

World Association for Psychosocial Rehabilitation.  
Asociación Mundial de Rehabilitación Psicosocial.  
Association Mondiale pour la Réadaptation Psychosociale.

# WAPR BULLETIN



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### WAPR Bulletin.

WAPR [www.wapr.net](http://www.wapr.net) is registered as a non-profit organization in France and Italy; it is recognized as a charity in Madras (India) and Edinburgh, (Scotland, U.K), registered as a voluntary, non-profit organization in New York State (U.S.A.) WAPR has a constitution approved at Vienne in 1986, amended at Barcelona in 1989, at Montreal in 1991, and at Dublin in 1993.

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#### WAPR HEAD OFFICE.

Zografu Community Metal Heath Center. Davaki-Pindou 42. 15773 Athens. Greece. Tel/Fax.: +30 210 7481174 [madianos@nurs.uoa.gr](mailto:madianos@nurs.uoa.gr)

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Edited in Hospital de Dia Madrid. c/ Manuel Marañón, 4. 28043 Madrid (Spain). Tel. ++34 91 7596692 Fax. ++34 91 3003355; [guinea@hdmadrid.org](mailto:guinea@hdmadrid.org) [www.hdmadrid.org](http://www.hdmadrid.org)

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## Rehabilitacion Psicosocial; de los Principios a las reformas.

*Dr. Ricardo Guinea. Gerente de Programas Mil S. Coop.  
Vice-Secretario General de WAPR.. Presidente FEARP.  
[guinea@hdmadrid.org](mailto:guinea@hdmadrid.org)*

Uno de los éxitos que podremos admitir modestamente en el haber de WAPR, en su relativamente breve pero significativo recorrido desde su creación en Vienne en 1986, es haber incluido la Rehabilitación Psicosocial en la agenda científica en prácticamente todo el mundo. En efecto, hoy día, en medios científicos, no se puede hablar de programas para personas con enfermedad mental severa y sin tener en cuenta las sólidas propuestas de la WAPR, basadas en principios éticos pero también en acreditadas evidencias científicas. Por mencionar algunos, las políticas de salud pública, las estrategias de des-institucionalización, las políticas que aseguren accesibilidad a servicios comunitarios y a medicamentos de calidad, la defensa de los derechos humanos, los tratamientos orientados a la recuperación, el apoyo a las familias o la lucha contra el estigma, son componentes de políticas generalmente admitidas como virtuosas sin discusión.

Este tipo de programa puede perfectamente situarse junto a los de grandes y tradicionales instituciones como la OMS o la ONU porque, en síntesis, defiende valores similares - dignidad y respeto a los derechos de las personas-, con la particularidad, en el caso de WAPR, de prestar especial atención a los problemas específicos de las personas con trastornos psiquiátricos potencialmente mas discapacitantes.

Pero también esta claro que las transformaciones necesarias van mas allá de cambios en el vocabulario profesional, y requieren procesos de cambio muy ambiciosos. Todos quienes han trabajado en organizaciones locales conocen la cantidad de tiempo y esfuerzo que requiere cualquier proceso de reforma. Los cambios propuestos, fácilmente enunciables, pueden requerir profundas reorganizaciones, o incluso la creación de sistemas completos de servicios, en los muchos países



Dr. Ricardo Guinea. Budapest 2006.

del mundo donde todavía son una realidad los manicomios y prevalecen prácticas basadas en la hospitalización prolongada o, sencillamente, el abandono de los enfermos.

Los cambios necesarios suelen requerir importantes consensos políticos para efectuar reformas en las políticas legislativas, sanitarias, sociales y, por supuesto, también en las presupuestarias. Y el tiempo de las reformas puede medirse en décadas.

Desde luego, los cambios deben de tener en cuenta la situación concreta de cada país, su condición

económica, y sus factores culturales. Como hemos tenido ocasión de comprobar recientemente, en nuestro IX Congreso Mundial de Atenas o en la reunión WPA-WAPR de Seul, las prioridades y el camino de los procesos de reforma depende tanto de los principios generales como de factores locales, de manera que no es posible establecer las mismas prioridades concretas en África, en las Américas, en Asia o en Europa.

Si los profesionales locales cuentan con la adecuada formación, son las personas mejor situadas para conocer cuales son los cambios concretos que se deben implementar. En ese sentido, la tarea de WAPR podría describirse como la de dar el estímulo, el apoyo y, si fuera necesario, el asesoramiento adecuados para adoptar las iniciativas necesarias que hagan posibles los cambios. La existencia de organizaciones locales que impulsen las reformas suele ser un paso fundamental para ello.

En este sentido, merece la pena destacar algunas recientes iniciativas, tomadas en el seno de WAPR, que podrían potenciar la influencia de nuestros planteamientos en orden a mejorar su aplicabilidad.

En un mundo tan complejo, con multiplicación de redes y agentes sociales, la búsqueda de sinergias es una estrategia prometedora. Así, como se ha sugerido, la sinergia entre WAPR y las organizaciones locales debería ser básica. En otro nivel, la colaboración entre WAPR y OMS pueden representar otro ejemplo, como la colaboración entre WAPR y los movimientos de familiares y de usuarios. La reunión de Milán en 2005 fue una buena muestra. La fructífera colaboración entre la rama británica de WAPR y las de países de Asia como India o Pakistán, basada en afinidades culturales, puede ser otro modelo a seguir, así como la creación de la revista on-line en español "Rehabilitación Psicosocial"(1), accesible gratuitamente a través de Internet para todo el mundo hispanoparlante.

La propuesta formulada en Lahore de creación de una Federación Asiática de Salud Mental, o la creación en Atenas de la Comisión de la WAPR para el Desarrollo de la RPS en países de habla hispana, pueden ser otros elementos que potencien nuestra capacidad de influencia, para que las ideas que defendemos puedan acceder al nivel local, que es donde se toman las decisiones que pueden producir los cambios que necesitan las personas con enfermedad mental.

En un mundo global, la comunicación es un instrumento de primer orden. Los recientes cambios tecnológicos permiten simplificar y abaratar la difusión de información. El Boletín y la Web de WAPR, a pesar de su corto recorrido, contienen un gran potencial de

diseminación de información en tiempo real, con bajo coste y a escala global. El desarrollo pleno de ambos instrumentos requeriría afianzar una red regular de colaboradores en todo el mundo, que las provean de la información que no es posible reunir desde el nivel local desde donde se editan, pero podría representar una herramienta potente de intercambio de información, que es la semilla de cualquier cambio.

Son modestas iniciativas en el presente que pueden representar grandes cambios en el futuro.

#### Referencias:

- 1.- *Rehabilitación Psicosocial* se puede consultar on line en [www.doyma.es](http://www.doyma.es)

## **Psychosocial Rehabilitation: from the Principles to the Reforms.**

*Dr. Ricardo Guinea.*

*Mil S. Coop. Programs Manager.*

*FEARP President.*

*WAPR Deputy-Secretary General.*

*[guinea@hdmadrid.org](mailto:guinea@hdmadrid.org)*

We can admit, modestly, that in its short but significant history since its creation in Vienne France in 1986, the World Association for Psychosocial Rehabilitation (WAPR) has succeeded in including Psychosocial Rehabilitation in the scientific agenda, almost all around the world. Nowadays, in scientific circles, it is not possible to talk about services or programmes for those people with severe mental illnesses without a reference to WAPR's solid proposals, based upon ethical principles but also on evidence based practice.

Public mental health policies, de-institutionalization strategies, accessibility to quality services and medicines, human rights, advocacy, recovery oriented treatments, giving support to families, or fighting stigma, to mention some of them, are some of the principles defended by WAPR that are now widely accepted.

This strategy fits perfectly with some others supported by traditional and well established agencies, such as WHO or UN, because at the end, all of them are

defending similar values, such as taking in into account the dignity and the rights of the people, with a particular emphasis, in the case of WAPR, on the specific problems of people with potentially disabling psychiatric disturbances.

Nevertheless, it is also clear that the necessary transformations should go further than changing the professional vocabulary, and require very ambitious change processes. Those who have worked at local organizations know the amount of energy and time required for any reform process to succeed. The proposed changes, easily formulated, may require major processes of reorganization, or even the creation of whole service systems, in many countries where the asylums are still a reality, and long term hospitalization is still a current practice, or where the mentally ill are simply abandoned.

The necessary changes usually require important political consensus in order to introduce reforms in the laws, health and social policies, and of course, in the budgets. The time for the reforms to be established usually takes decades.

And obviously, the reforms have to take into account the current situation in each country, the economic condition and the particular cultural issues. As we have seen recently in our IX World Congress in Athens, or in the WPA-WAPR meeting in Seoul, the priorities and the path in every reform process depends as much on the general principles as on the local particularities. Thus it is not possible to establish the same priorities in Africa, in the Americas, in Asia or in Europe.

When the professionals working at the local level have the appropriate training, they are the best agents in order to know which are the particular changes needed to be implemented in their locality. In that sense, WAPR's task could be described as reinforcing, supporting and, when necessary, informing the local initiatives in order to make the changes possible and adequate. So, the existence of local organizations able to take responsibility on leading the reforms, is a fundamental step in the process.

Some recent initiatives taken by WAPR could reinforce the influence of our approach in order to improve its applicability.

In a very complex world, with multiple networks and social agents, the search for synergy is a promising strategy. Thus, it has been suggested that the synergy among WAPR and the local organizations should be a basic issue. In other levels, the collaboration between WAPR and WHO could be another example, as well as the cooperation among WAPR and the social movement

of users and families. The meeting that took place in Milan in 2005 was a very good example. The fruitful cooperation among the UK WAPR Branch and other organizations from Asia, based upon common cultural links is another good example. So is the creation of the Journal "Rehabilitacion Psicossocial", accessible for free through the Internet for all the Spanish speaking community.

The recent proposal, launched in Lahore, to create an Asian Federation for Mental Health, or the creation of the Committee for the Development of Psychosocial Rehabilitation in Spanish Speaking Countries in Athens are other elements able to increase our influence at the local level, in order to implement the necessary changes needed by those who suffer from mental illnesses.

In a Global World, communication is a basic instrument. Recent technological developments allow us to reduce the cost of the distribution of information. WAPR Bulletin and Website, despite its short existence, has a great potential to spread information in real time, at a low cost and on a global scale. The full development of both instruments would require the consolidation of a regular network of correspondents all around the world, able to provide relevant local information that is not possible to gather from the editorial team, but could represent a powerful tool for information exchange, which is necessary for any change.

In the history of WAPR, these modest initiatives at the present time could be the starting point of significant transformations in the future.

*Thanks to Dr. P. Sidandi, Regional WAPR Vicepresident for Africa, and Dr. A. Javed, WAPR Secretary General, for revising the english version of the Editorial Article.*



## Islam and Mental Health

*Dr. Afzal Javed*

*Consultant Psychiatrist & Visiting Senior Lecturer, University of Warwick  
The Medical Centre, Manor Court Avenue, Nuneaton, CV11 5HX, UK.*

E-mail: [afzal.javed@ntlworld.com](mailto:afzal.javed@ntlworld.com)

(This paper was presented at the annual meeting of WAPR Hungary Branch)

Mental Health and Mental well-being are getting a significant importance in terms of general health needs. It is becoming well recognised that for a healthy body we need a healthy mind and when we talk about Mental Health we are not only referring to the mental illnesses, but, also talking about a positive and stress free mental health. In addition to the belief that many mental illnesses are caused by “chemical imbalances” in the brain, recent research emphasize a lot to the importance to the socio-cultural factors. It is now becoming clear to most mental health professionals that mental disorders need to be defined in a holistic manner that includes the interaction of the environments and other biological factors including genetic and non-genetic predispositions.

Religion forms the basis of many cultural norms, as man’s faith in religion is as old as humankind itself. The relationship of religious beliefs and various types of sufferings dates back to the start of many civilizations across the world. The impact of religious faith has always been acknowledged as an important factor in the well being of individuals and its need to be a greater force for survival is considered as old as humankind itself. The links of religion with mental health are equally fascinating as ideas of possession and evil forces have dominated the aetiology of many mental disorders. The dual role of priest-physician in managing such conditions has also been mentioned in the literature and as a result mental illnesses have been cared and managed by the priests, shamans and religious leaders in the past.

This relationship has however been fluctuating. Until the 15th century, medicine and the priesthood worked together. This was followed by waves of

secularisation and “scientification” of medicine which led to the two professions going their separate ways. The establishment of exclusive places for the mentally ill and physical methods of treatment in psychiatry provided further gaps between these two disciplines. With the innovation and advent of scientific theories, the mysteries of mental disturbances were explained to a large extent on the basis of underlying structural and biochemical disturbances in brain. Whereas formally the mentally ill were seen by the priest as possessed by devils and spirits, their odd behaviour was subsequently explained by mental health professionals as disturbances of mind.

Although the 20th century has witnessed a significant shift of beliefs and spirituality, the interaction between religious and mental health still continued to be viewed as mutually beneficial and helpful in understanding and managing a number of psychiatric disorders. It is true that religion, its psychological aspects, and its practice all affect mental health. Similarly beliefs about mental illnesses and their treatment are closely tied to beliefs about sins and sufferings in many societies and views that mental illnesses may result from some kind of separation from the divine, or even possession by evil still prevails in many cultures. If we look at the interaction of psychiatry and religion, a number of factors appear playing an important role. Beliefs of the patient, beliefs of the mental health professionals, cultural influences and attitudes and beliefs about treatment of the mental illnesses, all have variable influences in this regard.

Islam is one of the leading religions in the world. There are over a billion Muslims in the World and with

50 Muslim nations more than 10 million Muslims are living in the western countries. Unfortunately, a lot of misconceptions about Islam and Muslims are prevalent in the western world and these perceptions are creating more conflicts & difficulties in understanding the view points of Muslims. It is a pity that Islam, as a religion, is being conceptualised in a very different way and some of the conflicts in the international scenario are being attributed wrongly to the practice of Islam.

Islam literally means submission and this applies that the Muslims are submitting themselves to God for leading and practicing a preferred way of life Islam in its true sense is not simply a religion but is also a way of life and gives a number of directions about leading life and sorting out the day-to-day problems. There are five pillars of Islam i.e., faith in oneness of Allah and prophet Muhammed being the last prophet, prayers five times a day, fasting in the month of Ramadam, Zakat (Alms) and Pilgrimage to Mecca at least once a life if one can afford it. These are the basic pillars and every Muslim has to believe and practice on these principles. In addition to the pillars of Islam the Code of Conduct to lead day-to-day life has been explained in the religion with some approvals and disapprovals. The basic philosophy of Islam is adherence to a group and acting on an improved code of attitudes and behavioural norms. Similarly, the concept of after death life is very important and an understanding of events which would otherwise be non-understandable on the basis of knowledge makes the Islamic philosophy more intact & helpful.

In terms of the community living Islam offers a vision of self realisation and self respect. Belonging to this religion and following socially conditioned approaches make it more fascinating as the positive reinforcements are mediated through the social approvals and social support and similarly positive extinction is governed by social disapproval and legal disapprovals.

Mental illnesses are also recognised as disease entities and emphasis has been made about the care and the rights of the mentally ill. Islamic doctoring has dealt with a number of psychosocial issues including marital relationships, child rearing, family care, adoption, orphanage, women's rights, love, mercy, dutifulness, justice, modesty, as well as topics that include well defined guiding principles for normal and civic duties.

In terms of religious practices clergy or priests have no mediation function between man and God. Their only function is to guide the people to the code of



Dr. Javed. Budapest, 2006.

conduct. In terms of day-to-day living quoting of right (halal) and wrong (haram) forms the basis of principles of daily life. If we look from a psychological point of view, the concept of ego and super ego along with consciousness & sub-consciousness are imbedded in such coding of life. The development of ego or self is governed by the pillars of Islam and the super ego is strengthened by the acceptance of behaviour by the social norms of the society. Similarly internalisation of socially shared religious criteria forms the basis of group ego and this is how the integration of self and society is determined in terms of healthy functioning.

The Islamic religion like many other religions has a belief system and a code of approved conduct. The Islamic code of conduct includes details of personal and inter-personal relationship and constitutes goodness and fairness that leads to rewards in the afterlife. This obedience of the basic rules of conduct by wrong doings leads to punishment in later life.

An understanding of some of the basic beliefs of Islamic religion and ritual practices may be of interest for the mental health professionals who are not following this religion. In terms of psychopathology delusions and hallucinations relating to the religious beliefs need

to be evaluated keeping with the Muslim religious background. Similarly following the rituals may need to be distinguished from obsessional acts and any inappropriate behaviour that may be falsely conceived. In terms of using the principles of religion in dealing with complex mental health issues like suicide, stress, abuse of drugs and conflict resolution there are a number of good points that can help the mental health professionals in their day-to-day practice.

Let us take the example of suicide. Islam advocates preservation of life. Suicide or harming oneself is prohibited. There have been a number of reports that confirm that suicidal acts are less common in severely Muslim depressed patients. They may be having the suicidal thoughts equal to non-Muslim patients, but, when it comes to ending life, the frequency of suicidal acts or rituals decrease significantly. The religion thus provides a shield and this is an important aspect of Islamic religion that can be used successfully in dealing with the suicidal problems and complications.

Drug abuse and intoxication is prohibited in Islam and if one explains about gambling, alcohol, intoxication and other related problems with special reference to the religion a lot of support can be extended to these growing mental health problems.

Stress, another common presentation in Mental Health, can also be managed in terms of Islamic perspectives. Stress is considered as a test of endurance and patience. It is accepted as God's will, calling for patience and then appealing to God to relieve stress. This is a very interesting concept as here there is no hopelessness, but, there is a hope and one approaches God to get guidance and help to overcome the stress. Looking from the religious perspectives, stress also elicits the support of others, limits personal responsibility towards events and is based on forgiveness and generosity.

Guilt an important psychopathology is also explained in a more favourable prognostic way in the Islamic religion. The concept is that no one is expected to do more than what could be done by an individual and one is not responsible for the sufferings or the wrongs of others. Attributing all wrongs beyond ones own control and asking for forgiveness by God's mercy helps to alleviate the guilt through the religious concepts.

Coming to anxiety and anger management, teachings of Islam assure that you are going to control

yourself at the times of being angry and irritable by thinking of God and you are exposing yourself to feared situations with a strong intent to get over it. Islam has very clearly stressed the importance of conflict resolution in all fields of life and it has been mentioned in Koran in different verses that Islam promotes and supports interpersonal conflict resolution. This is again an important approach while dealing with the day-to-day difficulties and conflicts.

Another psychological aspect of understanding and following Islamic religion is based on the role modelling. Islam supports modelling and the prophet Muhammed has been considered as the best model amongst the people. He was considered the most honest, reliable and trustworthy even before Islam and used to be called as "Muhammed the honest". Through the role modelling it is reinforced that Muslims have to follow their religious head and get guidance from his life.

In terms of interpersonal approaches Islam supports the development of mature interpersonal roles and the formation of mature group relations in the society. This helps members of the society to relate to others and co-operates with fostering care for each other. Islam does support mature group social relations through support acceptance and group identification and stresses the importance of positive and constructive behaviour not only towards one's own self but also towards others.

The status of women in Islam is considered as very important and highly respected. Their rights match with their duties & respect, love and affection are the main directions to deal with the women. They have got equal but may not be identical rights and contrary to the knowledge of many non Muslims, women do have share of inheritance and the right to be a witness in the court.

In summary Islam is a religion that brings healthy lifestyle, promotes stress free life and generates brotherhood providing better coping mechanisms. It does give a message of peace and advocates self realism and respect to others and emphasises the responsibility and duties of care for others. Islam is a religion promoting peace and never encourages violence, destruction or terrorism. This needs to be taken as a code of life that sets direction for helping people to overcome their day-to-day psychosocial problems. Looking at the current conflicts and miss conceptions about Islam, it is the need of the time that we examine Islamic religion and practices with an open mind. This will certainly need more work both at clinical and research levels.

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## Entrevista: Angelo Barbato.

*Ex-Presidente WAPR..*

*Coordinador de Proyectos de Formacion e Investigación.*

*Instituto Mario Negri. Milan. Italy.*

*Por R. Guinea. Editor del Boletin de WAPR .*

*Angelo Barbato tiene 58 años. Se doctoró en medicina en el 1972 en Palermo, terminó el curso de especialidad en psiquiatría en Milán en el 1977 y en epidemiología psiquiátrica en Paris en el 1993. Ha trabajado sin interrupción en los servicios psiquiátricos en Italia desde 1974 hasta 2006, con la excepción de dos años pasados en Australia (1988-1989). Desde 1997 hasta cuando terminó su carrera en los servicios psiquiátricos públicos, ha sido director del departamento de salud mental de Garbagnate (Milan), donde ha llevado a termino el proyecto de cierre del Hospital Psiquiátrico de la Provincia de Milán, uno de los mas antiguos y mas grandes de Italia. Este proyecto ha sido descrito y evaluado en uno de los pocos estudios disponibles donde el éxito del cierre completo de un hospital psiquiátrico ha sido objeto de investigación (Barbato et al.,2004)<sup>1</sup> En la actualidad coordina proyectos de formacion e investigación en epidemiología psiquiátrica y psiquiatría comunitaria en el Instituto Mario Negri de Milán.*

*WAPR: La WAPR fue creada en 1986. ¿Cual ha sido su influencia en estos años sobre la política sanitaria y social en el mundo?*

*A. Barbato: La WAPR es una asociación joven, pero en los últimos años su importancia ha crecido, como se ha podido ver en el congreso de Atenas. El influjo de la WAPR es considerable por su contribución a sostén de las políticas sanitarias de la OMS y su papel en los países en vía de desarrollo, en los cuales es necesario afirmar la importancia de la perspectiva comunitaria en salud mental. No tenemos que olvidar que esta perspectiva no es considerada para nada en la mayoría de los países del mundo.*

*Uno de los temas importantes que han sido puestos de relieve por WAPR ha sido el problema del estigma. Las personas con enfermedad mental deben afrontar*



Dr. Angelo Barbato.

*además de los problemas derivados de su enfermedad, los de una imagen social distorsionada y muy desfavorable. ¿Cuales son las mejores estrategias para cambiar afrontar este problema a nivel institucional?*

El estigma es un problema serio, que no es fácil de enfrentar porque está vinculado a aspectos culturales y a representaciones sociales colectivas que tienen raíces profundas. Las campañas desarrolladas en muchos países a gran escala, la mayoría basadas en la información, no han llevado a los resultados esperados. La idea que la difusión de un modelo biomédico de los trastornos mentales reduzca el estigma es infundada. Acaso podrían ser mas importantes las iniciativas locales

que favorezcan la visibilidad, el contacto directo y el conocimientos de personas con trastornos mentales. Además, aunque haya evidencias científicas de que las enfermedades mentales obtienen éxitos variables pero frecuentemente favorables, la opinión pública sigue pensando que no existe cura y que las personas que sufren de esto trastornos estén condenadas a la cronicidad. A veces hay mas posibilidad de cura para los trastornos mentales que para otras enfermedades físicas para las cuales, sin embargo, no hay el mismo estigma. Otro obstáculo en al lucha contra el estigma es constituido da el hecho que los profesionales de la salud mental muy frecuentemente tienen disposiciones que estigmatizan las personas con trastornos mentales. Desde esta perspectiva el cambio de la cultura profesional de los trabajadores, así como de la imagen y de las prácticas de los servicios de salud mental es fundamental. En esta dirección el camino es, lamentablemente, todavía muy largo.

*Usted esta trabajando en el grupo de trabajo para la "Revisión del diagnostico psiquiátrico y de los sistemas de clasificación". ¿Cuales son las líneas de trabajo de este grupo?*

El grupo de trabajo sobre la revisión de la clasificación diagnóstica en psiquiatría esta desarrollando la integración en los sistemas diagnósticos del DSM y del ICD de aspectos que van mas allá de la descripción puramente clínica, como la evaluación funcional. Además, existe la exigencia de pasar los limites de la diagnosis categorial favoreciendo una visión dimensional, mas congruente con la realidad. Todavía sobre este aspecto no hay bastante consenso al momento. En realidad no tengo muchas expectativas por lo que atañe este asunto. Los limites intrínsecos de la diagnosis clínica en psiquiatría, su característica descriptiva y parcialmente artificiosa, queda, y hay que tenerla en cuenta. La diagnosis no es y no será tampoco en el futuro un instrumento completo y concluyente para la formulación y la evaluación de un proyecto de cura y rehabilitación.

*A pesar de las tendencias integradoras en psiquiatría, todavía son visibles en muchos lugares políticas e intereses aparentemente divergentes. Un ejemplo de ello puede ser la política de la industria farmacéutica y de la psiquiatría social. Ello es visible en las áreas de interés, en sus publicaciones, en su política de investigación. ¿Cual es su visión de este problema?*

El influjo de la industria farmacéutica en psiquiatría en los últimos años ha sido muy profundo y ha coincidido con la introducción de estrategias de marketing muy agresivas y innovadoras, vinculadas a la introducción en el mercado de fármacos diferentes y mas caros para el tratamiento de los trastornos afectivos y psicóticos. El problema es que la industria farmacéutica influye de manera creciente en la investigación y la formación de los médicos. También muchas asociaciones de familiares se han vuelto dependientes, por lo menos en parte, del sostén económico de las industrias. Necesitamos que la asociaciones científicas den con decisión un fuerte empuje a una visión crítica y racional de la utilización de los fármacos en psiquiatría y impulsen las investigaciones sobre los fármacos de manera independiente de los recursos de las industrias, reservando una adecuada atención a modelos de intervenciones integradas como las intervenciones psico-sociales que tienen un papel determinante. En la actualidad este es un aspecto central de mi trabajo en calidad de investigador del Instituto Mario Negri. Tan solo de esta manera podremos alcanzar una relación equilibrada con la industria. También la investigación neurobiológica tiene que integrarse con una perspectiva social y con la valorización de la subjetividad como aspecto fundamental para enfrentar los problemas de salud mental.

*Los países en vías de desarrollo afrontan grandes problemas para establecer sistemas sanitarios públicos, y mas aun para establecer sistemas de salud mental. En algunos países de África, por ejemplo, los profesionales afrontan pandemias como la del SIDA. ¿Cual puede ser la línea de desarrollo de la salud mental en esos países?*

En países con falta de recursos hay que pensar en los problemas mas importantes y como se puede alcanzar buenas soluciones utilizando las redes sociales existentes. Además, en los países donde los servicios de salud mental no han sido todavía desarrollados, es posible que puedan pensarse servicios innovadores que implementen aspectos psico-sociales menos caros de los servicios hospitalarios y mas competitivos en eficacia. Es claro como en estos países, las intervenciones vayan proyectadas en su mayoría en la atención primaria. Desde este punto de vista, el modelo de Thornicroft y Tansella (*The mental health matrix*) es muy utilizable.

Tambien se debe decir claramente que en todos los países del mundo y, sobre todo en los a baja renta, una política sanitaria coherente tiene que excluir de manera absoluta que sean invertidos recursos en la apertura o ampliación de hospitales psiquiátricos.

*¿Desde su reciente experiencia como ex-presidente, cuales son a su juicio los principales retos que afronta la WAPR del futuro?*

En el futuro la WAPR tendrá que enfrentar múltiples retos que se sitúan a distintos niveles:

- El desarrollo de las políticas de salud mental comunitaria por la cual es fundamental mantener y ampliar el importante papel de colaboración y intercambio con la OMS que hemos reconquistado en estos últimos años después de un periodo de interrupción
- La atención hacia la investigación científica innovadora acerca de los modelos psico-sociales de comprensión de los trastornos mentales severos y acerca de las determinantes socio-ambientales de las enfermedades y de la discapacidad
- La formación continua de los trabajadores orientada a una perspectiva integrada, capaz de contrastar y pasar el reduccionismo biomédico que hace años está perjudicando la psiquiatría
- La acentuación de su presencia en áreas culturalmente diferentes, como la Asia Oriental, la África y la América Latina, cuyas experiencias tienen que ser valoradas, yendo más allá de la tradicional posición europea y norteamericana.
- La aceptación de las instancias del movimiento de los usuarios y el mantenimiento de un dialogo crítico intenso y sin ambigüedades entre usuarios, profesionales de distintas disciplinas, investigadores, administradores y representantes de los familiares sobre los temas de la rehabilitación.

Esta característica de centro permanente de debate y confrontación de ideas sin hipotecas por afiliaciones profesionales y institucionales es un bien precioso que tenemos que desarrollar.

*¿Cuales son las experiencias más exitosas de colaboración con movimientos de usuarios que usted ha conocido?*

El desarrollo del movimiento de los usuarios es el acontecimiento cultural más importante de los últimos veinte años en el campo de la salud mental. Sin duda la experiencia de colaboración con los representantes de los usuarios en el Global Forum for Community Mental Health ha sido para mí un ejemplo muy significativo. He también verificado que en algunos países como Australia, Nueva Zelanda, Inglaterra, Holanda y otros, la presencia de los usuarios en la programación, gestión y evaluación de los servicios de salud mental está alcanzando niveles considerables.

*Uno de los acontecimientos importantes de su presidencia fue el congreso de Milán, en el que participaron cientos de usuarios de Italia ¿Como surgió la idea y como se pudo organizar el evento?*

La idea de organizar el congreso de Milán ha nacido de mi reflexión sobre el hecho que en los congresos y seminarios de las asociaciones científicas y profesionales las intervenciones de usuarios eran poco frecuentes y restringidas a una función de testimonio, por lo tanto tenían un papel muy limitado que no permitía un verdadero debate. Partiendo de esta consideración el paso sucesivo ha sido la organización de un congreso en el cual representantes de usuarios provenientes de todas las partes del mundo pudieran presentar, de manera cualitativamente y cuantitativamente considerable, sus posiciones sobre temas importantes y discutidos, implicando también un nivel científico y relacionándose con clínicos, investigadores y representantes de las familias en un nivel de equiparación. Esta idea ha encontrado el entusiasmo y sostén de Benedetto Saraceno director del departamento de salud mental del OMS y la apasionada adhesión de la WAPR Italiana. Así ha nacido un acontecimiento que no tenía precedentes en la historia de las asociaciones en campo psiquiátrico y que ha marcado un momento decisivo en el debate entre usuarios, mundo científico y profesional. Esta experiencia ha sucesivamente inspirado la iniciativa de la OMS de incluir los usuarios en el Global Forum for Community Mental Health, y por esto no es casual que la WAPR ha sido llamada como miembro fundador.

*¿Cual es la línea de trabajo del Global Forum for Community Mental Health, con la que colabora?*

El Global Forum for Community Mental Health es una red de líderes de los servicios de salud mental, de usuarios y familiares implicados en los servicios, de organizaciones y expertos representativos, establecida con la ayuda y el sostén de la Organización Mundial de la Salud para promover y diseminar en todo el mundo, y especialmente en los países a baja renta, los principios y las prácticas de la salud mental comunitaria. La WAPR es miembro fundador del Forum, que ha sido presentado oficialmente el año pasado en el Congreso Mundial de la WAPR en Atenas. El Forum ha tenido su primer encuentro el 30-31 Mayo 2007 en Ginebra, en la sede de la Organización Mundial de la Salud. Ha sido la primera vez que grupos de usuarios fueron invitados en una reunión oficial por la OMS para contribuir al debate sobre los problemas de la salud mental. Para información

completa sobre el Forum se puede visitar el sitio web [www.gfcmh.com/](http://www.gfcmh.com/)

Los objetivos del Forum son los siguientes:

- Proveer una red de sostén para todos los interesados a promover servicios comunitarios de salud mental para personas con trastornos mentales severos, incluyendo la implicación de usuarios y de los grupos de *advocacy*.
- Compartir experiencias avanzadas de nivel regional y nacional realizadas por los servicios comunitarios de salud mental y de estas derivar algunas lecciones
- Identificar las barreras y discutir las maneras para pasarlas, fortaleciendo los servicios de salud mental en los países a baja y media renta.

*Muchas gracias y enhorabuena por su trabajo.*

*Ricardo Guinea. WAPR Editor for WAPR Bulletin*

Notas:

1. Barbato, A.; B. D'Avanzo, G. Rocca, A. Amatulli, D. Lampugnani A study of long stay patients resettled in the community after closure of a psychiatric hospital in Italy, *Psychiatric Services*, 55 (1): 67-70, 2004.

## **STIGMA ! Overcome discriminations in mental health.**

Third International Meeting of the Lille  
WHOCC  
12th- 15th., 2007.

The World Health Organization Collaborating  
Centre for research and training in mental health.  
(WHOCC, Lille, France)

How to tackle stigma and discrimination in Mental Health ? To answer this question the WHOCC Third International Meeting will present the latest research on stigma in Mental Health, innovative experiences of integrated mental health care organisations and actions in Community Mental Health.

Mediterranean University Centre  
65 Promenade des Anglais  
06000 Nice June  
[www.epsm-Lille-metropole.fr](http://www.epsm-Lille-metropole.fr)

During the WHOCC Third International Meeting, the stress will be put on concrete actions of the fight against stigma and discrimination. Three stages will be developed during these days : stigma, discrimination and actions.

**STIGMA:** knowledge statement on stigmatization in the mental health field. The survey "mental health in the general population: perceptions and realities" carried out by the WHOCC (Lille, France) in several countries describes the stigmatization of people having psychiatric disorders, in various cultures. It was recently carried out in the towns of Nanterre and Trieste (Italy). On the basis of this survey and those of other studies, a picture of stigmatization will be developed by sociologists, philosophers, psychiatrists, psychologists and anthropologists.

**DISCRIMINATION:** new practices in psychiatric care to fight against discrimination of people with psychiatric disorders. The prejudices linked to psychiatry and mental health will only change if the care practices themselves evolve. Everywhere in Europe, innovative answers to mental health problems are being developed. It acts to avoid exclusion, to work in partnership and to intervene closely with the person's needs, in and with the daily environment : intensive care in residence, mobile teams, social rehabilitation and integration, co-operation with users' associations and "peer support", networking with general practitioners and municipalities. An international network was created to gather and develop these experiments which will be presented during the meeting.

**ACTIONS:** efficient actions to counter prejudices

A European tour of actions developed to change the perception related to mental health disorders : communication and information campaign, ethical charters for the media, partnership with journalists.

Lastly, the Congress will end with a call for the creation of Stigma Watch Committees against stigmatization and discrimination in the Mental Health Field.



## **CHANGE: A User- Led Mental Health Service.**

Mervyn Morris, Change Chief Executive.  
Matt Brayshaw, Crisis House Worker.

CHANGE – ‘CHOice AlterNatives for Growth Experience’ – is a small but landmark charity based in Birmingham, England. It was founded specifically to provide a crisis house service for people who were referred to local ‘Psychiatric Emergency Teams’ teams, now called ‘Crisis Resolution/ Home Treatment (CRHT) teams.

CRHT teams had been developed by Northern Birmingham Mental Health Trust (NBMHT), the local National Health Service (NHS) service provider, during the early 1990’s, to provide an alternative to hospitalisation. These teams offered a 24 hour emergency referral service in the community, with the capacity to provide support and treatment at home as an alternative to hospital (Minghella et al, 1998). Change was created as a charitable organisation (NGO) to provide an additional option; a place independent of psychiatric services for people to go to in crisis, where hospital was not necessary but staying at home was not helpful.

CHANGE was set up and supported by a group of local professionals and people who identified themselves as ‘survivors’. It is most notable for developing a service that was ‘user led’, employing people whose ‘qualifications’ for the work came from their own ‘lived experience’ of crisis and distress, often also with experience of psychiatric services.

The first house, ‘Skallagrigg’, was opened in Aston, Birmingham in December 1997, managed by a person with ‘lived experience’. The crisis house was originally a two-bedroomed house adjacent to a local mental health centre, but moved into a rented private house in a residential area with facilities for up to six residents.

Change later obtained additional funding from the local mental health service provider (NBMHT) to open a second house that was for women only (the first house was for both men and women).

The ‘acceptance criteria’ for the houses were partly determined by insurance policy requirements; people with a history of arson, suicide attempts (not simply self-harm) and violence were not covered. In addition the service was not routinely offered to people who were homeless, unless there were guarantees regarding accommodation after the crisis had resolved.

The relationship with the CRHT team was crucial to the crisis houses working. All new referrals were received from the CRHT teams, who would routinely assess people for the acceptance criteria, and positively but appropriately consider the crisis house as an option. The teams would continue to visit residents during their stay, and work together with Change to help people return home.

CHANGE based its work with residents on ideas and strategies that developed from personal experience, the area of literature broadly associated with the ‘survivor’ movement, using a ‘recovery’ based philosophy. In practice this meant focusing on wellness and developing a strengths based approach, with strategies to help people manage emotional distress, including relaxation techniques, and also the use of ‘alternative’ methods such as Reiki and use of essences.

The environment of the houses was also very striking, using furniture, lighting, artwork, as well as colour and textures that not only provided a very different experience

to a hospital, but also provided a calming, warm and emotionally positive atmosphere.

The houses developed their own methods of assessment and planning, partly to reflect funding and insurance related requirements, but mainly to promote a structured way of working with people. The tools used were based upon a person-centre planning approach, where 'recovery guides' (the preferred job title of staff working in the houses) facilitated people identifying personal strengths and goals. Residents were given the option of keeping all personal documentation, to which they could add to or change as they wished.

All staff undertook an induction training programme when starting work with CHANGE, with on-going training thereafter, with regular team and individual supervision from an experienced external facilitator.

The emphasis of the crisis house is community rather than therapy, with sharing of daily life; cooking, cleaning, shopping and gardening were shared and not the preserve of the 'staff'. Family and friends, supporters and carers were also welcomed to be involved, so that support and risk planning was a collaborative exercise.

The crisis house work was documented in a report (Mental Health Foundation, 2002) on innovative crisis services, discussing both difficulties and achievements, as identified through project evaluation.

The report demonstrates:

*'the value of these types of services in helping to meet the needs of people in crisis and the unique, but complementary role they play.. [it] also show[s] the benefits of user-led services..., which also ensure good working relationships with mainstream services.'* (Mental Health Foundation, 2002)

The work of CHANGE has further developed in a number of ways. As CHANGE established a presence within local mental health services, the reputation of the house spread amongst service users and an increasing number of people would request access. As CHANGE was not funded for 'outreach' or 'aftercare', so it developed an open door policy for ex-residents who wanted to keep in touch with staff and other residents.



Mervyn Morris and Matt Brayshaw.

In collaboration with the local mental health service provider (NBMHT) CHANGE also managed a 'Family Sponsor Home' project where, for a small payment, members of the local community offered spare rooms in their domestic home for people in crisis.

Whilst CHANGE as a service provider has always remained a local organisation, once the crisis houses had become established it developed a wider involvement in education and service development. Initially it worked with local Universities to provide teaching on professional programmes, including developing a post-professional qualification course on 'recovery' that was designed, delivered and assessed by service users.

CHANGE also created the 'Changing Futures' project, a 3 year National Health Service (Department of Health) funded training programmes for professional mental health workers, and required working with other user and health service organisations across England. The project networked and supported service users who wanted to use their experience for the benefit of other users and professionals. In particular the project created a volunteer group who extended changes links with local



A CHANGE house.

community groups and organisations, leading to running recovery based mental health training for people without experience of mental health services. Examples of the work of this project and stories from the crisis house can be found on CHANGE's website: [www.change123.ik.com](http://www.change123.ik.com)

CHANGE has also become actively involved in European Union Leonardo funded projects. The first project focussed on developing a modular European curriculum for community based mental health nursing. Change's contribution was to develop a specific component of the training delivered by people with expertise derived from personal experience. This inspired a second European Union funded project, 'Experienced Involvement' bringing together service users from six countries who are currently developing a curriculum to train service users as mental health workers and educators (Utschakowski and Morris, 2007)

Despite its many successes, CHANGE is also a demonstration of the fragility of small charitable organisations. Funding has not been secure enough to ensure long-term strategic development. The charity continuously struggles to maintain salaries and employment conditions comparable with the public sector, a core objective for the trustees of the charity.

Health service reorganisation led to change of local mental health service management with different priorities, and has led to the withdrawal of all funding for the crisis houses. Whilst funding has also become available from other sources, without the commitment

and involvement of the local NHS organisation, this type of crisis service is not viable, so that at present the houses are closed.

CHANGE has played a significant role both as a local service provider and as a model for developing involving people whose expertise derives from personal experience and use of services. It provides a working example of what can be achieved in drawing on the resources of people with 'lived experience', of collaboration between professionals and service users and between government and non-government organisations.

Mervyn Morris is the unsalaried Chairman/Chief Executive of CHANGE. He is also Professor of Community Mental Health at the University of Central England, and Professor II at Buskerud University College, Drammen in Norway.

Matt Brayshaw started to volunteer at the CHANGE charity at the suggestion of one of his mental health workers whilst receiving services in Birmingham. He went on to work at the Crisis Houses and as a trainer for the 'Changing Futures' project. He currently works for a project called User Voice, a service user participation project funded by Birmingham and Solihull Mental Health Trust.

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Mental Health Foundation (2002) Being There in a Crisis; A report of the learning from eight mental health crisis services. London: Sainsbury Centre for Mental Health. ISBN1 90 3645 26 3

Utschakowski, J., & Morris, M. (2007) Involvement of Experienced People in Mental Health. WAPR Bulletin, vol 19, Jan., pp 14-17.

We would like to acknowledge the contribution to Change of Alison Reeves, Helen Glover and Marion Aslan.

## Seoul KAPR Meeting and WAPR Board meeting.

*Seoul, Korea. April 19th-20th. 2007.*

*Reported by A. Javed & R. Guinea.*



Under the excellent organization of the Korean Association for Psychosocial Rehabilitation (KARP), the WPA-WAPR meeting was successfully celebrated in Seoul.

Under the excellent organization of Tae-Yeon Hwang, Scientific Organizer of WAPR Regional Meeting in Seoul, a very attractive programme, and the participation of relevant professionals from more than 25 countries, from all around the world (including Korea, Japan, India, Pakistan, Australia, Malaysia, Philippines, Brazil, USA, Spain, Italy, Greece, China), was successfully developed, and included papers dealing with very crucial issues in the field of Psychosocial Rehabilitation.

“How to organize a rehabilitation service with minimum resources”, by M. Madianos, and “De Facto Psychosocial Rehabilitation in Korea”, by Maeng Je Cho, President of KAPR (Korea) were the issues dealt in the opening lecture.

Other relevant papers were presented by N. Sartorius (Swiss), A. Barbato (Italy), Young Moon Lee (Korea), MP Deva (Malaysia), Chih-Yuan Lin (Taiwan), R.P. Lieberman (USA), Tsuyoshi Akiyama (Japan), A. Javed (UK), Yong-Jin Seo (Korea), M. Gittleman (USA), Soo Yang (Korea), P. Ruiz (USA), Soo Jin Kim (Korea),

S. Ito (Japan), Sung Man Shin (Korea), L. Ignacio (Philippines), M. Jorge (Brazil), M. Chiu (Hong Kong), dealing with many different issues, such as migration, adolescents, low income, mental health in developing countries, deinstitutionalization, community reintegration, crisis intervention, stigma, family interventions, etc.

An extent report is expected to be offered in the next release of WAPR Bulletin.

In the Board meeting, M. Madianos received the board's congratulation for the success of the IX World Congress, celebrated in Athens.

Regarding the next world congress, Dr. Tyloth Muraly from India, offered a very detailed proposal, to be celebrated in Bangalore, India, in 2009.

The project was carefully discussed and finally, was approved.

Dr. Guinea from Spain submitted the proposition of celebrating a European Regional meeting in Bilbao (Spain) in June 5th.-7th 2008, that was also accepted.



M. Gittleman, R. Guinea, T. Muraly, A. Barbato, M. Madianos, A. Javed and L. Ignacio, after the WAPR Seoul Board meeting.

## UK Branch meetings.

28<sup>th</sup> April, 2007. Preston. UK

WAPR UK branch organised its annual meeting on 28<sup>th</sup> April at Preston. Like the previous meetings this was again a well attended activity and brought a lot of praise and acknowledgements to the local branch and especially to Dr. Quraishi, president WAPR UK branch..

Prof. Edvard Hauff, European Regional Vice president was the guest speaker from WAPR and the meeting was also addressed by Dr. Afzal Javed Secretary General WAPR, Prof. Sue Bailey, Registrar, Royal College of Psychiatrists, UK, Prof. Max Marshall, University of Manchester, Dr. JS Bamarah, CPD Coordinator Royal College of Psychiatrists, Caroline Johnson, Nurse Therapist Lancashire Mental Health Region & Dr. Peter Haddad Consultant Psychiatrist from Salford.



Dr. Hauff, Dr. Qurishi and Dr. Javed.



## Midlands Psychiatry Research Group

14th.16th. June.  
International Seminar on Psychiatry.  
Hollyday Inn Hotel. Jn 4 Motorway 6.  
Coventry. UK.

Organised by Midlands Psychiatric Research Group  
*In collaboration with* World Psychiatric Association (WPA)'s Section on Psychiatry in Developing Countries of & World Association for Psychosocial Rehabilitation (WAPR)

For details of the programme, registration and confirmation  
about your participation, please contact

Dr. A. Javed [afzal.javed@ntlworld.com](mailto:afzal.javed@ntlworld.com) ; Prof. M. Mohan: [mohan@blueyonder.co.uk](mailto:mohan@blueyonder.co.uk)

## **WAPR Collaborates with WPA Section for Lahore meeting.**

*Reported by Dr. Afzal Javed.  
WAPR Secretary General.*

WAPR collaborated with WPA's Section on Psychiatry in Developing Countries for its first international meeting (from February 15-19th 2007) held in Lahore, Pakistan that attracted the key players in the field of mental health from all over the world. The conference was organized by WPA Section on Psychiatry in Developing Countries and South Asian Forum on Mental Health and Psychiatry in collaboration with BIA and Asian Division of Royal College of Psychiatrists, Asian Federation of Psychiatric Association, World Association of Psychosocial Rehabilitation, World Federation of Mental Health and Pakistan Psychiatric Society.

This rare academic activity in a country like Pakistan was attended by over two hundred foreign delegates from twenty two countries. Yet another important feature was the presence of Presidents of seventeen professional specialty organizations in the field of mental health including President World Psychiatric Association Prof. Juan Mezzich, President of American Psychiatric Association Prof. Pedro Ruiz, Prof. Sheila Hollins President of Royal College of Psychiatrists UK, Prof. Shona Sturgeon President World Federation of Mental Health, Prof. Nalaka Mendis President South Asian Forum on Mental Health and Psychiatry, Prof. Hamid Ghodse Director



Drs. Ruiz, Shona, Naotaka, Deva, Madianos, Javed and other delegates in Lahore.

Board of International Affairs Royal College of Psychiatrists, Prof. Pichet Udomratn President ASEAN Federation of Psychiatry and Mental Health, Dr. I. R.S. Reddy National President Indian Psychiatric Society, Dr. Sunil Mittal President of Indian Private Psychiatric Association, Dr. M. P. Deva Founder Patron of Asian Federation of Psychiatric Associations Dr. Russell De'Souza WPASPDC & SAFI besides many others.

It was a unique gathering of mental healthcare professionals who came from Afghanistan, Australia, Bangladesh, Canada, Greece, Egypt, Hong Kong, Japan, Taiwan, Korea, a strong delegation of over sixty psychiatrists from India who actively participated and richly contributed to the scientific programme, Iran, Iraq, Indonesia, Japan, Kenya, Korea, Kuwait, Myanmar, Malaysia, Nepal, Oman, Philippines, Sri Lanka, South Africa, Taiwan, UAE, UK and United States of America. Since it is difficult to check brain drain of professionals from the developing, low resources countries, the organizers working on the concept of brain circulation and cross fertilization arranged this academic activity bringing the experts back to their countries of origin to contribute whatever they can to the development of mental health care and psychiatry. The conference provided a rare opportunity to the participants for networking, socialization and initiation of joint collaborative research projects in various fields.

Prof. M.P. Deva, chairman of the Section and who has contributed a lot in the development of mental health care in Asia was Chairman of the organizing committee. While Dr. Afzal Javed as the Secretary of the Section and Secretary General WAPR was responsible for the overall organization of this meeting with Prof. Haroon Rashid Chaudhry as the organizing secretary of the conference who did a commendable job. The scientific committee, lead by Prof. R. N. Mohan, had intentionally changed the format of the scientific programme, there were a few paper presentations but major emphasis was on interactive workshops, state of the art presentations in different fields of mental health, psychosocial rehabilitation and providing an opportunity to the young talented psychiatrists from different countries in this region to have joint collaborative research projects in different fields through networking between the psychiatrists in the region as well as in the developed world.

The main objectives of organizing this international event in Pakistan was to provide an

opportunity to many of our young psychiatrists as well as postgraduates from the developing countries to have an interaction with world leaders in the field of mental health as many of them cannot afford to attend international conferences overseas. This is no doubt a milestone in the field of mental health and psychiatry in Asia. The topics which came under discussion during the deliberations included Bipolar Psychiatry, Mental Health Legislation in developing countries: problems and their solutions, Psychosocial Rehabilitation, Children's Mental Health, Needs and Priorities in mental health services for developing countries, Psychiatry around the Globe, Needs and priorities in mental health training for developing countries, Psychiatry in Pakistan. Plenary sessions were devoted to WPA and APA, Royal College of Psychiatrists UK, WAPR for Rehabilitation Psychiatry in developing countries. In addition special sessions were devoted to issues in women's mental health, Psychiatry and other disciplines. However, the most important highlight of the conference was a series of Workshops organized at Aiwane-Iqbal the main venue of the conference, Fountain House, Services Institute of Medical Sciences and a Rehabilitation Centre in Johar Town running under the supervision of Prof. Khalida Tareen. The topics covered in these workshops included Psychosocial Rehabilitation, Total Awareness Therapy in neurosis especially depression, Spirituality and Well being by Prof Russell D'Souza. Other areas included alternative to Medical Mental Health Model, Media and Psychiatry and Leadership Management and Organizational Psychiatry, How to publish paper in a cited Journal, Leadership, Management and Organizational well being, Child Psychiatry besides a special workshop on Examination techniques OSCE.

It was decided to formally launch Asian Federation of Psychiatric Associations and Asian Journal of Psychiatry. Besides plenary sessions, three parallel sessions were held throughout the conference. Inaugural dinner was preceded by a lecture by Prof. Sheehan from United States who talked about Management of Depression and Anxiety. A special session of Royal College of Psychiatrists, Regional chapter meeting of Royal College of Psychiatrists, business meeting of South Asian Forum on Mental Health and Psychiatry, special debate on Lessons from Partition in the sub-continent: Making sense of history held on the concluding day of the conference at Fountain House were some other highlights of the conference.

WAPR's sessions and workshop provided the young psychiatrists an overview of our organization. It is

worth mentioning that Lahore meeting was attended by a number of central office bearers of WAPR who participated in the scientific deliberations of this meeting.

*Reported by A. Javed.*

## **WAPR – PHILIPPINES HOLDS 7<sup>TH</sup> NATIONAL CONFERENCE ON PSYCHOSOCIAL REHABILITATION**

**by Rhodora Andrea M. Concepcion, M.D.**

The World Association for Psychosocial Rehabilitation- Philippines (WAPR- Phils.) held its 7<sup>th</sup> National Conference on Psychosocial Rehabilitation on November 28-29, 2006 at the Hyatt Regency Manila and culminating with its 8<sup>th</sup> Mini-Olympics on November 30, 2006.

This year's theme was "Integrating Psychosocial Care: Keeping in Step with the Challenges of the Times". Psychosocial Care and Rehabilitation for children and adults were given focus through topics that tackled about children victims of abuse, domestic violence and disaster. Along with other mental health and psychosocial concerns were also topics on social and economic burden

of depression; depression among the chronic medically ill; the challenges and opportunities for psychosocial rehabilitation programs in surviving disasters; the development of a mental health clinic and family support group in Infanta, Quezon and the introduction to telepsychiatry as a tool in sustaining the management of psychosocial care in the community.

Also highlighting the event was the presence of WAPR President from Athens, Greece, Dr. Michael G. Madianos. This year's conference also cited Dr. Lourdes L. Ignacio WAPR-Philippines on her election as President-Elect of WAPR for the year 2006-2009 during the WAPR IX World Congress in Athens, Greece held on October 12-15, 2006.



WAPR-Philippines 7<sup>th</sup> National Conference held at the Hyatt Regency Manila on November 28-29, 2006. With Dr. Michael G. Madianos are Dr. Lourdes L. Ignacio, President-Elect for WAPR-Global for the years 2006-2009, and other speakers, board members and organizers of the 7<sup>th</sup> WAPR-Philippines Conference. (Photo by Rhodora Andrea M. Concepcion, M.D.)



*First announcement.*

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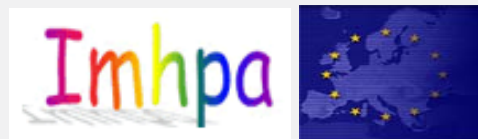
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**WORLD ASSOCIATION FOR PSYCHOSOCIAL REHABILITATION -ASSOCIATION MONDIALE POUR LA RÉADAPTION PSYCHOSOCIALE -ASOCIACIÓN MUNDIAL PARA LA REHABILITACIÓN PSICOSOCIAL**

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**President:**

Michael Madianos  
Zografou Comm Ment. Health  
C.  
Davaki-Pindou 42  
15773 Athens Greece  
[madianos@nurs.uoa.gr](mailto:madianos@nurs.uoa.gr)

**President-Elect**

Lourdes Ladrado-Ignacio  
Manila Philippines  
[ignacio@ibahn.net](mailto:ignacio@ibahn.net)

**Secretary-General**

Afzal Javed  
Nuneaton. United Kingdom  
[afzal.javed@ntlworld.com](mailto:afzal.javed@ntlworld.com)

**Immediate Past-President**

Angelo Barbato  
Milano Italy  
[dirba@tin.it](mailto:dirba@tin.it),  
[barbato@marionegri.it](mailto:barbato@marionegri.it)

**Past Presidents**

Zebulon Taintor  
New York USA  
[taintz01@med.nyu.edu](mailto:taintz01@med.nyu.edu),  
[taintor@nki.rfmh.org](mailto:taintor@nki.rfmh.org)

Jacques Dubuis  
Cedex France  
[jacques.dubuis@ch-le-vinatier.fr](mailto:jacques.dubuis@ch-le-vinatier.fr),  
[jacques.dubuis@wanadoo.fr](mailto:jacques.dubuis@wanadoo.fr)

M. Parameshvara Deva  
Ipoh Malaysia  
[devaparameshvara@hotmail.com](mailto:devaparameshvara@hotmail.com)

Benedetto Saraceno  
World Health Organization  
Geneva Switzerland  
[saraceno@who.int](mailto:saraceno@who.int)

Martin Gittelma  
New York, USA  
[gittem01@med.nyu.edu](mailto:gittem01@med.nyu.edu)

Gaston Harnois.  
Montréal, Québec  
Canada  
[hargas@douglas.mcgill.edu](mailto:hargas@douglas.mcgill.edu)

Oliver Wilson.  
Scotland, United Kingdom  
[o.wilson@virgin.net](mailto:o.wilson@virgin.net)

**Vice Presidents**

Ida Kosza  
Hungary  
[kosza@mail.datanet.hu](mailto:kosza@mail.datanet.hu)

Marianne Farkas  
Boston. USA.  
[mfarkas@bu.edu](mailto:mfarkas@bu.edu)

**Representing Families**

Ernesto Muggia.  
Milano. Italy.  
[ernestomuggia@tin.it](mailto:ernestomuggia@tin.it)

**Representing Consumers**

René Van der Male  
Utrecht The Netherlands  
[r.van.der.male@utrech.nl](mailto:r.van.der.male@utrech.nl)

Kobus Jordaan  
South Africa

**Representing Voluntary Organisations**

Geraldine Marshall  
British Columbia  
Canada  
[gmarshall@lynx.bc.ca](mailto:gmarshall@lynx.bc.ca)

**Liaison to UN and Its Agencies**

Humberto Martinez.  
New York, USA  
[Dr44hlm@pol.net](mailto:Dr44hlm@pol.net)

**Treasurer**

Stelios Stylianidis  
Athens. Greece  
[epapsy@otenet.gr](mailto:epapsy@otenet.gr)

**Deputy Secretary-General**

Ricardo Guinea  
Madrid, Spain  
[guinea@hdmadrid.org](mailto:guinea@hdmadrid.org),

**Regional Vice-Presidents and Deputies**

**AFRICA**  
Paul Sidandi,  
Lobatse Botswana  
[paul.sidandi@it.bw](mailto:paul.sidandi@it.bw)

Leana Uys,  
Durban South Africa  
[uys@nu.ac.za](mailto:uys@nu.ac.za)

Arouna Ouédraogo  
CHU Yalgado Ouédraogo  
Ouagadougou Burkina Faso  
[arounaouedraogo@univ-ouaga.bf](mailto:arounaouedraogo@univ-ouaga.bf)

**AMERICAS**

Roger Montenegro.  
Argentina.  
[rmontenegro@wpanet.org](mailto:rmontenegro@wpanet.org)

Lorraine Barnaby  
Kingston Jamaica  
[teneight8@aol.com](mailto:teneight8@aol.com)

**EASTERN MEDITERRANEAN**

Haroon Rashid Chaudhry.  
Lahore Pakistan  
[prrc@wol.net.pk](mailto:prrc@wol.net.pk)

Ibrahim Murad  
Jerusalem. Israel.  
[jamalmurad@hotmail.com](mailto:jamalmurad@hotmail.com)

**EUROPE**

Edvard Hauff.  
Oslo Norway  
[edvard.hauff@medisin.uio.no](mailto:edvard.hauff@medisin.uio.no)

Antonio Maone  
Roma Italy  
[maone@tin.it](mailto:maone@tin.it)

Marc Habib.  
France.

**SOUTH-EAST ASIA**

Thyloth Murali.  
Bangalore, India  
[mut47@nimhans.kar.nic.in](mailto:mut47@nimhans.kar.nic.in),  
[reva\\_th9@rediffmail.com](mailto:reva_th9@rediffmail.com)

Nalaka Mendis,  
Columbo ; Sri Lanka  
[nalaka@sri.lanka.net](mailto:nalaka@sri.lanka.net)

**WESTERN PACIFIC**

M. Parameshvara Deva  
Ipoh Malaysia  
[devaparameshvara@hotmail.com](mailto:devaparameshvara@hotmail.com)

Tae-Yeon Huang.  
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**Members at Large**

Naotaka Shinfuku  
Fukuoka, Japan.  
[shinfuku@seinan-gu.ac.jp](mailto:shinfuku@seinan-gu.ac.jp)

Maria Economu.  
Greece.

Dale Johnson.  
Houston. USA.  
[DLJOHNSON@uh.edu](mailto:DLJOHNSON@uh.edu)

Anjum Bashir.  
Essex. UK  
[anjumDR@aol.com](mailto:anjumDR@aol.com)

Yair Carlos Bar-El  
Har Adar, Israel  
[barel4@bezeqint.net](mailto:barel4@bezeqint.net)

Gregory C. Bunt  
New York, USA  
[gbunt@daytop.org](mailto:gbunt@daytop.org)

Anna Meneghelli  
Milano, Italy  
[annameneghelli@tiscali.it](mailto:annameneghelli@tiscali.it)

Bernard Jacob  
Vottem Belgium  
[bernard.jacob@aigs.be](mailto:bernard.jacob@aigs.be)

Gabriele Rocca  
Milano Italy  
[garocca@libero.it](mailto:garocca@libero.it)

Michael Sadre Chirazi-Stark  
Asklepios Westklinikum  
Hamburg, Germany  
[m.stark@asklepios.com](mailto:m.stark@asklepios.com)

John Talbott  
Baltimore, USA  
[jtalbott@psych.umaryland.edu](mailto:jtalbott@psych.umaryland.edu)

José Uriarte  
Vizcaya. Spain  
[juriarte@hzam.osakidetza.net](mailto:juriarte@hzam.osakidetza.net)

Marit Borg  
Drammen; Norway.  
[maritbor@online.no](mailto:maritbor@online.no)