prevalence of

Table 1
Summary of included studies.

Source	Objective	Setting	Study Design	Sample	Commentary on CRPD/Article 19	Support Structures & Barriers to Living in the Community	Support Services & Facilities	Commentary on Article 19 Concepts
Aviram et al. (2007)	To explore why Israel did not succeed in implementing a mental health policy that would shift services from hospitals to the community.	Israel	Qualitative Document and policy analysis for period over 1995–1997.	Stakeholders from various government Ministries (n = 6).	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** Reform from hospital- to community-based care was unsuccessful due to fears of additional burden on over-burdened local welfare service, loss of funding for psychiatric hospitals, loss of status and power of professionals working in hospitals, lack of experience working with PWMI in the community.	**Specialised**: MH hospital, government-funded MH services, private sector, NGOs. **Non-specialised**: N/A.	**Community:** N/A **Support:** Insufficient support for community MH care due to fear of lack of expertise in clinical, rehabilitation and integrative services. **Independence:** N/A
García Iriarte et al. (2014)	To define key concerns of adults with an intellectual disability in relation to their participation in society.	Ireland	Qualitative	Adults with intellectual disability (n = 168) and their family carers.	**CRPD:** Reference to multiple Articles (8/12/13/19/23/27/30) to highlight that participants had limited decision-making with regards to money management, living options, relationships and employment and had limited rights due to lack of awareness by staff, family and the public. Persons with intellectual disabilities are unable to exercise their rights under the CRPD **Article 19:** Participants had differing views about their living situation, relating to (lack of) opportunities, freedom and cost. They valued privacy and greater independence, but felt that living independently in places of their choice and with the people with whom they wanted to live was not always possible.	**Support structures:** N/A **Barriers:** Negative employer attitudes; resistance to having relationships in service organisations; tension between independence and parental control; staff control over their movement; insufficient financial resources; communication challenges with community; feelings of rejection and denial of their individuality, adulthood and capacity by others.	**Specialised**: N/A **Non-specialised**: N/A	**Community**: Inclusion in activities provided sense of belonging; but participants often felt marginalised and rejected from social events. Participants' experiences in community was negatively influenced by community reactions i. e., staring, bullying, name calling, ignoring. **Support**: N/A **Independence:** Independence was valued by participants, but most felt that living independently was not always possible.

Table 1 (*continued*)

Source	Objective	Setting	Study Design	Sample	Commentary on CRPD/Article 19	Support Structures & Barriers to Living in the Community	Support Services & Facilities	Commentary on Article 19 Concepts
Hamaideh et al. (2014)	To examine levels and correlations of quality of life (QOL), social support, and severity of psychiatric symptoms; and identify variables that best predict QOL among Jordanian patients with schizophrenia.	Jordan	Mixed methods	Adults with schizophrenia ($n = 160$) in outpatient clinics.	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** N/A	**Specialised:** N/A **Non-specialised:** N/A	**Community:** N/A **Support:** Social support from friends mainly, including friendships with other psychiatric patients; social support from friends had strong influence in social QOL. **Independence:** Participants living alone reported greater QOL, with more opportunities to participate in various daily activities and less restrictive environment, than those living with others.
Hawkins and Tilman (2011)	To describe history and recent development of mental health services in post-conflict Timor-Leste, and discuss challenges and development plans regarding effective service delivery.	Timor-Leste	Descriptive narrative	N/A	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** Shortages in community, human, and financial resources. Limitations in infrastructure, challenging geography, and inadequate coordination between MH stakeholders. Stigma and discrimination against PWMI: negative effects on QOL and help-seeking behaviours. Lack of political strategy for greater prioritization and larger allocation of public resources to MH services. Lack of integration of mental health policy into other health and social health policies.	**Specialised support services:** Trained general nurses, based in community health clinics are first-line MH providers. With PRADET (est. 1999) trained nurses provided psychosocial services to PWMI and trauma sufferers. In 2002, PRADET became government-based ETNMHP, then became Ministry of Mental Health in 2008. Remaining PRADET staff continued as NGO. ETNETP aims to improve health of people with epilepsy & increase work capacity of MH workers by reducing their non-mental health-related caseload. Plans to build acute care facility for assessment and management of severely ill, & development of standardized MH curriculum for general nurses. **Non-specialised support services:** Fully community-based MH model (no psychiatric hospital or MH beds). Central treatment and supporting roles of relatives and society.	**Community:** N/A **Support:** N/A **Independence:** N/A
Laplante and Holguin (2006)	To discuss 'The Peruvian Truth and Reconciliation Commission (TRC)' formed in 2001 to study the causes, consequences, &	Peru	Qualitative	Survivors of internal conflict ($n = 407$).	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** Distrust of Peruvian state dissuaded victims of conflict from	**Specialised:** N/A **Non-specialised:** N/A	**Community:** N/A **Support:** N/A **Independence:** N/A

Table 1 (*continued*)

Source	Objective	Setting	Study Design	Sample	Commentary on CRPD/Article 19	Support Structures & Barriers to Living in the Community	Support Services & Facilities	Commentary on Article 19 Concepts
	responsibilities of Peru's 20-year internal armed conflict, and how the TRC prioritized reparations in mental health.					seeking state MH services. Perception of an absent, non-responsive state to demands for social programs. Avoidance of state services due to prior mistreatment. Lack of knowledge of right to MH; war survivors do not perceive that they are rights holders. Health care not perceived as state obligation, instead as act of charity. Perception that MH is not a priority but part of daily existence. Stigma that MH services are only for the weak and crazy, and sickness; prevents help-seeking. Lack of culturally appropriate MH services (e.g. doctors who speak native language).		
Saymah et al. (2015)	To provide new knowledge on current mental health policy and legislation, and services and resource use, in Gaza to identify quality gaps and areas for urgent intervention.	Gaza, occupied Palestinian territory (oPt)	Mixed methods	Key informants (n = 6) from: Ministry of Health (n = 4), Ministry of Education (n = 1), and Islamic University of Gaza ($n = 1$).	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** N/A	**Specialised support services:** One mental hospital, community-based mental health centres (CMHCs) ($n = 7$), one day care centre for occupational therapy for people with severe mental illnesses. All CMHCs provide follow-up care but not mobile MH teams. Many local & international NGOs, providing range of psychosocial, trauma-focused, programmes; few provide specialised MH services. **Non-specialised support services:** Governmental PHC clinics ($n = 57$); most have assessment & treatment protocols for key MH conditions, and prescribe psychotropic medicines with restrictions. All primary and secondary schools have either a part-time or full-time MH professional; most schools have school-	**Community:** N/A **Support:** N/A **Independence:** N/A

Table 1 (*continued*)

Source	Objective	Setting	Study Design	Sample	Commentary on CRPD/Article 19	Support Structures & Barriers to Living in the Community	Support Services & Facilities	Commentary on Article 19 Concepts
							based activities to promote MH. **Specialised:** N/A **Non-specialised:** N/A	
Schwartz and Gronemann (2009)	To examine the contribution of self-efficacy, social support, social participation, living arrangement, and employment status to predicting loneliness in individuals with schizophrenia.	Israel	Quantiative	Adults with schizophrenia living in supported community-based residences (*n* = 97).	**CRPD:** N/A **Article 19:** N/A	**Support structures:** Functional social support (unspecified), participation in leisure and social activities in the community (unspecified), and support provided in group homes and supported apartments to participate in the community. **Barriers:** N/A		**Community:** Higher levels of participation in leisure and social activities in the community associated with less loneliness. Loneliness due to: alienation, feelings of exclusion, lack of acceptance, outright rejection and stigmatization in the community. Deinstitutionalization and the development of supported residences resulted in growing numbers of PWMI returning to the community. **Support:** Participants who reported higher levels of social support felt lower levels of loneliness. **Independence:** Participants living in semi-independent and independent apartments felt lonelier but higher social participation in the community than their counterparts living in group homes.
Shackman and Price (2013)	To evaluate the Mental Health, Behavioural Change, and Social Inclusion programme in Sierra Leone.	Sierra Leone	Qualitative	Informants (*n* = 260): partner organization staff, government agency personnel, counselling center clients and their families, and community members.	**CRPD:** N/A **Article 19:** N/A	**Support structures:** Provision of direct services, community outreach, and training reduce stigma. **Barriers:** Rights of persons with mental disorders tenuous; existing outdated 'Lunacy Act' perpetuates discrimination and societal alienation. Stigma against treated individuals and families at counselling centre, even among healthcare professionals. Lack of national prioritisation, lack of resources incl. Medication, and delayed adoption of MH policy. Volunteer resignation from community outreach services. Geographical distance and transport difficulties	**Specialised:** MH services severely lacking; only one psychiatric hospital in Freetown, and two psychiatric nurses left in capital. Joint programme by CAFOD and UNIMAK in two districts, set up centres to provide medication and counselling services. **Non-specialised:** Community outreach to promote MH issues awareness through radio station run by Diocese, supported by CAFOD project. Catholic charity in Makeni province provided access to livelihood support for those completing treatments. Traditional healers facilitate provision of MH services.	**Community:** N/A **Support:** N/A **Independence:** N/A

Table 1 (*continued*)

Source	Objective	Setting	Study Design	Sample	Commentary on CRPD/Article 19	Support Structures & Barriers to Living in the Community	Support Services & Facilities	Commentary on Article 19 Concepts
						in accessing services.		
Shaked et al. (2004)	To describe a service provision network of mental health program: "Mental Health Supermarket" in town of Lod, Israel	Israel	Descriptive narrative	N/A	**CRPD:** N/A **Article 19:** N/A	**Support structures:** Integrative medical follow-up care, social and vocational rehabilitation & skills training, family interventions, resource management, reintegration into working facilities, and adult psychosocial education. **Barriers:** Regional political conflict, inter-ethnic tensions both in social and care settings.	**Specialised:** Professional MH workers and MH system network within community. "Mental health supermarket": individuals choose own treatment package from multiple options, provided by MH multidisciplinary team at local municipal hall. Liaison with psychiatric hospital, patient info exchange, community nurse ward and home visits. Centre for diagnosis education and multi-component rehabilitation part of 'supermarket' daily MH care unit. Community interagency collaborative care – knowledge sharing among 'supermarket' professionals. **Non-specialised:** N/A	**Community:** Local community described as special: ethnically mixed and little tension due to social services and municipal organisation. Importance of creating apolitical atmosphere to enhance community sentiment; normalisation; reduction of tensions; inter-ethnic dialogue. **Support:** MH care unit provides sessions on personal hygiene, nutrition, exercise, psychoeducation, recognition of early relapse, medication. Training in interpersonal skills and self-esteem. Support in formal education. Tailored vocational rehabilitation & occupational retraining. **Independence:** Rehabilitation process geared towards enabling maximum independence through gaining self-esteem, interpersonal skills, empowerment and self-determination.
Shawahin and Çiftçi (2012)	To provide historical and current overview of counselling and mental health care in Palestine.	Occupied Palestine territory (oPt).	Descriptive narrative	N/A	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** Political situation in Palestine, specifically prevalence of military violence due to occupation, unemployment, incarceration, poverty are risk factors for MH distress and disorders. Lack of universal healthcare or welfare system hinders access to MH services, most located within large cities. Social stigma hinders seeking MH services by individuals and families. Stigma and negative attitudes prevalent among healthcare professionals. Little distinction between different MH professionals, services offered based on	**Specialised:** Approx. 70 instiitutions providing MHPS services including two psychiatric hospitals. Smaller clinics also present. Various interventions provided: individual and group counselling, telephone counselling. MH practitioners employ crisis debriefing techniques and psychotherapeutic approaches. **Non-specialised:** N/A	**Community:** N/A **Support:** N/A **Independence:** N/A

Table 1 (*continued*)

Source	Objective	Setting	Study Design	Sample	Commentary on CRPD/Article 19	Support Structures & Barriers to Living in the Community	Support Services & Facilities	Commentary on Article 19 Concepts
						organisations worked for, not based on training or field.		
Somasundaram et al. (1999)	To discuss the risks and opportunities in introducing mental health services in war-torn Cambodia.	Cambodia	Quantitative	Reports and paitent records from mental health clinics and provincial hospitals.	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** Limited resources; poverty; frequent droughts and food shortages; diseases like malaria, dengue fever, tuberculosis and HIV/AIDS; low intensity conflict, land mine dangers, political instability, national budget exhausted; traditional healing services.	**Specialised:** Introduction of MH services in hospitals. **Non-specialised:** Dependence on traditional healers.	**Community:** Level of social integration in Cambodia unique: range of people and communities to maintain social relationships with is small compared to neighbouring countries due to land ownership structure, low population density, large forest habitat. Khmer Rouge period hit communal life, shattering trust and collective loss of meaning and social structure. **Support:** N/A **Independence:** N/A
Stough et al. (2017)	To review the empirical literature on psychosocial factors relating to children with disabilities in the context of disaster or terrorism.	Global; various contexts of disaster or terrorism.	Qualitative; literature review.	Studies of children with disabilities in the context of disaster or terrorism.	**CRPD:** N/A **Article 19:** N/A	**Support structures:** Parental emotional support after emergency experiences. **Barriers:** Children with disability likely to live in poverty, not complete school, have poorer health than children without disabilities. Also, less likely to receive appropriate psychological, medical and rehabilitative services after disaster or conflict. School emergency plans don not consider needs of disabled students. Lack of accessible counselling spaces post-disaster for those with wheelchairs. Disruption in special education services may lead to further academic difficulties. Destruction of infrastructure and facilities, and electricity shortages impact medical equipment/device use. Displacement increases social isolation. Parental distress or poor coping strategies post-disaster, and societal stigma negatively affect	**Specialised:** Psychiatric and psychological support through individual and family-focussed CBT. School-based MH professionals and staff support family and evidence-based interventions post-disaster. Special education teachers provide emotional support. **Non-specialised:** N/A	**Community:** Children and their families rely on multiple school and community supports. Community is considered supportive but also a context of exclusion and stigma. **Support:** Support relates to disability support (physical) and mental health support that allow children with disabilities to live and be protected in the community. **Independence:** Supporting children with physical disabilities allows them to participate more 'independently' within the community, their schools and families.

Table 1 (*continued*)

Source	Objective	Setting	Study Design	Sample	Commentary on CRPD/Article 19	Support Structures & Barriers to Living in the Community	Support Services & Facilities	Commentary on Article 19 Concepts
						children with disabilities.		
Thabet et al. (2006)	To establish mothers' perceptions of child mental health problems, etiology and methods of intervention.	Gaza, occupied Palestine territory (oPt).	Quantitative	Mothers of children under-16 living in El-Nusirate in Gaza (*n* = 249).	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** N/A	**Specialised:** 43% of mothers were aware of child MH centres and services. Majority of mothers would take children to primary health care, psychologist or psychiatrist, or social worker. Few mothers would take children for cauterisation. **Non-specialised:** Traditional healing using cauterisation techniques; Quran readings; inhaling Bokhour smoke.	**Community:** N/A **Support:** N/A **Independence:** N/A
Weine et al. (2005)	To describe the effects of a psychoeducational multiple-family group program for families of people with severe mental illness in post–war Kosovo.	Kosovo	Mixed methods	Families of people with severe mental illnesses (*n* = 30).	**CRPD:** N/A **Article 19:** N/A	**Support structures:** Extended intergenerational families provide support to families caring for persons with severe mental illness. The multi-family groups in this intervention program are also source of peer support. **Barriers:** Shame and stigma against PWMI and their families, drives families to close up individual at home. Social isolation of families.	**Specialised:** Psychiatric hospitals; community-based MH centres; home visits; psychoeducation. Multiple-family groups of families with persons with severe mental disorders, established in program. **Non-specialised:** Traditional healers and religious leaders.	**Community:** N/A **Support:** Support for persons with mental illness is mainly provided by the family. What this support exactly entailed is not clear. **Independence:** N/A
Zraly et al. (2011)	To refocus public attention on the obligation to respond to the mental health impacts of Collective Sexual Violence (CSV) on Rwandan women and girls who survived such violence during the 1994 genocide.	Rwanda	Qualitative	Female CSV survivors during 1994 genocide (*n* = 57).	**CRPD:** N/A **Article 19:** N/A	**Support structures:** N/A **Barriers:** High rates of HIV/AIDS and persistent psychiatric suffering documented among CSV survivors. Severe social stigmatisation and marginalisation of CSV survivors. CSV survivors continue to face danger as their status as direct witnesses of genocide crimes.	**Specialised:** 1% of national health budget dedicated to MH; shortage of psychiatrists and psychiatric nurses. NGOs provide trauma counselling and training. Some hospitals have counselling services for hospitalised rape survivors. Inadequate rural health clinics: link between physical and mental health overlooked. Formal MH services: low quality and negligent. **Non-specialised:** Women's genocide survivor associations such as AVEGA-Agahozo, provide emotional peer support, trauma counselling, voluntary HIV	**Community:** N/A **Support:** N/A **Independence:** N/A

Table 1 (*continued*)

Source	Objective	Setting	Study Design	Sample	Commentary on CRPD/Article 19	Support Structures & Barriers to Living in the Community	Support Services & Facilities	Commentary on Article 19 Concepts
							testing, income-generating activities. District and sector-level associations such as Abasa act as informal community MH services.	
Zwi et al. (2011)	To examine how policy decisions regarding mental health and wellbeing were incorporated into the national agenda of the Solomon Islands in the years following the internal conflict.	Solomon Islands	Qualitative Document review	Key informants from government, bilateral and multilateral institutions, media, local and international NGOs (n = 16).	**CRPD:** N/A **Article 19:** N/A	**Support structures:** Shift in focus from custodial care and protection of individuals and the community (already under-way before the conflict) to community-based services. **Barriers:** The burden to individuals, families and society associated with mental disorders has become increasingly apparent. Ongoing economic challenges are significant and combined with migration to urban areas, present new hurdles to psychosocial wellbeing and mental health.	**Specialised:** National Psychiatric Unit with beds for psychiatric patients. MH workforce includes nurses and nurse-aide posts, but shortage in specialists and psychiatrists. No local psychologists, social workers or occupational therapists in MH workforce. Five-year National Mental Health Strategy created in 2005. Trauma support provided to people affected by conflict, in two areas. General move toward integrating MH into primary healthcare. **Non-specialised:** Churches and CSOs (but not NGOs) met social welfare needs. Traditional healers, witchcraft and sorcery. Community-based counselling. Media provided voice.	**Community:** Generally, community is stressed and overburdened by MH problems. 'Wantok' system present: family and clan affiliations. Obligation to 'Wantok' is taken seriously societally. Indigenous community structures and practices include traditional mechanisms for coping with stress. **Support:** Lack of support structures for persons with MH problems. Securing equitable and effective treatment, and support are ongoing challenges. **Independence:** N/A

Abbreviations: CRPD (Convention on the Rights of Persons with Disabilities), MH (mental health), PWMI (persons with mental illness), QOL (Quality of Life), NGO (Non-Governmental Organisations), PRADET (Psychosocial Recovery and Development in East Timor), ETNMHP (East Timor National Mental Health Project), ETNETP (East Timor National Epilepsy Training Program), TRC (The Peruvian Truth and Reconciliation Commission), PIR (Plan of Integral Reparations), CMHC (Community Mental Health Centre), MHPS (Mental Health and Psycho-Social), CAFOD (Catholic Agency for Overseas Development), UNIMAK (University of Makeni), CBT (Cognitive Behavioural Therapy), CSV (Collective Sexual Violence), CSO (Civil Society Organisation).

military violence, unemployment, incarceration, and poverty are likely to cause mental health problems (e.g., low self-esteem, depression, anxiety)" (379).

Other authors explain that the increase in mental illness itself can be perceived as imposing stress on the community accelerating the breakdown of traditional value systems, relations and structures. Such perceptions, it is argued, can result in vilifying those with psychosocial disabilities leading to further stigma, marginalisation and exclusion (García Iriarte et al., 2014; Stough et al., 2017; Zwi et al., 2011). Interestingly, only two articles explicitly state that community can play a vital role in the aftermath of war by building community sentiment, allowing for normalisation and reduction of tension, and enhancing inter-ethnic dialogue (Shaked et al., 2004; Stough et al., 2017). Accordingly, this body of literature provides little insight into how community integration can lead to improved quality of life and mental health.

3.2.2. Support with community living

The review shows that support with community living for people

with psychosocial disabilities varies according to the economic situation of the conflict-affected countries. Articles focusing on LMIC settings make apparent that such support is primarily provided by family members and, in some cases, neighbours and friends (Hamaideh, Al-Magaireh, Abu-Farsakh, & Al-Omari, 2014; Hawkins & Tilman, 2011; Stough et al., 2017; Weine et al., 2005; Zraly, Rubin-Smith, & Betancourt, 2011). While none of the authors explain the nature and extent of this support, one article identifies how families often feel overburdened by the responsibility of the care they provide and overwhelmed by the stigma they experience from the community (Weine et al., 2005). Besides family, two articles mention other support mechanisms including self-help groups in the case of Rwandan women rape survivors suffering from trauma-related mental health problems (Zraly et al., 2011) and religious charities providing livelihood support in Sierra Leone (Shackman & Price, 2013).

In the high-income countries of Ireland and Israel, support for community living is only partly provided by the family with professional support provided by government-run health and social services as well as charities (Shaked et al., 2004; Schwartz & Gronemann, 2009; García
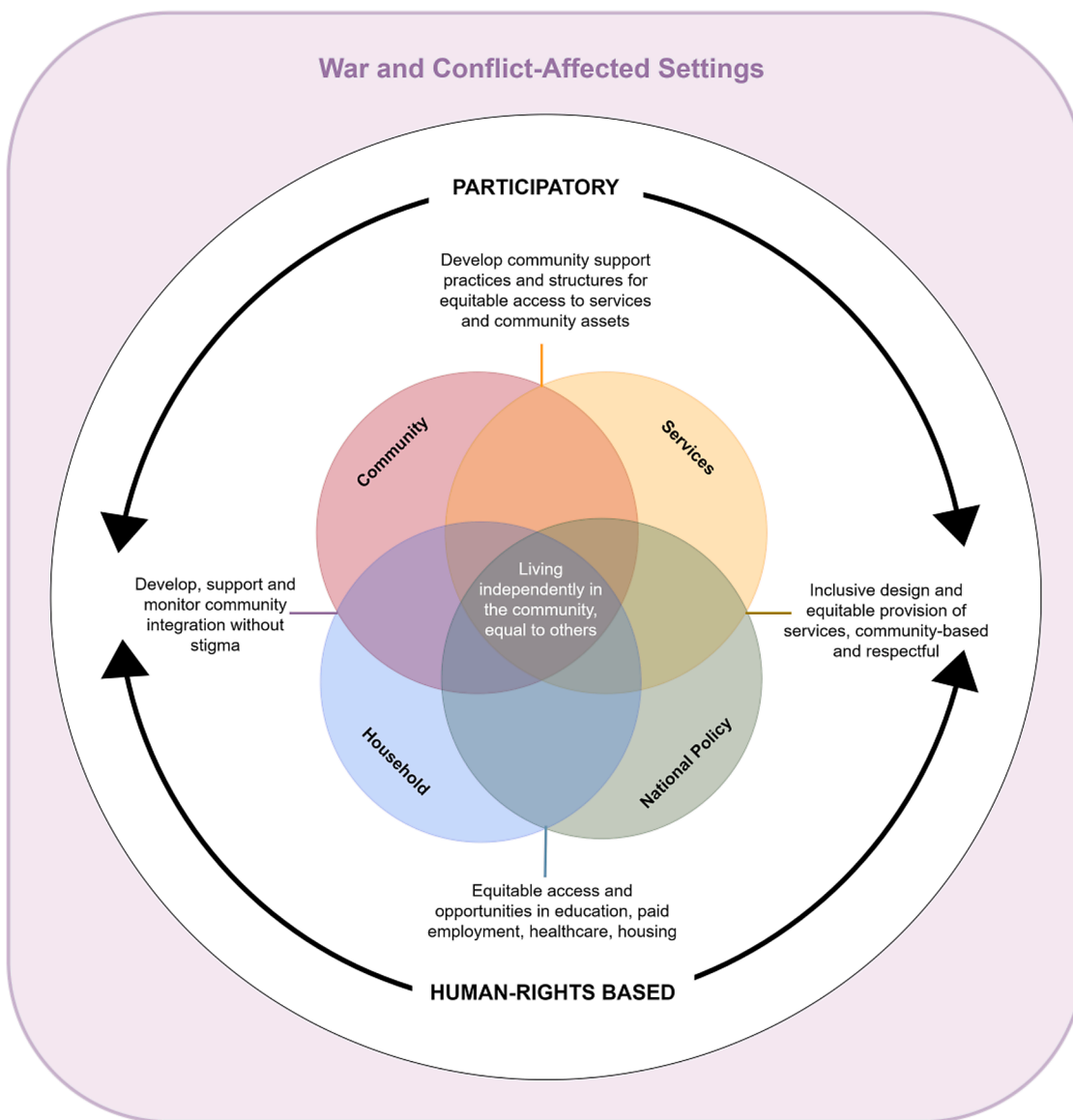
Fig. 2. Framework for intersectoral approaches to independent living and community inclusion near here.

Iriarte et al., 2014). In Israel, for example, a community mental health program is described that supports patients with formal education, daily life skills, and communication techniques (Shaked et al., 2004). In Ireland, García Iriarte et al. (2014) write: "Some people enjoyed living where they were valuing their freedom to move around and the cost of living. For example, 'I love my hometown. I can come and go and do what I want within reason and the neighbours and the whole place are nice'" (568). Despite the availability of such supporting mechanisms, people with psychosocial disabilities in both HIC settings report experiences of exclusion and marginalisation in their communities.

3.2.3. Barriers to community living

The results indicate that barriers to community living are not exclusively war-related but more broadly connected to social exclusion and isolation, which are at times produced or exacerbated by the effects of war and conflict. In the context of Israel, Shaked et al., 2004 note that the presence of ongoing inter-ethnic tensions and conflict-induced disruption between Israel and the oPt pose significant barriers to community living for persons with severe psychosocial disabilities. Moreover, Stough et al. (2017) highlight in their review on children with mental and physical disabilities that, "Children with disabilities often

have limited peer friendships and experience loneliness at higher rates than their peers, in part, due to differences in social skills, making both the loss of old peers and the obtaining of new friends difficult" (29). They explain how this worsens children's already challenging experiences with peer interaction in daily life and within public institutions such as school.

Alongside barriers exacerbated by war, persons with psychosocial disabilities endure deep-seated social barriers within their communities. The main social barrier identified across all studies was stigma and, related to this, exclusion from community living (García Iriarte et al., 2014; Schwartz & Gronemann, 2009; Zraly et al., 2011). Schwartz and colleagues (2009) note that in Israel "individuals with schizophrenia have described responses such as lack of acceptance, outright rejection and stigmatization in the community accompanied by a sense of not belonging to the mainstream of society" (121). Similarly, in Ireland, García Iriarte et al. (2014) explain that experiences in the community for people with psychosocial disabilities can be negatively influenced by "people's excluding reactions such as staring, bullying, name calling, not being addressed in conversations and being ignored. Feeling of rejection was also experienced in social events" (270).

In LMIC contexts, the situation appears to be similar. For instance, in

post-genocide Rwanda, Zraly et al. (2011) explain that wartime collective sexual violence (CSV) survivors experience severe stigmatisation and marginalisation from their families and the community. This stigma prevents CSV survivors from speaking to others about their experiences and seeking peer support for mental health and psychosocial problems, even when among other survivors in a dedicated support group. Moreover, one article based in Kosovo highlights how the experience of social exclusion can extend beyond persons with psychosocial disabilities, to their family members. Specifically, Weine et al. (2005) report that exclusion is exacerbated by feelings of familial shame and stigma, which reflects the collective association of an entire family with a person's psychosocial disability. The authors explain that, "Because mental illness in Kosovo has been associated with tremendous shame to the whole family, families would often try to keep the person closed up in their homes" (18). Overall, the results reveal that there are crucial social barriers that prevent people with psychosocial disabilities and their families from accessing support, including medical and psychiatric treatment.

3.3. Place of residence and living arrangements

"Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement" (CRPD Article 19, Clause A).

Five articles discussed living arrangements in relation to different types of residences, such as living with family, living alone, and living in supported residences (García Iriarte et al., 2014; Hamaideh et al., 2014; Schwartz & Gronemann, 2009;Weine et al., 2005; Zwi et al., 2011). However, little in-depth information is available about these living arrangements and their evaluation by persons with mental illness and their families. Even less information is provided on ways in which people with psychosocial disabilities exercise choice in relation to living arrangements in war-affected settings. Only García Iriarte et al. (2014) explain that, in Ireland, people with intellectual disabilities experience various tensions when choosing their place of residence. While they are allowed to choose where and with whom they want to live, they rarely feel supported to do so and are afraid that they might lose existing support networks. The authors write: "There was (…) a general feeling of people wanting to move from their present residence but having limited opportunities if they changed the organization where they received services" (568). Additionally, those who had chosen their place of residence struggle with the tension between their need for independence and their carers' control over their lives.

Two articles explicitly describe that the default living arrangement for people with psychosocial disabilities is with family (Weine et al., 2005; Zwi et al., 2011). Living with family is described to be fraught with tension as paternalistic attitudes (García Iriarte et al., 2014) and stigma-driven familial shame (Weine et al., 2005) can create restrictive, rather than supportive living environments. In Ireland, García Iriarte et al. (2014) report that adults with intellectual disabilities living with family carers felt that their decision-making rights were being hampered and struggled for greater independence regarding aspects of daily living. In Kosovo, on the other hand, community stigma leads some families to hide mentally ill family members away from the public eye, which severely restricts the persons' right to exercise autonomy and independence (Weine et al., 2005). While discussions that support independent living for those with psychosocial disabilities is lacking, the scarcity of information available suggests that the choice of where and with whom to live in order to pursue meaningful independent living, is fraught with challenges and ambiguities.

3.4. Access to in-home, residential and other community support services

"Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community." (CRPD Article 19, Clause B).

3.4.1. Mental health infrastructure and resources

Our findings highlight huge challenges for mental health service provision in the community, in contexts of war and conflict. These are mainly related to limited infrastructure, human resources, and finances as well as barriers related to accessing existing services. Mental health infrastructure in the form of institutions and buildings are listed in six of the reviewed articles including psychiatric hospitals (Aviram, Guy, & Sykes, 2007; Shaked et al., 2004; Shawahin & Çiftçi, 2012; Weine et al., 2005), a psychiatric unit within a general hospital in the Solomon Islands (Zwi et al., 2011) as well as community-based mental health centres in Israel (Shaked et al., 2004), the Gaza Strip (Saymah, Tait, & Michail, 2015) and Kosovo (Weine et al., 2005).

All these hospitals and community-mental health centres face severe shortages in trained psychiatric personnel (Shackman & Price, 2013; Zraly et al., 2011; Zwi et al., 2011). For instance, in Rwanda, Zraly et al. (2011) highlight that the genocide had left the public health system "decimated with over 80% of the country's health professionals killed or having fled the country" (259). Similarly, the mental health system in Sierra Leone is described as virtually non-existent, with no psychiatrists and only two psychiatric nurses in the only psychiatric hospital in the entire country at the time of publication. Shackman and Price (2013) note, "The only psychiatric hospital is in Freetown and the recent retirement of the sole psychiatrist left the country without a board-certified psychiatrist. There are only two formally trained psychiatric nurses in the capital, and none outside it" (263).

The underlying reason for infrastructure and staff shortages is linked to the lack of financial resources. Authors in six articles explain that available resources tend to be earmarked for relatively narrow and often short-term projects such as war-trauma counselling (Saymah et al., 2015; Zraly et al., 2011; Zwi et al., 2011) and training courses (Hawkins & Tilman, 2011; Shackman & Price, 2013) or related to intervention studies as was the case in Cambodia (Somasundaram et al., 1999). Shackman and Price (2013) note that such short-term projects, led by non-governmental organizations (NGOs) working independently of government oversight, leads to the fragmentation of services and hinders long-term local capacity-building to meet the needs of persons with psychosocial disabilities. For instance, they note:

Those who could offer services, whether ancillary or direct, were often poorly paid and constantly under the threat of losing their position at the end of a project cycle. Two counsellors, employed at one centre treating over 600 clients, received less than 25 US dollars a week and did not know if they would be able to continue working at the end of a three-year contract (265).

Available services are in many cases described as difficult to access due to geographical location as most are concentrated in urban centres leaving rural areas underserved (Shawahin & Çiftçi, 2012; Zraly et al., 2011). For instance, Shawahin and Çiftçi (2012) note that: "Most clinics in Palestine are located in large cities" (281). Besides geographical barriers, community stigma is noted to deter people from accessing services (Hawkins & Tilman, 2011; Laplante & Holguin, 2006; Saymah et al., 2015; Shackman & Price, 2013; Shawahin & Çiftçi, 2012; Stough et al., 2017). Laplante and Holguin (2006) note that there is "a stubborn stigma that mental health services are only for the weak and crazy often prevents members of this population from seeking help" (146), while Shawahin and Çiftçi (2012) report that "[some] mental health professionals indicated that they believed mentally ill patients were

dangerous, rude, and dirty" (381). In Sierra Leone, both persons with psychosocial disabilities and their families are reported to face stigma at counselling centres by health professionals, some referring to persons with severe psychosocial disabilities as "the crazies" (Shackman & Price, 2013, 269). Consequently, the stigma prevents these persons from accessing mental health services leaving them with inadequate support for community living (Shawahin & Çiftçi, 2012). Overall, authors blame such stigmatising attitudes for the low priority given to mental health services, lack of resources and training, restriction of medication access, and delay in adopting national mental health policies.

3.4.2. Mental health and psychosocial services

Relatively little information is available about what kind of mental health and psychosocial support services are provided to people with psychosocial disabilities. Six studies report that counselling and therapy are provided by government clinics, with the support of NGOs, which try to fill the mental health treatment gap in public health systems emerging from war and conflict (Hawkins & Tilman, 2011; Saymah et al., 2015; Shackman & Price, 2013; Weine et al., 2005; Zraly et al., 2011; Zwi et al., 2011). In the Gaza Strip, for example, specialised mental health and psychosocial interventions are provided in outpatient community mental health clinics, while several local and international NGOs provide a range of psychosocial and trauma-focused programs (Saymah et al., 2015). In Timor-Leste, it is described how psychosocial services are delivered in community health clinics by trained general nurses (Hawkins & Tilman, 2011) while a study from the Solomon Islands mentions that trauma support is provided in two districts and community-based counselling is delivered by NGOs to people affected by conflict (Zwi et al., 2011). Similarly, in Kosovo, mental health and psychosocial support were initially mainly provided by NGOs (Weine et al., 2005).

There is limited discussion regarding the variety and choice of mental services for persons with psychosocial disabilities. Exceptions are three studies in HIC settings, namely Israel and Ireland, where the governments provide not only a variety of mental health services but also actively encourage deinstitutionalisation efforts by providing specialised supported residences for people with psychosocial disabilities, including the most severe cases, in order to foster community rehabilitation and reintegration (García Iriarte et al., 2014; Schwartz & Gronemann, 2009; Shaked et al., 2004). One article describes an Israeli project rooted in choice called the Mental Health Supermarket "where individuals could choose different 'ingredients' and create their own treatment package from a choice of multiple options" (Shaked et al., 2004, 208). Services to choose from include medical, social and vocational rehabilitation as well as adult psychosocial education. In LMIC contexts, the option for choice among services is not described except for one study that indicates that patients in the oPt can choose between various interventions including individual, group, telephone counselling techniques, and in some cases, crisis debriefing and psychotherapeutic methods (Shawahin & Çiftçi, 2012).

Little information is available about the quality of provided services. Exceptionally, Zraly et al. (2011) note that the few available mental health services are often of low quality and negligent predominantly due to the brain drain of health professionals who fled during the war. Specifically, they report that "when CSV survivors in Rwanda overcame barriers to accessing formal mental health services, the care they received was often of low quality and perhaps negligent or even harmful" (Zraly et al., 2011, 266). Moreover, the degree to which available services are sustainable remains unclear.

3.4.3. Traditional and faith-based healing

Across five studies, traditional healing forms an important community resource that people use for their or their family members' psychosocial disabilities (Shackman & Price, 2013; Somasundaram et al., 1999; Thabet, El-Gammal, & Vostanis, 2006; Weine et al., 2005; Zwi et al., 2011). People appear to consult with traditional and religious

healers before or instead of mental health professionals (Shackman & Price, 2013; Somasundaram et al., 1999; Weine et al., 2005) and approach health centres offering Western-style approaches later (Zwi et al., 2011). The high uptake of traditional healing in war-affected settings is explained by several related factors: 1) traditional healing has historically formed an important part of a society's sociocultural fabric; 2) traditional healers fill an important treatment gap during armed conflicts and in the immediate aftermath when mental health professionals have fled; 3) and traditional healers fill a gap in settings where mental health services are difficult to access due to their concentration in urban centres (Shackman & Price, 2013; Somasundaram et al., 1999; Weine et al., 2005; Zwi et al., 2011).

Specifically, three studies highlight that while traditional healing forms an important source of support for people with psychosocial disabilities, it is rarely integrated into national health systems as it is overlooked or ignored by policymakers (Thabet et al., 2006; Weine et al., 2005; Zwi et al., 2011). However, this is not the case in all contexts, with two studies illustrating otherwise. In Cambodia, Somasundaram et al. (1999) note that clinicians refer patients to traditional sources of healing such as Kruu Khmer practitioners, monks, village elders, or mediums. In Sierra Leone, in turn, traditional healers are referred to in the national strategic plan for mental health services (Shackman & Price, 2013). According to the 2009 National Mental Health policy, "collaboration with traditional and spiritual healers in the detection, treatment and follow-up of people with mental disorders will be further explored and researched, with a view to define clear roles and responsibilities within the next five years" (Shackman & Price, 2013, 267). Consequently, traditional healers are familiar with mental health problems although they are described as sceptical of Western approaches, which they consider fail to treat the root causes of mental ill health. Several authors highlight the importance of integrating traditional healing into the mental health response in conflict-affected contexts to provide holistic and culturally-relevant care and to maximise scarce resources (Shackman & Price, 2013; Somasundaram et al., 1999; Zwi et al., 2011).

3.5. Community services and facilities for the general population available on an equal basis

> "Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs." (CRPD Article 19, Clause C).

Except for three of the reviewed studies, there is little information about whether persons with psychosocial disabilities have access to general community services or facilities on an equal basis to other community members. Some information is provided by Stough et al.' (2017) review, which focuses on school integration of children with psychosocial and physical disabilities. School integration, the authors note, is difficult to achieve as classmates stigmatise and distance themselves from children with mental health issues that, in turn, leads to a lack of participation in the curriculum. In the context of Israel, Schwartz and Gronemann (2009) highlight the importance for people with schizophrenia to partake in social and recreational activities as such participation affects mental health and quality of life positively. The authors explain that:

> Recreational and other social activities in the community [...] are meeting points where people interact and share common activities and concerns. Taking part in a social club, sitting in a cafe, or simply food shopping naturally involve interaction with other people. Such interaction may help to alleviate some of the feelings of loneliness described by people with schizophrenia (122).

Conversely, García Iriarte et al. (2014) highlight the negative consequences when people with severe psychosocial disabilities are excluded from community services in Ireland. The authors further note

that these persons are often excluded from work opportunities due to negative employer attitudes, as well as poor treatment in the workplace. Such barriers to employment, it is argued, make it difficult for them to lead financially independent lives and contribute to society as a valued member of the community. Overall, this limited discussion of specific modes of support, and the availability and accessibility of community facilities and services, reveals a gap in the literature on current understandings of how persons with psychosocial disabilities lead their daily lives in conflict and post-conflict settings.

4. Discussion and concluding remarks

Communities affected by war and conflict face enormous political, economic and social challenges and, therefore, their capacity to support persons with psychosocial disabilities to live independently in the community is limited. Yet, marginalisation and exclusion from community living is not solely due to resources, but also reflects a lack of political will and stigmatising attitudes among policy makers, health professionals, and the general population. Unfortunately, crucial information continues to be lacking on the lived experiences of persons with psychosocial disabilities in war-affected settings and the voices of those affected are mostly absent (Gradwohl, 2017; Pérez-Sales et al., 2011; Power, 2013; Priddy, 2019; UN General Assembly, 2014). (See Fig. 2.)

Our literature review sought to address this knowledge gap by investigating key concepts of Article 19 of the CRPD including community, support and independence as described in articles published before and after the CRPD's inception. Unfortunately, only limited insight could be provided considering our small sample of 16 articles - which is indicative of a continued lack of interest in exploring the lived experience among persons with psychosocial disabilities in war-affected settings.

Our findings indicate that while none of the included articles explicitly defined the core concept of 'community', authors highlighted that wars have a long afterlife in changing societies by weakening community bonds. Articles connected the weakening of communities to an increase in and worsening of both common and severe psychosocial disabilities. This situation was perceived to unleash a vicious circle whereby higher rates of psychosocial disabilities imposed further stress on communities, accelerating their disintegration and, connected to this, the vilification, stigmatisation and exclusion of those suffering from psychosocial disabilities and their families.

Support for community living was not described in detail in any of the articles reviewed. In war-affected LMICs, people with psychosocial disabilities were mainly cared for by their families who had limited or no professional support at their disposal. Consequently, it was revealed how such families felt overburdened by the work involved and overwhelmed by the stigma they faced from the community. The situation differed in war-affected HICs where family support appeared to be coupled with professional, government-run support for community living including supported housing. However, even in comparatively well-resourced contexts, authors highlight that persons with psychosocial disabilities did not experience the support as sufficient or of adequate quality and complained of paternalism and exclusion. Our findings are in line with other research which shows that people with psychosocial disabilities lack professional support to live independently in the community with choices and decision-making power equal to others (Hammarberg, 2012). For instance, Drew et al. (2011) highlight that people with psychosocial disabilities rarely receive support with their own decision-making. Rather, guardians (i.e., family members, government officials or local service providers) make decisions on their behalf "in areas such as where and with whom they should live, how their money, property and personal affairs should be managed, and other aspects of their daily lives" (ibid, p.5).

Besides a lack of information about support for community living, hardly any insight is provided into how people with psychosocial disabilities access and experience community services and facilities for the

general population in settings affected by war. One study by Stough et al. (2017) notes that children with psychosocial disabilities and physical health problems predominantly faced stigma, harassment and exclusion in schools which, in turn, negatively affected their overall mental health and quality of life. On the other hand, a study conducted in Israel highlights how community participation and access to community services and facilities improved the quality of life for persons with schizophrenia. The results evidence how integration requires resources, work, awareness raising and constant support if it is to enhance the lived experience of persons with psychosocial disabilities.

While there appears to be a lack of community service integration, it would be wrong to assume this means a greater reliance on specialised services and hospitalisation. The reason is that the latter were mostly unavailable in war-affected LMIC settings as the mental health infrastructure was limited, financial support was lacking, and health workers were missing. This is also evidenced by other studies including WHO's Mental Health Atlas which indicates that a mere 62% of countries have mental health policies while 70% have some kind of mental health programme and 62% have some form of community care facilities for persons with psychosocial disabilities (Drew et al., 2011; Priddy, 2019; WHO, 2005). Instead, our findings suggest that mental health support was mainly available through short-term projects carried out by NGOs and charities that were mostly difficult to access. This is partly due to societal stigma and stigmatising attitudes among healthcare providers but also because such services tended to be concentrated in urban locations leaving rural areas underserved. In several contexts, our research shows that this treatment gap was filled by traditional and faith healers who mostly work outside government run mental-health systems.

Our review further revealed that available mental health and psychosocial support services varied with some barely functioning (e.g. Sierra Leone), some receiving strategic aid to rebuild their respective systems with reasonably well functioning services (e.g., Kosovo and the oPt), while others were relatively well equipped due to their countries' high-income status (e.g., Ireland and Israel). Especially in HIC settings, the move towards deinstitutionalisation (rather than just a lack of institutions) can be linked to the availability of a wider variety of mental health and psychosocial support services to enable community integration and independent living. Unfortunately, only limited information is provided as to what services in both HICs and LMICs consisted of and how they were perceived and evaluated by service users and their families.

In order to ensure independent living and community integration in contexts of war, we argue against a one-size-fits-all approach. We call for considering complexity by taking the different histories, political structures, and social and cultural contexts within which people live their lives, into account. Such complexity, in turn, must go together with the question of 'what is possible' in order to identify what can be done to advance the situation in contexts with very limited resources and infrastructure, or settings where most of a country's population struggles with independent living, such as people in the oPt under Israeli military occupation.

Such "pragmatic complexity" (Ansell & Geyer, 2017) considers the context in which community inclusion of persons with psychosocial disabilities occurs while also understanding that it is both orderly and chaotic, and that situations can only partially be modelled and controlled. Community integration in such contexts must be considered as emergent whereby new strategies and targets take shape as contexts shift, insights are generated, and different knowledges and views are mobilised.

The political scientists and philosophers Ansell and Geyer (2017) notice that such complexity and fluidity create challenges for policy making. Accordingly, they bring complexity together with pragmatism based on "open, educated, democratic society engagement in continual learning and dialogue with itself (free expression, debate, speech and interaction and its governmental structures" (163). In order to achieve independent living and community integration for persons with

psychosocial disabilities in war-affected settings, we propose a dialogic approach rooted in three key premises.

First, it is crucial for community support practices and structures to be developed through participatory approaches (de Jong et al., 2015; Pérez-Sales et al., 2011). Assessments of needs, development of meaningful and diverse support mechanisms, and monitoring and evaluation of such support must be participatory involving various stakeholders, including persons with psychosocial disabilities and their families, the general public, employers, social workers, health providers, and policy makers. Second, such participatory approaches should be designed with a human rights perspective in order to give particular attention to survivors of violence, people displaced by violence, loss of loved ones and family and community disintegration (Pérez-Sales et al., 2011).

Third, the development and provision of support for community living is an intersectoral endeavour. Inspired by the WHO's (2013) Health in All Policies (HiAP) approach and Kienzler's (2019) call for mental health in All Policies (mHiAP) in contexts of war and conflict, we propose that community integration must be developed, supported and monitored at the intersection between households, communities, services, and national policy-making. Among households it will be crucial to provide resources and social support across extended families with a particular focus on women who are often the main carers for persons with psychosocial disabilities in war-affected settings. In the context of community, it is important to create information systems and raise awareness about psychosocial disability, carry out community needs assessments with central involvement of persons with psychosocial disabilities and their families, and enable community involvement in creating environments that welcome and integrate persons with psychosocial disabilities. With regards to services, it is crucial that mental health and psychosocial services are made more broadly available in both urban and rural areas, that attention is paid to pluralistic medical traditions, and that effective referral systems are created connecting medical, psychosocial, and social services while being mindful of people's use of various forms of traditional healing.

Finally, national policies must be geared toward protecting the human rights of persons with psychosocial disabilities, poverty reduction, and implementation of national policies ensuring access to education, employment, decent wages, healthcare and housing for those with psychosocial disabilities while also providing support mechanisms that allow for equitable access to opportunities and services.

To enable such human rights-based intersectoral work, policies and laws alone will not be sufficient. Rather, it is crucial to get buy-in from the community at the very start (Campbell & Burgess, 2012; De Weger, Van Vooren, Luijkx, Baan, & Drewes, 2018). Thus, the endeavour must be rooted in solidarity that is, relational practices whereby people and institutions are committed "to carry 'costs' (financial, social, emotional or otherwise) to assist others within whom a person or persons recognize similarity in relevant respect" (Prainsack & Buyx, 2017, 52). Evaluating the impact of a solidarity-based approach on community inclusion of persons with psychosocial disabilities in war-affected settings is crucial to ensure sustained commitment by local and global actors, and to capture other "knock-on effects" of solidaristic exchanges between groups and institutions. Such evaluations must be long-term as it is predicted that the lag between action and effect takes time; and direct links between them might be impossible to establish retrospectively, particularly as practices take place in complex, radically shifting and unstable contexts.

In conclusion, our literature review brought together existing insights into community living and participation for people with psychosocial disabilities in war-affected settings. Yet, the small sample size of 16 articles highlights that not enough research has been conducted in order to understand the lived experience of persons with psychosocial disabilities and their families, which makes the development of meaningful support structures and services difficult. Additionally, the review highlighted that the development of support structures and services is often hindered due to the lack of political will compounded by scarcity

of resources, conflict-related community fragmentation, persistent stigmatising attitudes against people with psychosocial disabilities and their families. Nevertheless, the findings also highlight the importance of developing holistic, intersectional approaches to community integration and support for community living and participation that are locally meaningful while participatory in nature and based on human rights.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijlp.2021.101764.

References

Ansell, C., & Geyer, R. (2017). Pragmatic complexity. A new foundation for moving beyond 'evidence-based policy making'? *Policy Studies, 38*(2), 149–167.

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Aubry, T., Flynn, R. J., Virley, B., & Neri, J. (2013). Social role valorization in community mental health housing: Does it contribute to the community integration and life satisfaction of people with psychiatric disabilities? *Journal of Community Psychology, 41*(2), 218–235. https://doi.org/10.1002/jcop.21524

Aviram, U., Guy, D., & Sykes, I. (2007). Risk avoidance and missed opportunities in mental health reform: The case of israel. *International Journal of Law and Psychiatry, 30*(3), 163–181. https://doi.org/10.1016/j.ijlp.2007.03.001

Braveman, P., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: The issue is justice. *American Journal of Public Health, 101*(S1), S149–S155. https://doi.org/10.2105/AJPH.2010.300062

Byrne, M., White, B., & McDonald, F. (2018). A new tool to assess compliance of mental health laws with the convention on the rights of persons with disabilities. *International Journal of Law and Psychiatry, 58*, 122–142.

Campbell, C., & Burgess, R. (2012). The role of communities in advancing the goals of the movement for global mental health. *Transcultural Psychiatry, 49*(3–4), 379–395. https://doi.org/10.1177/1363461512454643

Campbell, S. P. (2017). Ethics of research in conflict environments. *Journal of Global Security Studies, 2*(1), 89–101.

Coldiron, M. E., Llosa, A. E., Roederer, T., Casas, G., & Moro, M. R. (2013). Brief Mental health interventions in conflict and emergency settings: An overview of four médecins Sans Frontières–France Programs. *Conflict and Health, 7*(1), 1–6. https://doi.org/10.1186/1752-1505-7-23

Collins, P., Patel, V., Joestl, S. S., March, D., Insel, T., Daar, A., Bordin, I., Costello, J., Durkin, M., & Fairburn, C. (2011). Grand challenges in global mental health. *Nature, 475*(7354), 27–30. https://doi.org/10.1038/475027a

De Weger, E., Van Vooren, N., Luijkx, K. G., Baan, C. A., & Drewes, H. W. (2018). Achieving successful community engagement: A rapid realist review. *BMC Health Services Research, 18*(1), 285. https://doi.org/10.1186/s12913-018-3090-1

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Lepine, J. P., Angermeyer, M. C., Bernert, S., De Girolamo, G., Morosini, P., Polidori, G., Kikkawa, T., Kawakami, N., Ono, Y., Takeshima, T., Uda, H., Karam, E. G., Fayyad, J. A., Karam, A. N., Mneimneh, Z. N., Medina-Mora, M. E., … WHO World Mental Health Survey Consortium. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the world health organization world mental health surveys. *Journal of*

the American Medical Association, 291(21), 2581–2590. https://doi.org/10.1001/jama.291.21.2581

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L., & Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: An unresolved global crisis. The Lancet, 378 (9803), 1664–1675. https://doi.org/10.1016/S0140-6736(11)61458-X

García Iriarte, E., O'Brien, P., McConkey, R., Wolfe, M., & O'Doherty, S. (2014). Identifying the key concerns of irish persons with intellectual disability. Journal of Applied Research in Intellectual Disability, 27(6), 564–575. https://doi.org/10.1111/jar.12099

Gradwohl, C. (2017). The right to live in the community as the right to have rights [Master's Thesis, University of Uppsala]. Uppsala University Publications https://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-322826.

Hamaideh, S., Al-Magaireh, D., Abu-Farsakh, B., & Al-Omari, H. (2014). Quality of life, social support, and severity of psychiatric symptoms in jordanian patients with Schizophrenia. Journal of Psychiatric and Mental Health Nursing, 21(5), 455–465. https://doi.org/10.1111/jpm.12112

Hammarberg, T. (2012). The right of people with disabilities to live independently and be included in the community. Council of Europe Commissioner for Human Rights.

Harpur, P. (2012). Embracing the new disability rights paradigm: The importance of the convention on the rights of persons with disabilities. Disability and Society, 27(1), 1–14. https://doi.org/10.1080/09687599.2012.631794

Hart, N., Crock, M., McCallum, R., & Saul, B. (2014). Making every life count: Ensuring equality and protection for persons with disabilities in armed conflicts. Monash University Law Review, 40, 148.

Hawkins, Z., & Tilman, T. (2011). The family is the clinic, the community is the hospital': Community mental health in timor-leste. Australian Psychiatry, 19(Suppl. 1), S95–S97. https://doi.org/10.3109/10398562.2011.583067

Hinchliffe, S., Jackson, M. A., Wyatt, K., Barlow, A. E., Barreto, M., Clare, L., Depledge, M. H., Durie, R., Fleming, L. E., & Groom, N. (2018). Healthy publics: Enabling cultures and environments for health. Palgrave Communications, 4(1), 1–10. https://doi.org/10.1057/s41599-018-0113-9

de Jong, J., Berckmoes, L., Kohrt, B., Song, S., Tol, W., & Reis, R. (2015). A public health approach to address the mental health burden of youth in situations of political violence and humanitarian emergencies. Current Psychiatry Reports, 17(7), 60. https://doi.org/10.1007/s11920-015-0590-0

de Jong, J. T. V. M., Komproe, I. H., & Van Ommeren, M. (2003). Common mental disorders in postconflict settings. The Lancet, 361(9375), 2128–2130. https://doi.org/10.1016/S0140-6736(03)13692-6

Kamundia, E. (2013). Choice, support and inclusion: implementing article 19 of the convention on the rights of persons with disabilities in Kenya. In C. Ngwena (Ed.), African disability rights yearbook (1st ed., pp. 49–71). Johannesburg: Preotria University Law Press (PULP).

Kienzler, H. (2019). Mental health in all policies in contexts of war and conflict. The Lancet Public Health, 4(11), e547–e548. https://doi.org/10.1016/S2468-2667(19)30208-7

Kirmayer, L., Kienzler, H., Afana, H., & Pedersen, D. (2010). Trauma and disasters in social and cultural context. In D. Bhugra, & C. Morgan (Eds.), Principles of social psychiatry (Vol. 2, pp. 155–177). New York: Wiley-Blackwell.

Laplante, L., & Holguín, M. R. (2006). The peruvian truth commission's mental health reparations: Empowering survivors of political violence to impact public health policy. Health and Human Rights, 9(2), 136–163. https://doi.org/10.2307/4065405

Levy, G., & Levac, A. (2018, Dec 17). The disabled palestinian slowly walked away. Then, Israeli troops shot him in the back of the head. Retrieved from https://www.haaretz.com/middle-east-news/palestinians/.premium-idf-troops-shot-disabled-palestinian-in-the-back-of-the-head-as-he-walked-away-1.6743207.

Lewis, O., & Richardson, G. (2020). The right to live independently and be included in the community. International Journal of Law and Psychiatry, 69, Article 101499. https://doi.org/10.1016/j.ijlp.2019.101499

Llosa, A., Ghantous, Z., Souza, R., Forgione, F., Bastin, P., Jones, A., Antierens, A., Slavuckij, A., & Grais, R. (2014). Mental disorders, disability and treatment gap in a protracted refugee setting. The British Journal of Psychiatry, 204(3), 208–213. https://doi.org/10.1192/bjp.bp.112.120535

Lord, J., Suozzi, D., & Taylor, A. (2010). Lessons from the experience of un convention on the rights of persons with disabilities: Addressing the democratic deficit in global health governance. The Journal of Law, Medicine and Ethics, 38(3), 564–579. https://doi.org/10.1111/j.1748-720X.2010.00512.x

Miller, K., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. Social Science and Medicine, 70(1), 7–16. https://doi.org/10.1016/j.socscimed.2009.09.029

Millner, U. C., Woods, T., Furlong-Norman, K., Rogers, E. S., Rice, D., & Russinova, Z. (2019). Socially valued roles, self-determination, and community participation among individuals living with serious mental illnesses. American Journal of Community Psychology, 63(1–2), 32–45. https://doi.org/10.1002/ajcp.12301

Munn, Z., Peters, M. D., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. BMC Medical Research Methodology, 18(1), 1–7.

Patel, V. (2007). Mental health in low-and middle-income countries. British Medical Bulletin, 81(1), 81–96.

Pearce, N., & Smith, G. D. (2003). Is social capital the key to inequalities in health? American Journal of Public Health, 93(1), 122–129. https://doi.org/10.2105/AJPH.93.1.122

Pedersen, D., Tremblay, J., Errázuriz, C., & Gamarra, J. (2008). The sequelae of political violence: Assessing trauma, suffering and dislocation in the peruvian highlands. Social Science and Medicine, 67(2), 205–217. https://doi.org/10.1016/j.socscimed.2008.03.040

Pérez-Sales, P., Férnandez-Liria, A., Baingana, F., & Ventevogel, P. (2011). Integrating mental health into existing systems of care during and after complex humanitarian emergencies: Rethinking the experience. Intervention, 9(3), 345–357. https://doi.org/10.1097/WTF.0b013e32834e26a1

Peters, M., Godfrey, C., McInerney, P., Soares, C., Khalil, H., & Parker, D. (2015). The Joanna Briggs Institute Reviewers' Manual 2015: Methodology for JBI Scoping Reviews. Adelaide: The Joanna Briggs Institute.

Power, A. (2013). Understanding the complex negotiations in fulfilling the right to independent living for disabled people. Disability and Society, 28(2), 204–217. https://doi.org/10.1080/09687599.2012.699280

Prainsack, B., & Buyx, A. (2017). Solidarity in Biomedicine and Beyond (Vol. 33). Cambridge: Cambridge University Press.

Priddy, A. (2019). Disability and Armed Conflict. Geneva Academy of International Humanitarian Law and Human Rights. Geneva: Geneva Academy of International Humanitarian Law and Human Rights (Geneva Academy).

Puente, M. G., Ramón, E. P., Agirre, O., Morán, J. M., & Peco, I. H. (2020). Research note. open letter to the users of the new pubmed: A critical appraisal. El profesional de la Información, 29(3), 13.

Saymah, D., Tait, L., & Michail, M. (2015). An overview of the mental health system in Gaza: An assessment using the world health organization's assessment instrument for mental health systems (WHO-AIMS). International Journal of Mental Health Systems, 9, 4. https://doi.org/10.1186/1752-4458-9-4

Schwartz, C., & Gronemann, O. (2009). The contribution of self-efficacy, social support and participation in the community to predicting loneliness among persons with schizophrenia living in supported residences. The Israel Journal of Psychiatry and Related Sciences, 46(2), 120–129.

Shackman, J., & Price, B. K. (2013). Mental health capacity building in Northern Sierra Leone: Lessons learned and issues raised. Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 11(3), 261–275. https://doi.org/10.1097/WTF.0000000000000010

Shaked, G., Renert, N., Mahuda, I., & Strous, R. D. (2004). Psychiatric care in the Middle East: A "mental health supermarket" in the town of Lod. Psychiatric Rehabilitation Journal, 27(3), 207–211. https://doi.org/10.2975/27.2004.207.211

Shawahin, L., & Çiftçi, A. (2012). Counseling and mental health care in Palestine. Journal of Counseling and Development, 90(3), 378–382. https://doi.org/10.1002/j.1556-6676.2012.00048.x

Somasundaram, D., van de Put, W., Eisenbruch, M., & de Jong, J. (1999). Starting mental health services in Cambodia. Social Science and Medicine, 48(8), 1029–1046. https://doi.org/10.1016/S0277-9536(98)00415-8

Steinert, T. (2020). Potential language bias in systematic reviews on the use of coercion in psychiatry. Acta Psychiatrica Scandinavica, 142(1), 68–69.

Stough, L., Ducy, E., & Kang, D. (2017). Addressing the needs of children with disabilities experiencing disaster or terrorism. Current Psychiatry Reports, 19(4), 24. https://doi.org/10.1007/s11920-017-0776-8

Szmukler, G., Daw, R., & Callard, F. (2014). Mental health law and the Un convention on the rights of persons with disabilities. International Journal of Law and Psychiatry, 37 (3), 245–252. https://doi.org/10.1016/j.ijlp.2013.11.024

Tamimi, N., Kienzler, H., Hammoudeh, W., Khalawi, H., Regent, M., & Giacaman, R. (2021). "Qualitative research methods for mental health in war and conflict": The development and implementation of a locally responsive online learning initiative for researchers and practitioners in the Gaza strip. Global Mental Health, 1–17. https://doi.org/10.1017/gmh.2021.46

Thabet, A., El-Gammal, H., & Vostanis, P. (2006). Palestinian mothers' perceptions of child mental health problems and services. World Psychiatry, 5(2), 108–112 (PMID: 16946953).

The King''s Fund. (2015). Case study 1: Deinstitutionalisation in UK mental health services. https://www.kingsfund.org.uk/publications/making-change-possible/mental-health-services.

Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., Golaz, A., & Van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: Linking practice and research. The Lancet, 378(9802), 1581–1591. https://doi.org/10.1016/S0140-6736(11)61094-5

UN CRPD. (2006). The convention of the rights of people with disabilities. United Nations CRPD.

UN General Assembly. (2014). Thematic Study on the Right of Persons with Disabilities to Live Independently and be Included in the Community (A/HRC/28/37, 12 December 2014, para. 25).

Weine, S., Ukshini, S., Griffith, J., Agani, F., Pulleyblank-Coffey, E., Ulaj, J., Becker, C., Ajeti, L., Elliott, M., Alidemaj-Sereqi, V., Landau, J., Asllani, M., Mango, M., Pavkovic, I., Bunjaku, A., Rolland, J. S., Cala, G., Sargent, J., Saul, J., … Weingarten, K. (2005). A family approach to severe mental illness in post-war Kosovo. Psychiatry, 68(1), 17–27. https://doi.org/10.1521/psyc.68.1.17.64187

World Health Organization (WHO). (1998). Programme on Mental Health: WHOQOL User Manual. Geneva: World Health Organization.

World Health Organization (WHO). (2005). *Mental Health Atlas 2005*. Geneva: World Health Organization.

World Health Organization (WHO). (2013). In *The Helsinki Statement on Health in all Policies*.

World Health Organization (WHO). (2020). *Mental Health Atlas 2020*. Geneva: WHO.

Wynne-Bannister, E., & Venkatapuram, S. (2020). Grounding the right to live in the community (CRPD Article 19) in the capabilities approach to social justice. *International Journal of Law and Psychiatry, 69*, Article 101551. https://doi.org/10.1016/j.ijlp.2020.101551

Zraly, M., Rubin-Smith, J., & Betancourt, T. (2011). Primary mental health care for survivors of collective sexual violence in Rwanda. *Global Public Health, 6*(3), 257–270. https://doi.org/10.1080/17441692.2010.493165

Zwi, A., Blignault, I., Bunde-Birouste, A., Ritchie, J., & Silove, D. (2011). Decision-makers, donors and data: factors influencing the development of mental health and psychosocial policy in the Solomon Islands. *Health Policy and Planning, 26*(4), 338–348. https://doi.org/10.1093/heapol/czq069