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How to organize a rehabilitation program with minimum resources: the role of community systems.

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1. Introduction

In the world, many western and developing countries are lacking the necessary social and economic resources to maintain or develop new programs or services for the psychosocial rehabilitation of the chronically mentally ill.

In the era of political globalization, economic recession and in some occasions economic crisis, in several western societies and economic deprivation in developing countries, socioeconomically disadvantaged persons such as the elderly, the physically or mentally disabled, are usually deprived from their own social resources. They are subjected to dramatic impairment of their quality of life, leading also to the deterioration of their health status.

In this hopeless situation western “welfare” states are usually budget-cutting those specialized programs are addressed to individuals of low political pressure, such as the chronic mentally disabled, programs related to their psychosocial rehabilitation.

In view of this condition, there are two approaches. The first is to give up and let the hopelessness prevail and see the streets of the metropolitan areas full of homeless individuals. The second choice is the self-actualization and the organization of the methodology related to the development of community-based psychosocial rehabilitation programs with limited resources and based on community support system and the active participation of voluntary N.G.O.s.

2. Methodological approaches

The program or service organization framework could be based on three basic components: Ideology, planning management, community actualization and participation.



Dr. Michael Madianos. WAPR President.

It is essential for the rehabilitation team to share a specific ideology to influence the outcome positively and prevent burn out phenomena related also to negative socioeconomic conditions and the demoralization atmosphere.

Careful planning and management of each stage of rehabilitation process could prevent time-consuming work, when the number of personnel is limited. It could also contribute to a better therapeutic outcome.

The last and the most important component is the community actualization participation in the rehabilitation

process. With the term “community” we include individuals, families and social institutions e.g. local authorities, schools, churches, voluntary organizations and individuals who are willing to help.

2.1 The Phase of planning and organization:

The organization process could include the following issues:

- Completion of legal status of the Program or Service (e.g. legal formalities etc)
- Defining priority target groups
- Selection of the type of programme.
 - Do we need a:
 - Day care?
 - Occupational therapy?
 - Vocational workshop?
 - Social Evening club?
 - Housing?

The selection of the type of the programme will be based upon the following:

Firstly the identification of the priority patient groups for rehabilitation, which will follow the certain clinical criteria. According to the Definitions of Severe Mental Illness (Goldman 1981, Tyrer 1989, Audit Commission 1994) it is a prerequisite:

- a. Diagnosis: patients diagnosed according to ICD9 or 10, criteria with these 3 conditions:
 - o Schizophrenia and schizo-affective.
 - o Bipolar disorders and major depression
 - o Delusional (paranoid) disorder
- b. Duration at least one year since onset of disorder
- c. Disability sufficiently covers disability to seriously impaired functioning of roles performance in at least one of the following areas:
 - o occupation
 - o family responsibilities
 - o accommodation
- d. Patients with chronic psychosis. Two/more inpatient admissions in the past 5 years or aggregate one year stay in hospital in past 5 years.
- e. Contact with two/more psychiatric agencies in past year
- f. Frequent consultations
- g. Risk of being imprisoned or persecuted.

2.2. The assessment of needs

The assessment of needs or the identification of the individuals in need of rehabilitation, will include:

- a the method of choice for a survey.

- b the data collection.
- c the data analysis and
- d the dissemination of findings in all community organizations.

The method of choice of the survey could exclude techniques very expensive and time consuming. We could conduct a small-scale survey among community key persons through personal interviews, such as the pharmacists, medical officers, social insurance clerks, local authority leaders, clergy, members of NGO's, to ask their opinion on issues related to the possibility of their participation in the initiative for rehabilitation programme and their views on the local psychiatric morbidity.

A second phase of research should include a census of all existing local institutions and agencies (outpatient clinics, inpatient services, welfare agencies, NGO's etc). This approach will enable the rehabilitation leaders to build relationships or alliances with key figures of the community. Participant observation technique or the old socioanthropological approach of snowball will enrich the information input.

The data collection will be followed by their analysis with the simplest form e.g. cross-tabulations and the writing of a short and clearcut understandable report, pointing out the major findings. The report will be disseminated to all persons or agencies in a previous contact. The hand out of the report will be accompanied by an exchange of opinions on the importance of the initiative e.g. the organization of a specialized programme for the disabled community citizens.

2.3. The Implementation

The implementation will include the decision taken by most of the experts and personnel on the specific type of rehabilitation programme or service as well as the number and the clinical characteristics of the members who will participate in the programme. The specific members and their families will be drawn from lists of possible candidates.

2.3.1. The social and clinical preliminary work with the client will include the following:

- o Evaluation of psychiatric status/psychosocial condition
- o Evaluation of social and vocational skills etc.
- o Evaluation of general functioning status
- o “Contract” of participation in the programme

The work with the family members upon admission will also include:

- a Evaluation of family's atmosphere and dynamics
- b Commitment in the participation in psychoeducation sessions.

- c Continuous contact on the progress of client-family.

In a parallel effort the design of a pilot daily schedule of socio-therapeutic activities will be posted.

2.2.2. The selection and the establishment of the place for the service or the programme.

This is the most crucial issue to be dealt. In the previous contacts with the key community figures this issue had to be addressed. The local alliances and the positive social network probably will enable the funding of the infrastructure (the building). The mobilization of social network along with families and users in many cases, will be effective in the materialization of commitments and assignments leading to the establishment of the service. The infrastructure could be owned by the rehabilitation agency through the donation (public or private sector) or rent through funds (public or private).

If renovations or remodeling of the building are needed, this could be materialized through funds (public or private) and voluntary work. The same mechanism will lead to the provision of equipment of the programme or service, through donations or purchase.

2.2.3. The recruitment of personnel

One of the common complaint by clients of existing rehabilitation services is the shortage of staff. Additionally the central authorities complaint for the costly programs due to the salaries of their personnel.

How this problem could be solved in our case when the resources are limited?

If the rehabilitation programme under implementation, is connected with a mother service, some basic staff could be transferred. If there are some funds (grants) available there must be a minimum number of personnel on a paid basis.

One other important resource is the voluntary work by some therapists or instructors, who are willing to offer some of their time for the benefit of chronically mentally ill.

The basic issue for the team is the solid ideological background to guide their therapeutic relationship and alliance with the members of the rehabilitation programme or service.

3. The role of community support resources in the psychosocial rehabilitation process

The community support resource comprise of 1) the family 2) the church 3) the welfare agencies 4) the voluntary organizations and the local authorities, providing support services, such as, food, clothing recreational activities, housing and sometimes employment to those persons are attending the rehabilitation programme. All these resources are precious allies in the support of local residents in need.

4. The evaluation

The success of this whole enterprise is based on the evaluation process.

- Evaluation must be built-in
- Evaluation provides feedback to everybody
- Evaluation is inexpensive
- Evaluation gives money by the persuasion and funding of the donors.

The annual report on activities refers to structured schedules recording individual and group progress e.g. levels of participation in therapeutic and social activities. It is also related to a cost-effectiveness analysis.

5. The Athenian experience

In 1978 a small multi-disciplinary team of experts with a common ideology and with very limited resources, started developing a multi dimensional community mental health programme, covering two neighboring boroughs in greater Athens area with a total population of 185,000, the first of its kind in Greece.

Planning included 1) assessment of local mental health needs by conducting a treated and untreated prevalence cross-sectional survey 2) establishment of a Community Mental Health Center providing in the beginning only outpatient mental health care 3) community mental health intervention and formation of local mental health committee 4) expansion of space and services by the establishment of a number of units such as the Adult Open Psychosocial Care, the Children and Adolescents Unit and the Psychosocial Rehabilitation Unit. The latter includes a Day Care Program, a Vocational Training Workshop and finally a Cooperative (the Lotus shop). These services are financed by different resources such as the Eginition Hospital, the National Employment Agency, the European Union's special regulation 815/84.

The Center had mobilized and utilized almost all local resources in a great extent according to the previously described methodology. Mental health quantitative and qualitative indicators assessed through the first fifteen year period of the Center's operation, provided evidence that utilization of local resources are favouring both the community integration and adjustment of chronic mentally ill residents, the prevention of inpatient services admissions and the involved community resident's self-actualization and awareness on mental health issues.

In 1998 the leader of the first CMHC took the initiative to develop another CMHC in a borough neighboring the previous ones. He faced the same problem the lack of appropriate funds, except for the rent of the

space. The previous experiences helped to form a network of alliances including the local municipality, the clergy, some NGO's, and some institutions which could provide some grants for the first years of the operation of the Center.

The Center soon started its operation with a walk-in clinic. After a funding by the Ministry of Health covering only the salaries of four additional personnel, a Day Care Programme was developed for 15 members suffering from severe mental illness. The programme was soon supported by four volunteers in various therapeutic activities, such as drama, music and art painting.

The local community resources provide also any complementary needed support such as housing for some members, or leisure time activities and in two cases food.

The examples shown here are based in the same philosophy and practice with the ultimate goal the community integration of the disabled citizens in full citizenship.

6. In conclusion

It is the easy way for a mental health professional to accept the pessimistic view that nothing can be done when there are no funds available and have their conscience clean. This other way is to struggle for the betterment of the chronically mentally ill persons even with the limited resources.

There are five basic principles of this approach.

- There are always community residents influenced positively toward the mentally ill.
- There are hidden and unlimited community support resources.
- The community's reaction is analogous to team's pressure.
- Community is serving as a rehabilitation workshop in vivo.
- Optimism is a strong weapon.

The areas of the community actualization – participation are dealing with the organizational support in terms of financing small projects or paying salaries to trainers etc, food and clothing for some cases of rehabilitees, housing, employment and recreational activities.

It is evident that all the categories of community support resources could cover all five described areas.

It seems that a psychosocial rehabilitation team has many inexpensive alternatives to choose. It is needless to say that mental health education and sensitization carried out by the team should promote this community intervention in terms of alliances and referral network formation and partnership as well.

There are numerous examples of services or programs established and functioning based upon this approach in all

geopolitical areas of the world, helping the disadvantaged people.

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Recovery - an integral part of everyday life.

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Background

The concept of recovery in severe mental illness is emerging as a new vision in mental health services in many countries. One of the key principles in the recovery vision is that of “people first,” meaning that individuals with mental health problems are human beings with resources and talents, hopes and dreams, and strengths and weaknesses, just like people in general. They no longer want to be seen or described as cases or disorders, or as vulnerable and deviant people governed by symptoms and diagnoses, but rather as equal citizens with a variety of roles – like being an employee, a sister or a brother, a dog-owner, a student or a neighbour.

Individualising mental health problems has a long tradition in psychiatry. Not only service users and their families, but also voices within mental health services and research, are critical of the lack of interest in the individual’s social and material situation. This criticism includes the medicalization of human and social circumstances, rather than attention paid to the person’s general life conditions (Borg & Kristiansen, 2004; Davidson, 2003; Mezzina et al., 2006; Read et al., 2004). When people’s problems are not viewed within the context of everyday life, recognized as the focus of considerable efforts, or as influenced by difficult situations or conflicts, these troubles simply become representations of an illness entity (Basaglia, 1987).

This article focuses on the social and everyday life aspects of recovery. Drawing on the recent doctoral theses in health science (Borg, 2007) the meanings and impact of everyday life issues in recovery will be outlined and discussed, arguing for broadening the perspectives of recovery in severe mental illness beyond the personal efforts. I will initially summarize some perspectives of recovery as an individual process, then discuss recovery emerging as an integral part of everyday life, and finally outline some implications for practise.



Marit Borg WAPR Board at large.

Recovery as an individual process

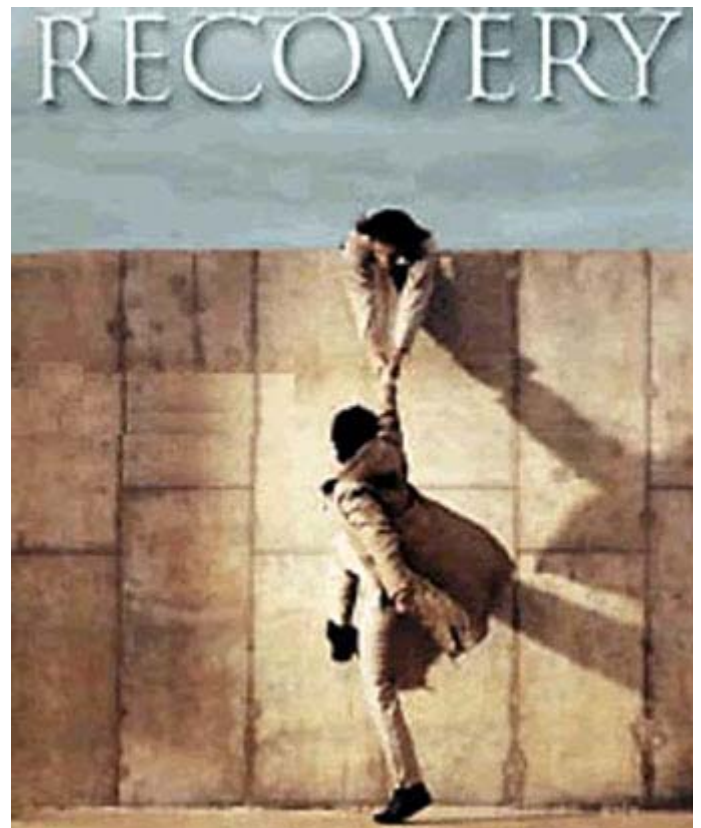
As with many new terms, the notion of recovery is inconsistently understood and used. One challenge involved in conceptualising recovery is that it is described partly as an individual or social process and partly as an outcome. Another source of confusion is the complexity of the concept, as in one way it is multifaceted, and yet in another way somewhat simple, as people with lived experience have recovered for many decades.

In a *person-centred framework*, recovery is described as a highly unique and personal process, involving taking back the control over one’s life situation. As Curtis (1997) emphasises, recovery involves regaining what may have been lost, such as rights, roles, responsibilities, decisions, potential, and support. It is about reclaiming the roles of a “healthy” person, rather than living life as a “sick” person.

Recovery is also characterised by developing new meaning and purpose in one's life, beyond the symptoms, disability and stigma of mental illness. It involves adjusting one's attitudes, feelings, beliefs and goals, and finding ways of being active agents in shaping one's own life (Anthony, 1993; Deegan, 1997; Boevink, 2006; Glover, 2005). Thus, recovery is not so much about symptom relief as about having a meaningful and reasonable life situation.

Another way of conceptualizing recovery is as an *outcome* or as a *process*. Seen as an *outcome*, recovery represents a change from a previously "maladaptive" state to a position of "normal" living. Recovery as an outcome means more than an improved state, although it does not necessarily mean symptom-free or without distress or functional problems. Typically it includes accomplishing life goals in such important domains as work, housing, psychological well-being and improved quality of life. However, many individuals with an experience of severe mental illness find the concept of outcome unsatisfactory, often due to the emphasis on externally imposed criteria instead of on the subjective experience of what is important in life (Onken et al., 2002; Ralph & Corrigan, 2005). They prefer the process-oriented characterization—with its emphasis on psychological well-being, coping with symptoms and getting on with their life in general—to that of whether or not they fit into a set of external criteria. When recovery is seen as a process, statistical measurement is of less interest. Frequently used concepts in the process-view are personal indicators of well-being, hope and spirituality—all beyond the typical theories of psychiatry and psychology.

Recovery research reveals that informants portray themselves as both active and goal-directed in dealing with their mental distress, social problems and everyday challenges, as well as trying to find good helpers to support them (Borg, 2007). They are "getting on with their lives," which is the major feature of how recovery needs to be understood. They show resilience and personal strength in finding ways to deal with everyday life tasks, like maintaining their homes, providing sufficient income, doing their shopping and laundry, taking care of themselves and being a family member. One striking feature of the narratives of recovery is the variety of contributions that individuals offer. This is an issue generally absent when portraying individuals with mental health problems as they are typically described as being on the receiving end, as vulnerable and fragile men and women. In the recovery stories we learn about all they do to help out in their families and in organizations, and as volunteers or colleagues. Although they have to face difficult living conditions, painful and chaotic experiences, and even neglect by the



services supposed to be there to help, they reveal having resources and capabilities.

Recovery as an experience in everyday life

Suggesting the use of everyday life as a platform for understanding recovery is quite logical; how and where else can individuals with mental health problems try out and work on "getting on" with life? There are several reasons for identifying everyday life as an appropriate context for learning more about what a recovery process actually involves. First, examining peoples' mental health problems in the framework of their daily lives opens up for discovery and exploration the consequences of the mental health problems on a practical level. By attempting to understand experiences and behaviours in ordinary environments, the activities, choices and strategies of those with mental health problems can be assessed and addressed in their naturalistic contexts. One can better avoid personalising problems that are often likely to be mainly social and structural. A life context approach also implies that regardless of one's aetiological perspective concerning the nature and cause of mental illness, it is in a person's everyday life that the numerous consequences of it need to be addressed (Borg & Davidson, in press).

Secondly, an everyday life perspective reveals the concrete environment people are living in and surrounded

by, consisting of places and arenas as well as family, friends, neighbour, colleagues or pets. Some kinds of environment may be nurturing and fostering of recovery, while others may well represent a great barrier. Some environments invite people to use their skills and talents, while others promote hopelessness and helplessness. In recovery interviews the informants talk about the importance of having an ordinary job and expectations on them; they talk about the meaning of a “normal” social environment and the value of a safe home (Borg, et al 2005, Topor, et al 2006). The richness and complexity of life becomes more obvious when keeping a focus on these daily aspects. Navigating all the everyday activities is made possible by having and making tacit use of a stock of practical knowledge ready at hand. Like everyone else, people with severe mental illness reveal a stock of knowledge, and they have developed practical and social routines that sustain and maintain their daily lives. It is, however, crucial to pay attention to the environment as well as to the individual in recovery.

Third, a recovery approach includes the understanding that while the personal distress of mental health problems is often devastating, the social consequences are often even more disabling. Being labelled with a severe diagnosis like schizophrenia represented social barriers for some of the informants. Recovery involved dealing with both internalized and externalized stigma and discrimination. Experiencing serious mental illness for many years often involved feeling “different,” not “belonging” in any social group, and feeling inadequate and marginalised. The individuals had to cope not only with problems like voices, anxiety or loneliness, but also with a community that had excluded them (Mezzina et al., 2006).

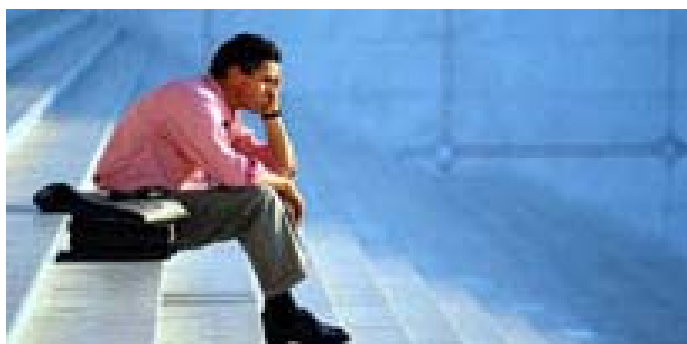
Just to give a concrete example. There is a difference between being a worker with mental health problems and being a psychiatric patient doing work training. The impact of valued social roles on quality of life is well known (Kristiansen, 1993). The importance of work for people in general is well documented from health, psychological, social, economic, and political perspectives and most people with mental health problems want to have a job. Societal barriers such as attitudes and discrimination, rather than personal deficits, are among the explanations for high unemployment rate in this group (Marwaha & Johnson, 2005). Marwaha and Johnson’s informants named stigma as a major obstacle in finding or maintaining a job, and the Roets et al. study (in press) found that people with histories of long-term mental distress who seek employment often ‘lose the game before it starts’ due to societal prejudice and low expectations.

In a Norwegian study achieving normality was presented as important in recovery. Having an active working role was a concrete and real opportunity to feeling normal, enabling and supporting stepping out of the problematic arenas of life and “being someone”. The actual work activities mentioned were of some importance to others, connoting being useful and respected and embodying capability and skills. Several also described the value of interpersonal relations at work, such as having ordinary discussions at work-breaks about what was happening in the local community or the world (Borg & Kristiansen, in press). Being surrounded by people without problems enhanced feelings of being ‘okay,’ as well as provided opportunities to grow and develop.

Concluding remarks

Much of everyday life is so taken for granted that it risks becoming invisible, and it may appear as trivial or mere commonplace. Yet it is these small bits of life that are often of critical importance in an individual’s recovery process. Conceptualizing recovery from severe mental health problems within the context of everyday life draws attention to very concrete life issues and coping with distress. In rehabilitation and treatment, professionals will do well to pay more attention to the trivialities of everyday life, as well as to the individual’s own expertise in managing these tasks. Everyday life tasks and skills need to be addressed as part of the practitioner’s agenda.

One final matter: recovery is hard to plan. In spite of all the good intentions of rehabilitation and treatment programs, things happen and people find other, and at times unorthodox, ways to deal with their problems and re-establish their lives (Borg & Davidson, in press). The stories of recovery reveal a need to appreciate the “little things” in the lives of individuals struggling with mental health problems and to recognize the turning points that make up building blocks in the recovery process. Practitioners, as well as people in recovery, need to remain open to opportunities, no matter how small, that present themselves and can make life a bit better.





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Achieving Social Inclusion for mental health service users through Life Long Learning: the EMILIA Project

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In the current debate about psychosocial rehabilitation the term is defined as an active contribution towards a “global public health strategy”¹, rather than a poor qualified technique within the psychiatric practice.

In order to achieve public health promotion in countries and regions presenting a great inequality of resources and of community mental health services the user’s involvement in a variety of ways appears to be critical for a process of change in any medical – centered psychiatric clinical practice. The different ways of participation might be self-help groups, interaction between service users and professionals, management of local services, planning and decision making of the overall services.

The EMILIA project, through the coexistence and incorporation of different European experiences and psychiatric cultures aims to bridge the existing gap between declarations of mental health professionals and real practice as far as the user’s participation is concerned.

The EMILIA project (Empowerment of Mental Illness service users: Lifelong learning, Integration and Action) commenced operation in September 2005, and is funded for four and a half years with 3.4 million • through European Union Framework 6 monies, drawn from the Lifelong Learning thematic area. The EMILIA project seeks to use a lifelong learning process to facilitate the social inclusion of mental health service users.

Lifelong learning is taken to mean that everyone should have equal and open access to high quality learning opportunities. It acknowledges that learning is not just confined to the classroom, and to the delivery and achievement of academic awards, but can be learned through many different means, including the training



packages being developed by the EMILIA Project. These training packages have been developed with service users and wherever possible will be taught by service users. It is hoped that, by facilitating service users in developing a lifelong learning process, this will aid service users in both understanding and putting a meaningful context around their potentially stigmatic experiences of being involved in the mental health service system. The purpose of these training packages is to assist service users in the management of their disability and also to equip them to work in an effective manner in a variety of employment settings, including mental health services themselves, colleges and universities. The training packages so far developed include:

- Recovery
- Building on a Service User Strengths
- Post Traumatic Stress Support

- Work-related social skills
- Service User Leadership
- Service User Research skills
- Dual Diagnosis
- Suicide Prevention

Social Inclusion, in terms of its emphasis in the EMILIA project, is understood to mean the occupational involvement of the service user through:

- Day-time activities which are regarded by the service user as meaningful but not necessarily paid
- Acting in a volunteer capacity
- Involvement in the monitoring of mental health services ensuring that service user feedback is given to local mental health services
- Paid work on a one-off or regular sessional basis
- Designated full or part-time employment.

Membership of the project

There are 17 centres involved in the project, as listed below, eight of which are demonstration sites which are attempting both to implement and evaluate the efficacy Lifelong Learning as a means to address the social inclusion of mental health service users.

Progress so far

Over its first eighteen months, much progress has been made. Amongst the highlights, the project has developed and validated where necessary a comprehensive range of

qualitative and quantitative measures in order to evaluate the efficacy of the Lifelong Learning intervention, as implemented in its eight demonstration sites. Each demonstration site has designed its own unique approach to Lifelong Learning, which accommodate to the particular culture, and mix of resources and developmental opportunities available in each location. A Learning Organisation system¹ has been developed for each demonstration site and across the project as a whole. Eight lifelong learning training packages have been developed with and for mental health service users as an aid to the implementation of lifelong learning intervention on the demonstration sites.

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The Emilia Consortium

Name	Country
Middlesex University *	UK
EPAPSY*	Greece
Hospital Maison Blanche *	France
Dept Education, County of Aarhus	Denmark
University of Tampere	Finland
Nordland Psychiatric Hospital *	Norway
Institute of Psychiatry and Neurology*	Poland
The Social and Psychiatry Department*	Denmark
Vilnius University	Lithuania
University of Ljubljana	Slovenia
HealthNet International*	Bosnia Herzegovina
Karolinska Institutet	Sweden
Municipal Institute of Medical Research Foundation*	Spain
Kings College, University of London	U.K
Skyark Project Consultants Ltd	UK
University of Athens	Greece
Wealden Computing Services	United Kingdom

(*: Demonstration sites)

WAPR WORLD CONGRESS BANGALORE 2009

12 to 15 November 2009, Bangalore.

"One world: quest for integration"



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FESTIVAL EURO PSY – PAMPLONA 2007

Encuentros con la ciudad.

MARGARITA ZABALA. Psicóloga Clínica.

Directora de la Clínica de Rehabilitación de Pamplona

Vicepresidenta del Com. Org. Europsy- Rehabilitación, Pamplona 2007. España.

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Durante los días 24, 25 y 26 del pasado mes de abril tuvo lugar en Pamplona (España) el Festival Euro Psy, un certamen internacional que se celebra cada año en un país europeo para crear espacios de convivencia entre usuarios, cuidadores y profesionales de la salud mental. Como las anteriores ediciones, en la capital del antiguo Reino de Navarra también se intercambiaron experiencias y se pusieron en común los avances sobre políticas de reinserción y rehabilitación social en esta materia para el conjunto de Europa. La cita de Pamplona era la novena organizada por la asociación Euro Psy Rehabilitación desde su fundación en Bélgica el año 1992, y la segunda en que la Comunidad Foral de Navarra acogía este festival.

En esta nueva edición, las **entidades responsables** de las jornadas -la Subdirección de Salud Mental del Gobierno de Navarra, la Clínica de Rehabilitación, y el Hospital Psicogeriátrico- pusieron especial énfasis en que las actividades programadas estuvieran orientadas y condujeran a un encuentro entre todos los participantes y el entorno físico, social, cultural y urbano donde se desarrollaba el Festival. Esta es la razón por la que el Comité Organizador del Festival buscó la mayor implicación posible de grupos, asociaciones e instituciones de ámbito local y regional.

Hay que destacar, en este sentido, la colaboración de los departamentos de Salud y Bienestar Social del Gobierno de Navarra, del Ayuntamiento de Pamplona, así como de la Mancomunidad Comarcal de Municipios, además de la Red de Salud Mental y Atención Primaria, la Universidad Pública, la Sociedad Vasco Navarra de Psiquiatría y diferentes empresas y organismos, tanto públicos como privados. Fue significativa, por ejemplo, la aportación de la Asociación de Vecinos Orvina 2, perteneciente al barrio donde se celebraron los encuentros, la Escuela Oficial de Danza, o la del grupo folklórico



Muthiko Alaiak, uno de los más antiguos y que cuenta con mayor prestigio de toda la región.

Los participantes

Dejando a un lado los miembros de las citadas entidades colaboradoras y los numerosos voluntarios que contribuyeron con su desinteresado esfuerzo a su desarrollo, el 9º Festival Euro Psy contó con la **inscripción** de 226 personas, entre usuarios, cuidadores y profesionales, procedentes de seis países europeos: Bélgica, Francia, Holanda, Austria, Reino Unido y España. Hay que resaltar la participación de Bélgica, cuya representación estaba compuesta por 61 personas, de las cuales 44 eran usuarios, 14 cuidadores y 3 profesionales, mientras que el país anfitrión contribuía con 67 usuarios, 4 cuidadores y 30 profesionales. Le seguían en número de asistentes Francia, con 30 inscritos; Holanda con 14, Reino Unido con 12 y Austria con 8. Del total de participantes, 152 eran usuarios, 25 cuidadores y 49 profesionales, lo cual pone en evidencia la importancia que en estas jornadas anuales tiene la participación de los usuarios.

Durante la celebración del 9º Festival, se pusieron en marcha **quince talleres**, que recogían distintas

facetas artísticas, socioculturales y deportivas, destacando aquellas que conducían, tal y como se había previsto inicialmente, a un contacto directo con la cultura y el entorno urbano. Solo por citar las actividades más relevantes con esta orientación, se pueden mencionar los paseos naturalísticos, tanto a pie como en bicicleta, por el centro y por los alrededores de Pamplona, recorridos históricos por las zonas más emblemáticas de la ciudad, cursos de gastronomía navarra, de pelota vasca y la exhibición de danzas, destacando el folclore vasco y el flamenco.

Como viene siendo costumbre en los festivales organizados por Euro Psy, usuarios y profesionales compartieron talleres de manualidades, pintura, fotografía, deporte y la edición de un periódico para recoger las noticias del encuentro. Paralelamente, se celebraron unas Jornadas Técnicas impartidas por especialistas, fundamentalmente llegados de otras zonas de España, con el objeto de profundizar e informar a los asistentes de las políticas sobre rehabilitación y reinserción social que se están poniendo en marcha en este país mediterráneo, para terminar con un conjunto de actividades lúdico-festivas que permitieron a todos los participantes, usuarios, cuidadores, profesionales, acompañantes y familiares, tener un contacto directo con la riqueza cultural de esta región del norte de España.

Estos festivales, que han visitado anteriormente países como Alemania, Francia, Holanda, Bélgica o Grecia, representan una de las principales iniciativas de Euro Psy Rehabilitación, asociación integrante de Mental Health. El principal **objetivo de Euro Psy Rehabilitación** es poner en práctica los derechos de las personas afectadas por enfermedades mentales en igualdad de condiciones que los demás ciudadanos europeos, impulsando políticas tendentes a conseguir su integración social, laboral, económica y cultural. Esta es la

razón por la que, desde su fundación hace 15 años, Euro Psy Rehabilitación ha dedicado buena parte de sus esfuerzos a fomentar, incentivar e intensificar la intercomunicación tanto de los usuarios como de los profesionales y cuidadores.

Entre sus principales iniciativas figuran las visitas de trabajo, la promoción de programas a nivel europeo, los seminarios intercomunitarios y el establecimiento de relaciones con las distintas instituciones gubernamentales y europeas dedicadas a la salud mental, siempre teniendo como meta la mejora de las condiciones de vida de los usuarios y su rehabilitación y reinserción en la sociedad. Resulta obvio que estos festivales anuales se han convertido ya en una de las herramientas más eficaces de Euro Psy para lograr estos objetivos, ya que en ellos se consigue la puesta en común y la extensión al conjunto de Europa de los avances que se realizan en los diferentes países comunitarios.

Las Jornadas Técnicas

Se presentaron valiosas aportaciones en diversos aspectos de la rehabilitación psicosocial, pero es obligado destacar la comunicación titulada “Medicaments et la prise de poids”, un interesante trabajo sobre la incidencia de los fármacos y sus efectos secundarios en el peso y el estado anímico de los usuarios. Su exposición corrió a cargo de Christine Canon y Franck Coronet, usuarios y miembros de “Le Crit” de Bruselas. Hay que señalar que es la primera vez que, dentro de las Jornadas Técnicas de un Festival Euro Psy, un grupo de usuarios presenta una comunicación sobre un estudio realizado por ellos mismos.

El comité organizador considera que la presentación de esta ponencia supone un salto cualitativo en la tendencia creciente a la participación de los usuarios en todas las actividades programadas. Hasta ahora su implicación era notable en la organización, preparación y puesta en marcha de actos y talleres; a partir del precedente de Pamplona, la participación de los usuarios en estudios o investigación sobre materias que les conciernen debiera ser tenido en cuenta a la hora de marcar los objetivos de las próximas ediciones del Festival Euro Psy.

El neurólogo y escritor, Iñaki Bidegain, por su parte, realizó una novedosa exposición analizando ciertos aspectos psicológicos asociados al juego de pelota vasca, un popular deporte especialmente extendido en el norte de España. Bidegain, que también presentaba en estas jornadas su libro “Mano a mano”, hizo una sugestiva propuesta sobre las posibilidades terapéuticas de la práctica de la pelota vasca en el marco de la salud mental. Dicha propuesta permitirá la celebración de un campeonato para-manomanista con usuarios de salud mental, que se celebrará en Pamplona con la participación de figuras destacadas de este deporte.





Reflexiones finales

Como es fácil de suponer, la preparación de unas Jornadas de estas características supuso un gran esfuerzo para el comité organizador, que asumió este reto anual en la ciudad de Pamplona. Precisamente por ello, tal vez la primera reflexión que se puede hacer tras la celebración del 9º Festival es que merece la pena acometer tal esfuerzo si se tienen en cuenta los resultados que se consiguen, y, de forma especial, la notable participación de los usuarios en las actividades de convivencia. Tanto su grado de participación como de implicación en el programa demuestran que los festivales itinerantes son un camino que es necesario continuar y ampliar, comprometiendo cada vez más a las instituciones y organismos locales y nacionales del país que reciba el encargo de poner en marcha estas jornadas.

Otra de las valoraciones positivas que merece la pena destacar en este 9º Festival es el esfuerzo realizado para implicar a un gran número de organismos locales, privados y públicos, en la celebración del mismo. Como ya se ha citado más arriba y además de la Clínica de Rehabilitación y del Hospital Psicogeriátrico, que fueron las sedes de la mayor parte de la programación, se contó con las principales instituciones regionales y ciudadanas, con los diversos centros de la Red de Salud Mental de Navarra y entidades privadas que también trabajan en el terreno de la Salud Mental, como ocurre con las Hermanas Hospitalarias. De la misma forma, se debe valorar la gran participación de voluntarios y la magnífica respuesta de multitud de asociaciones, colectivos e incluso de empresas privadas que se prestaron de forma desinteresada a colaborar con la organización del Festival.

Como ejemplo de dificultades se podría citar el problema que se presentó ante la escasez de plazas hoteleras de nivel medio en Pamplona, situación que se resolvió gracias a la colaboración de entidades y empresas privadas que, salvo contadas excepciones, mostraron su disposición a facilitar y reservar plazas a precios especiales. También podemos destacar la inexistencia de incidentes de

gravedad; solo se produjeron algunos pequeños desajustes de carácter logístico, a pesar de que el enfoque dado a los programas -desarrollar encuentros con el entorno urbano- suponían el desplazamiento de muchos usuarios por diferentes zonas de la ciudad. Habíamos articulado, en colaboración con entidades de protección ciudadana, medidas de actuación ante posibles eventualidades que no fue preciso utilizar.

Otra de las importantes metas que se alcanzaron fue la difusión del desarrollo de las jornadas en los principales medios de comunicación, un objetivo siempre importante para sensibilizar a la opinión pública sobre la problemática de la salud mental. Lamentablemente, la escasez presupuestaria para acometer la organización obligó a limitar el número de participantes, por lo que muchas personas que habían mostrado interés por acudir al Festival no pudieron participar en el mismo. Por último, la traducción simultánea de las ponencias de carácter técnico presentadas terminó siendo larga y tediosa, provocando momentos de cansancio entre los asistentes. Tal vez habría que reflexionar sobre este aspecto y buscar soluciones para que, bien a través de textos proyectados en pantallas o de resúmenes en inglés y francés, se encuentre una forma más cómoda y ágil de transmitir los conocimientos que se quieren exponer.

Pero, por encima de todo, hay que destacar que se consiguió el principal objetivo: crear un ambiente de convivencia, de disfrute, un espacio común en el que usuarios, cuidadores, profesionales y familiares compartieron talleres, paseos, conferencias y actividades lúdico-festivas sin tener en cuenta procedencia ni condición. Pamplona y su 9º Festival se unieron, de esta forma, a la corriente impulsada por Euro Psy en toda Europa para lograr una verdadera reinserción social y rehabilitación de aquellas personas que padecen enfermedades mentales.



Psychosocial Rehabilitation for the elderly people, a Program.

IDA KOSZA MD PhD (1) & MALGONA MOLNÁR MD (2).

(1) Vice President WAPR. President Committee of the Rehabilitation of Elderly People.

(2) Member of the Committee.

Pomáz- Hungary.

The program outlined below is working in Hungary, especially in the Collaborating Center of the WAPR, Gálfi Béla Psychiatric Teaching Hospital, Pomáz, Hungary.

The program offered for discussion regarding the differences of the different cultures, different regions and religions of the world.

The first step is to outline the definition of rehabilitation in this case.

The rehabilitation of the elderly people - but all types of psychiatric illnesses - is possible just on the level, what the patient by the help of a strong and proper program is able to realize. We cannot demand more, what the patient is able to realize, but we must demand to realize the highest levels of their abilities.

The need for this service is urgent. The societies are getting to have more and more elderly people not only in Europe. Therefore we organized gerontopsychiatric departments in our hospital for different levels and profiles of the old age.

In the very beginning of our program Ida Kosza as the general director of the hospital established the first department for the people of Alzheimer Disease and the patients with dementia of different types. The most demented patients are there. Rehabilitation program of this department: the first step the therapy with medicines (piracetam, donepezil, etc..)

The rehabilitation program wants to give and to keep the dignity for these demented persons. We apply group therapy, preferring for example the dance programs with evergreen melodies. The level of dementia doesn't allow for these people to live alone or without personal care. The most important goal to prevent or to slow down the progression. This is the highest level of rehabilitation for the very demented persons, what is possible to give for them.

The other departments are existing for the patients with not so serious dementia, who need some help to live. We have in these departments different individual and group



Ida Kosza. Vice President WAPR.

therapies beside the drug treatment. The members of the staff represent the different chances of therapies. There is a department for gerontopsychiatric patients of many types of somatic diseases as well.

But in general our main goal is to suggest the people to live in the community, when the needed circumstances are existing for them. When they have family, or other persons to care for them.

Our hospital is registered as Dementia Center as well, this network is existing in Hungary. We try to give help, advices for the family members to care for the elderly people in the family.

In Hungary this is difficult, because the people must work, must have job to survive, and therefore they cannot care for the old family members. Therefore it is needed to organize sheltered homes for these people, where they can manage their life relatively alone by the help of the staff of the homes.

This program is a basis for discussions and completion internationally. We would like to ask colleagues to join the work of the Committee of the Rehabilitation of the Elderly people.

TORUN DECLARATION

EUFAMI

Diestsevest 100. B - 3000 Leuven. Belgium.

www.eufami.org

All the delegates at the Congress, including representatives from the 50 EUFAMI family associations from across all parts of Europe, call on all European National Governments to fully implement the Helsinki Action Plan which aims to reduce the burden of care on families and recognises that it is a basic human right for all persons to have equal opportunities to experience a good quality of life.

EUFAMI declares that:

In today's world it is no longer acceptable that people with mental illness cannot fulfil their potential in society because of exclusion from social life due to stigmatisation, lack of employment or occupation, or poor physical health:

- Health care professionals must recognise that while people with mental illness have to be actively involved in their own recovery process, family and friends play an important role too - provided that they are properly informed, empowered and supported both by Mental Health Associations and by professionals.*
- Health and social care professionals must attend to physical health needs in addition to prescribing medications and psychological treatments, and we earnestly request them to adapt their training and practices accordingly. Furthermore health and social care professionals should promote a system of quality assurance to secure the important goal of remission and recovery.*
- It is essential that there is good communication between people with mental illness, their families and friends and the professionals involved in their care, and that they work in a coordinated way.*

It was once a widely held belief that the earth was the centre of the Universe, until Nicolaus Copernicus, astronomer and mathematician born in Toruń declared that on the contrary the earth and the other planets revolve around the sun. In the same way mental health hospitals and other services were once the focus of care for people with mental illness, but now the focus must be firmly on the patient and family.

EUFAMI

Some remarks on Psychosocial Rehabilitation in Botswana.

Reported by PAUL SIDANDI, M.D.
The Regional Vice President for WAPR Africa

The Botswana Situation

According to the World Health Organization (WHO), most middle and low-income countries devote less than 1 per cent of their health expenditure to mental health.

By contrast Botswana, a middle income country devotes about 4% to mental health. This is evident from the building of the new Lobatse Mental Hospital which will cost P300 million (US\$50 million) and the renovation of Jubilee Psychiatric Unit at a cost of P4,2 million (US\$700,000) and the provision of Psychiatric Units in the upgraded district hospitals.

The traditional mental health system now includes a modern system based around one referral mental hospital, two Psychiatric Units in General Referral Hospitals (Jubilee Psychiatric Unit at Nyangabgwe Hospital in the City of Francistown (35 beds) and Princess Marina Psychiatric Unit in the Capital Gaborone – No beds) and Psychiatric Units in the upgraded facilities at Maun, Serowe, Mahalapye and Molepolole.

This is in contrast to the pre-colonial days when patients were cared for by families and traditional healers until Lobatse Mental Hospital opened in 1938 as a forensic wing of Lobatse Prison initially for 5 patients and later 69 patients from 1954. It later became the observation wing for Athlone Hospital, a general facility located in Lobatse Population 30,000.

The country which is the same size as France, Texas or Kenya is divided into two catchment areas, the north served by Jubilee Psychiatric Unit of Nyangabgwe Hospital and the south served by Lobatse Mental Hospital which also acts as the national psychiatric referral centre. The new state of the art LMH will have 300 beds is due to open in May 2009.



Mrs. Lily Qobo, BAPR Project Coordinator

After the renovations at LMH and Jubilee Psychiatric Unit (JPU), the numbers of beds have gone up and males and females have different wards as the culture demands. Currently LMH has 180 beds (139 Male + 41 Female) and JPU has 24 Male + 12 Female beds. More males are admitted for the following reasons:

- Men are more violent than women
- More men abuse alcohol and drugs
- More men are admitted as State Presidential Detainees and on Court Orders following a guilty but insane verdict outnumbering women by a factor of 10:1
- Men are culturally socialised to be “strong” and not to cry or express their emotions but in reality they are “weaker” biologically than women. They therefore bottle up their emotions and succumb to stress by developing mental disorders.

Psychosocial rehabilitation in Botswana was developed from a base at the Lobatse Mental Hospital from 1993. On 31 October 2007 Mrs. Lily Qobo, BAPR Project Coordinator, made a Presentation on Botswana Association for Psychosocial Rehabilitation (BAPR) reproduced below:

Botswana Association for Psychosocial Rehabilitation (BAPR) is a Non-Governmental Organization (NGO) which exists to rehabilitate the mentally ill clients in the community with or without HIV/AIDS. The aim is to make them to be productive members of the community by improving their quality of life. We also want to help reduce the risk of them contracting HIV infection or help them live positively with their condition.

The objectives of BAPR are:

- To increase access to basic psychosocial rehabilitation services to the clients by training home based care providers in palliative care.
- To provide centre based psychosocial rehabilitation services to mentally ill and HIV infected clients also referred by other service providers.
- To promote on going palliative care for all our clients, and other home based care clients in the Lobatse community.

Palliative Care is a patient and family centered care which goes beyond management of infection, neurological or oncological complications that addresses the whole spectrum of the disease including discomfort, suffering, stigma and discrimination and aid in peaceful dying for the terminally ill. Quality of life involves clinical, psychological, spiritual and social or supportive care.

BAPR as an Association which started in 1993 at the Lobatse Mental Hospital. Then in 2001 for it to gain its NGO status it moved to the community. The only office staff members then were the Project Coordinator and a Volunteer. It was registered with the Registrar of Societies, as the World Association for Psychosocial Rehabilitation – Botswana on the 21st December 1993 and on the 9th September 1994 the name was changed to Botswana Association for Psychosocial Rehabilitation. Now the Association has a complementary staff of six, plus five Voluntary Lay Counsellors.

BAPR Provides the following services:

- Clinical Services – We are involved with preventive, supportive and nutritional rehabilitation.
- Psychosocial Rehabilitation – We are involved in mental health counselling, provision of information and education to both clients and primary care givers, bereavement and supportive counselling, behavioural change, encouragement, formation of support groups and occupational rehabilitation.
- Spiritual Support Care – We are involved in culturally sensitive intervention that supports the individuals and

families through faith activities, life review through assessment and counselling on hope, fears, guilt, forgiveness and meaning of life.

- Supportive Care Services – Linking clients to available care services such as adherence and treatment centres, voluntary counselling and testing, Prevention of Mother to Child Transmission (PMTCT), social services, support, food, schools, home based care and orphan care.
- We do home visits and also have a daily walk-in psychosocial counselling service.

Membership is open to all individuals or organizations in the community who share the aims of the Association and wish to participate in its pursuit. People join by filling a membership form and pay a membership fee. Voting rights are reserved for paid up members only.

BAPR members receive as benefits the satisfaction of helping the needy, being able to share knowledge with associate members, and receiving updated information on psychosocial rehabilitation matters.

The association is managed by an Executive Committee, the Project Director, and the Office Staff or Project Implementation Staff. The Association Members are free to visit the centre to offer any help, advice or expertise. The Association is governed by a constitution.

(For further information contact: Mrs. Lily Qobo, BAPR Project Coordinator. P.O. Box 1024, Lobatse Botswana. Tel: (267) 5300437) or e-mail paul.sidandi@it.bw

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BAPR Staff and offices.

1ª Jornadas Salud Mental y Trabajo Social. (Movimiento de Usuarios)

Madrid, 23 de noviembre de 2007. Conclusiones.

Reported by R. GUINEA (1) & JUAN CARLOS CASAL (2).

(1) Médico. Presidente FEARP. España. (2) Organizador Jornadas. Colectivo Orate.

Los días 16 y 23 de noviembre se celebraron las 1º Jornadas de Trabajo Social y Salud Mental. Han sido organizadas por el Colectivo Orate de alumnos de la UNED, con el patrocinio de Fundación AEQUITAS, Fundación VODAFONE y la UNED, y la colaboración, entre otras entidades, de la Comunidad de Madrid, Fundación Manantial, FEAFES, Asociación Alonso Quijano, Foro para la Vida Independiente, AMRP, FEARP y WAPR.

Adicionalmente al programa científico, se programaron reuniones de usuarios de servicios de salud mental, que continuaron la celebrada durante el 1º congreso FEARP en Madrid 2005, con el fin de desarrollar una red nacional de usuarios en España que pueda celebrar una reunión constituyente en el congreso de FEARP de Bilbao, España, en Junio de 2008.

Portavoces del colectivo organizador valoran positivamente la celebración de numerosas y valiosas actividades (jornadas, congresos) relacionadas con la Salud Mental, pero constatan hay un cierto “vacío” en el abordaje de la temática del asociacionismo de usuarios. Por este motivo, han decidido dar, a estas primeras jornadas, el título “Movimiento de Usuarios”.

Pretenden crear tejido social, que los ciudadanos sensibilizados por la problemática de enfermedad mental severa creen redes de comunicación, se firmen acuerdos entre diferentes colectivos para potenciar el asociacionismo de usuarios, dar voz a las personas afectadas por un trastorno mental severo, crear una plataforma de personas y colectivos en defensa de los derechos civiles de las personas con enfermedad, y comprometer a las asociaciones de familiares y profesionales para que se impliquen en potenciar el movimiento de usuarios. Han colaborado profesionales del derecho, de la medicina, de la psicología, del trabajo social y profesores universitarios, alumnos de la escuela de Trabajo Social de la UNED, y ciudadanos que se van sumando al proyecto según lo van conociendo.



Mesa del movimiento de usuarios con C. Lopez, J.C. Casal y L. Lopez de AAQ, A. Torras de ABM, Hector de AEMIS y A. Ferrer de ADEMM.

Tras varias reuniones de usuarios celebradas en los espacios paralelos de la Jornadas, se debatieron los puntos de partida posibles para un movimiento estatal de usuarios y se acordaron las siguientes conclusiones:

- 1.- “Consideramos enfermedad mental grave y duradera a la que cumple los criterios de diagnóstico, discapacidad y duración prolongada. Las patologías más frecuentes son: esquizofrenias, trastorno bipolar y trastorno grave de la personalidad. Suponen un deterioro cognitivo y síndrome de ejecución que conllevan dificultades de integración.
- 2.- “El movimiento de usuarios con enfermedad mental es considerado como la vía más certera y sólida para facilitar el ejercicio de los derechos fundamentales de este colectivo y luchar contra el estigma social.
- 3.- “Este movimiento debe ser democrático, proactivo, transparente, coordinado con otras entidades, independiente y debe incluir a familiares”.
- 4.- “Históricamente, España no ha mostrado una respuesta adecuada a un problema de tanto calado y los recursos actuales no son suficientes, en comparación a otros países de su entorno”.



5.- “Las políticas públicas relativas a la enfermedad mental deben coordinarse y encauzarse no sólo para la asistencia médica farmacéutica sino para la rehabilitación a través del tratamiento psicológico y la adecuación del entorno social (puesto de trabajo, prestación económica, apoyo a vivienda...)”

6.- “La relación del profesional y la persona con enfermedad mental debe ser más interactiva y de total colaboración, reconociendo la condición de éste último como conocedor de su enfermedad, y superando las relaciones de poder y autoestigma”.

7.- “El derecho al libre desarrollo de la personalidad debe ser amparado en el ejercicio de las actividades terapéuticas, promoviendo el proyecto personal del enfermo”.

8.- Ponemos de manifiesto las premisas del Movimiento de Vida Independiente: todo ser humano debe poder disponer de su propia vida y la diversidad funcional es un hecho inherente al ser humano, con lo que cada cual tiene sus propias capacidades.

9.- “Tenemos que apreciar que las personas con diversidad funcional también “crecen” con todo lo que ello implica”.

10.- “El tratamiento de la enfermedad mental requiere redes coordinadas a nivel sanitario y social así como equipos multidisciplinares que brinden apoyo a los que padecen enfermedad mental. La puerta de entrada a estos recursos deben ser los centros de salud mental”.

11.- Los poderes públicos y la sociedad civil deben generar acciones favorecedoras de la inclusión y el desarrollo personal desde el modelo social.

12.- “El 84% de las personas con enfermedad mental viven con su familia (y con frecuencia al cuidado de mujeres de una determinada edad). Su situación actual es, en muchas ocasiones, desoladora, por tanto se les debe prestar un especial cuidado y atención en el ejercicio de su actividad, por ser ésta de interés general”.

13.- “Nos congratulamos por la próxima entrada en vigor de la convención internacional sobre los derechos de las personas con discapacidad, su lectura compele a los poderes públicos a modificar no solo la normativa existente, sino también suprimir las prácticas médicas o jurídicas que sean contrarias a la propia convención”.

14.- “Valoramos positivamente las actividades que significan la comunicación de experiencias entre usuarios, trabajadores sociales con centros distintos del propio, tales como las que han tenido lugar con ocasión de estas jornadas”.

15.- “A través del deporte se pueden promover las capacidades de integración y el adecuado uso del tiempo de ocio, lo que beneficia el estado de salud general de la persona. Se trata de una actividad normalizada que ayuda a alejar el estigma. No se ha encontrado una actividad deportiva que interese mayoritariamente al género femenino”.

16.- “Las mujeres que se encuentran en situación de diversidad funcional mental, están sometidas a una doble discriminación. Faltan iniciativas destinadas a investigar su situación en casos de violencia de género, acceso a la educación, al trabajo...”

17.- “Es muy destacable el esfuerzo realizado por la Consejería de Familia y Asuntos Sociales de la Comunidad de Madrid para mejorar la Red de Servicios, sin embargo, sigue siendo necesario incrementar los recursos”.

Por último, invitamos a todas las personas que se sientan usuarios, a colaborar en la elaboración de un documento de propuestas para presentar del 2º Congreso FEARP de Bilbao en junio del 2008, en la que tendrá lugar una nueva reunión de usuarios.

Se evidenció la necesidad de potenciar el Movimiento de Usuarios del Estado Español. Los Colectivos AEMIS (extremadura), AVANTES (Cadiz), ADEMM (Cataluña), ABM y AAQ de Madrid e individuos se comprometieron a trabajar en ello, contactar con otras asociaciones y grupos, y presentar un documento de propuestas respaldado por el mayor número de personas que acudan a la reunión de BILBAO 2008.

La jornada, a juicio de organizadores, patrocinadores y asistentes, resulto un gran éxito por la nutrida asistencia, por la calidad de las aportaciones, y especialmente por el éxito de las reuniones de usuarios, que constituirán un paso significativo en la organización y crecimiento del movimiento de usuarios en España.



World Mental Health Day 2007 Ban Ki-Moon, U.N. Secretary General, calls for scaling up Resources for mental health.

New York, Oct 10 th. 2007.

More than 60 per cent of people globally who suffer from mental disorders are not receiving treatment, Secretary-General Ban Ki-moon said today, urging an increase in resources devoted to mental health care.

“We have a pressing obligation to scale up care and services for mental disorders, especially among the disadvantaged, while stepping up efforts to protect the human rights of those affected,” Mr. Ban said in his message for 2007 World Mental Health Day, observed each year on 10 October. According to the World Health Organization (WHO), most middle and low-income countries devote less than 1 per cent of their health expenditure to mental health.

The agency defines mental health as a state of well-being in which individuals can cope with the normal stresses of life, work productively and is able to contribute to the community.

Mental disorders comprise a wide range of problems with different symptoms but are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others, says WHO.

Touching on this year’s theme for the Day which focuses on the impact of culture and diversity on mental health, Mr. Ban noted that in today’s culturally interconnected world, people are competing for the same resources as they struggle to maintain their own cultures or fit into new ones.

“Dislocation from native communities, rejection by the host community and difficulties in adapting to the cultural norms of the host society are intensely stressful, and can contribute to mental illness in those who are vulnerable,” he stated. This makes it all the more important to develop “culturally competent mental health care services.”

The challenges in this regard include the fact that resources for mental health are “scarce,” Mr. Ban said, adding that the treatment gap – the proportion of those



Mr. Ban Ki-Moon, UN Secretary General.

who need but do not receive care - is more than 60 per cent.

In addition, the rate of mental disorders and the need for care is highest among disadvantaged people, who are also the groups with the lowest access to appropriate services. The fear of stigma leads many to avoid seeking care, he added.

As to how culture and diversity influence many aspects of mental health, he observed that culture not only determines what is seen as “normal” and “abnormal” within a given society, but it also affects how individuals manifest and communicate symptoms, styles of coping, family and community support and willingness to seek treatment.

To overcome these barriers, he advocated approaches that incorporate cultural backgrounds and beliefs, address language barriers and create culturally sensitive forms of dialogue, as well as incorporating cultural sensitivity in training, social policy and service provision.

For more details go to UN News Centre at www.un.org/news To listen to news and in-depth programmes from UN Radio go to: <http://radio.un.org/>

Submitted by A. Barbato.

“Recovery from psychosis: What does it mean?” Successfully celebrated the WAPR International Seminar.

Milano, December 1th.

In December 1st., the International WAPR Seminar “Recovery from psychosis: What does it mean?” was successfully arranged in Mario Negri Institute, Milano, Italy. The Seminar was a joint initiative by the World Association for Psychosocial Rehabilitation, the City of Milan, the Mario Negri Institute and the Milan Niguarda Hospital Trust. It didn't receive any commercial sponsorship.

The aim of the seminar was to highlight conceptual and practical issues related to the various meanings and definitions of recovery in reference to psychotic disorders. Six lectures addressed the following issues: The subjective experience of recovery, the epidemiological data on recovery from longitudinal studies of first-onset psychoses, the



Rene van der Male, WAPR board member representing consumers.



outcome of schizophrenia and related disorders in low income countries, the psychological aspects of recovery, the antipsychotic drug treatment and recovery, and how to organize recovery oriented mental health services. The speakers presented the standpoints of users and of researchers from various disciplines, such as psychology, psychiatry, epidemiology. A general discussion followed each lecture and a roundtable critically commented the seminar.

Different ways of understanding recovery, and its implications in the practice were discussed, over the general outlook of the current mental health and psychiatric practice. Some urgent problems raised in the debate regarding implementing a recovery oriented service was lack of resources, inadequate

service design, biased pharmacological research, or not properly attending the service users needs were examined.

The perspective of users was widely presented by Rene van der Male and Kobus Joordan, WAPR representing consumers delegates. They both gave illustrating examples on what hinders recovery in developed and wealthy countries.

A full report is expected to be published in the next issue of the Bulletin.

Reported by. R.Guinea.





1986 - 2008.

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