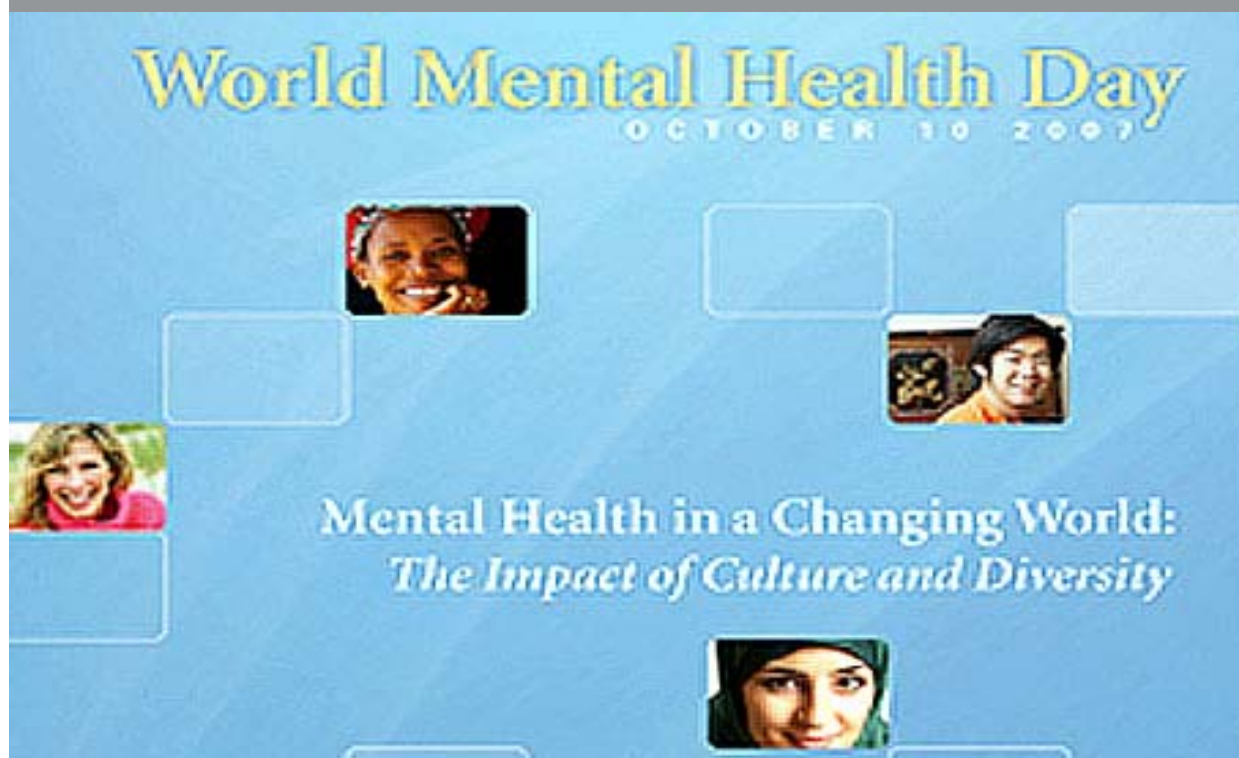


World Association for Psychosocial Rehabilitation.  
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Association Mondiale pour la Réadaptation Psychosociale.

# WAPR BULLETIN



October, 10th. 2007. Mental Health Day.

***“2007 Mental Health in a  
Changing World: The Impact of  
Culture and Diversity”***

Volume 21, sept. 2007.

*www.wapr.info*

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### WAPR Bulletin.

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## Mental health in developing countries: *some emerging priorities in Asia.*

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Issues relating to mental health and mental well being are assuming a paramount importance in the practice of health services in almost all countries. But despite the current awareness, growing emphasis on mental health as an integral component of general health & publication of high-profile reports and promising activities in several countries, progress in the development of mental health delivery and service development still remains slow and not very visible. This is particularly true for most of the low income countries.

Asia, as one of the biggest and most populous continent, is not an exception to these findings. More than half (3 billion) of the total world population (6 billion) live in Asia but mental health resources both in manpower and facilities are extremely scarce and mal-distributed in different Asian countries. With such a big population and huge geographical area & being host of diverse civilisations, Asian countries vary extensively in their mental health policies and differ in their practices at all levels of care. It is, for example, estimated that there are only 35,000 psychiatrists for 3 billion people who have to take a lead responsibility in the mental health system. In this region, one can see the most developed countries of the world with a wealth of resources but at the same time we can find a number of underdeveloped or developing (low income or middle income) countries where most of the people struggle even for survival and availability of very basic health and social needs.

WHO's Atlas (2005) provides a general overview about the extent of these problems. For example in South Asian, mental health policies only cover 24% of the population. Community care is available to 50% and median number of psychiatric beds per 10 000 population is 0.33% in this region. Similarly number of psychiatrists



Dr. Afzal Javed is WAPR Secretary General

available are 0.20 per 100 000 population, psychologists working in mental health are 0.03 per 100 000, social workers are 0.04 per 100 000 population and as compared to many other regions of the world less people have access to psychiatric nurses. Commenting on the comparison of data between 2001 & 2004, the authors of this publication concluded that despite efforts in increasing the emphasis on changing mental health services, improvement in the availability of mental health within different countries stays as very small and marked differences between high and low income countries are still observed as a norm rather than exception.

Recent findings from a WHO study highlight some of the barriers in the development of mental health in low income countries. These include low priority of mental health in the public health systems, limited number of mental health professionals, the complexity of & the resistance to decentralisation of mental health services, lack of interest in mental health policies and challenges to its implementation, scarcity of public health perspectives of mental health particularly in primary care settings and lack of public health skills and experiences among the mental health leaders. In terms of Asian perspectives, these issues are equally relevant and do pose major obstacles in policies and the practice of mental health in this region as well.

Although the above mentioned factors are important and need serious considerations while discussing the future of mental health services in developing countries in Asia, two issues require urgent considerations as less attention has been given to these aspects in many of these countries. The first one relates to the involvement of consumers, users, family members and professional associations from non-governmental organisations in the planning and implementation of mental health developments by the state governments. It is an agreed fact that in many parts of Asia, social stigma, lack of general public interest in mental health, perception that mental health indicators are weak and people with mental disorders are currently not a sufficiently powerful lobby do contribute to the disparities in mental health to a large extent. Similarly advocacy for mental health is not very visible and mentally ill & their families are only rarely mobilised to form powerful groups, and to press for the availability of effective and humane mental health care. There is no doubt that the formation of consumer movement is picking up some strength but not to the extent as seen in the West and there is still a long way to go to achieve some significant improvements in

this regard. The notion that the patients, consumers and family members are stakeholders in mental health & that Pt's involvement in the treatment should be a basic right for persons with mental health problems thus require urgent attention & more acceptances.

Furthermore, in providing treatment and in protecting patients, issues of basic human rights are generally not taken on board while planning reforms in mental health. In some Asian countries people do not have access to basic mental health care and treatment they require. And in many others, the only care available is in psychiatric institutions which are associated with gross human rights violations. People are exposed to inhuman and degrading living conditions as well as harmful practices - overmedicated to keep them docile and easy to manage, restrained in shackles or caged beds, and the list goes on. This inequality even exists outside the health care context and the stigma and misconceptions associated with mental disabilities means that people are marginalised from society. Many people are left to themselves without a family to care for them or a roof over their heads. They are excluded from community life and denied basic rights such as shelter, food and clothing, and are discriminated against in the fields of employment, education and housing due to their mental disability. Many are denied the right to vote, marry and have children. As a consequence, many people with mental disabilities are living in extreme poverty which in turn, affects their ability to gain access to appropriate care, integrate into society and recover from their illness. It is true that these violations are not just an issue for developing countries and many of the abuses are also occurring in developed countries but the impact is more detrimental in the developing world where most of the population is struggling for basic needs of living.



The second issue is about the leadership. The evidence is accumulating that psychiatry should be viewed in terms of public health perspectives and this is the preferred way to get more recognition about this speciality in the general health system. However, one major obstacle stays as many national mental health leaders have insufficient public-health skills, and this hinders rapid progress of service development. It is true that mental health leaders in low-income and middle-income countries have responsibility for complex tasks ranging from development of policy, strengthening of services, and advise on policy matters to the government departments but in reality this becomes a difficult task. It is not fair to expect these highly specialised skills from clinicians turned-by default-into-administrators/planners who later feel very limited in their approaches. It is a pity that many clinicians lack such experience and training & are not fully conversant with public health models in the health care delivery system. Often, senior psychiatrists who are promoted to become national mental health leaders focus on clinical management of individuals, rather than on wider perspectives including socio economic oriented actions.

But despite these limitations and inequalities, mental health scene in the developing world in general and in Asian countries in particular, is not that bleak. A number of innovations are being tried in different areas of mental health that show a changing trend in the practice of mental health in many Asian countries. It is heartening to note that despite limited financial resources, many countries are taking lead in many aspects of mental health. The community psychiatry movement is getting into the system in most of the countries and orientation about common mental health problems is emerging as an important agenda for the training of primary care physicians. Mental health legislations are refined and use of family support, religious institutions and supportive socio-cultural traditions are being promoted in the treatment, management and prevention of mental health problems. This certainly adds to the list of achievements as useful resources in many settings. The issues about Pt's involvement in the care system is however limited but it is hoped that professional organisations will continue coming forward in making these changes an integral part of the mental health policies in these countries. There is a dire need of acknowledgement of their role by the policy makers who may require constant reminders. It is worth mentioning that WAPR as an organisation has always highlighted the importance of Pts, carers and users involvement at all levels of mental health care and as an international organisation has promoted this cause with consistency and continuity. Similarly WAPR's role in propagating the rights of the mentally ill and efforts to highlight these issues in its national

and international meetings have made this organisation more distinct for its efforts in this area. It is hoped that these issues will continue having a priority in the future deliberations of WAPR and other associations will also join hands with WAPR in their efforts.

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## **“Triologue” - an exercise in communication between consumers, carers and professional mental health workers beyond role stereotypes.**

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“Triologue” stands for the encounter of the three main groups of individuals who deal with psychiatric problems and disorders and with the mental health system – people with experiences of severe mental distress, family members/friends and mental health professionals – on equal footing. This encounter occurs under special conditions - outside the family, outside psychiatric institutions, outside a therapeutic setting. It is the aim of the Triologue to facilitate communication about the personal experiences in dealing with psychiatric problems and disorders and their consequences. The participating groups strive towards giving up their isolation and lack of common language. Mutual understanding and necessary delimitation from the vast variety of the participants’ different backgrounds concerning experience and knowledge are to be established. Trying to understand and share the complex and very heterogeneous subjective experiences may well lead towards establishing a common language, which implies building the basis of a culture of discussion seen to be necessary for working together effectively. It is widely argued from different areas of research that acknowledging the personal experiences of users and their families and friends in planning, organizing and doing practical work is necessary to improve both research and practice in dealing with psychiatric problems and disorders. Engaging in the Triologue is the necessary training to further enhance this process.

Ingeborg Schürmann’s elaboration on the everyday life and ways of relationships within the framework of today’s psychiatry helps to illustrate a complex situation. Based on a research project set up in East and West Berlin she describes different patterns of relationships between professionals and long term users i.e. positive regard, commitment, goodwill, distancing, friendship and partiality, each of them having different strengths and weaknesses. To start with she draws a

picture of different service-“cultures” which can be found to a certain degree in different psychiatric situations:

- The culture of care characterized by well-meaning help and patronizing attitudes as well as a restriction of one’s personal autonomy;
- The culture of treatment, being based on experts and expertise and demanding users to be “compliant”, drawing on different mostly contradictory etiological models as the psychotherapeutic or the biomedical;
- The pedagogical culture which strives towards achieving normative goals using pedagogical means on a friendly and structured basis;
- The culture of empowerment seeking a balanced power-structure at the cost of expert based power offering a resource-oriented viewpoint and trying to work on conditions that may enable people to live their own lives and increase personal development.

It is within the framework of these different cultures that users experience helpful relationships, that expand their resources and choices and strengthen their resilience, but also limitations and devaluation, which stand in the way of a recovery path.

People who are or have been in touch with the mental health system are doing so in the roles of “mental patients”, “schizophrenics”, “mentally disabled” individuals, people “with mental illness”, as people “with experience of psychosis”, “with experience of psychiatric services”, “expatrients”, “survivors”, “clients”, “consumers”, “users” or “long-term users”, or “persons in recovery”. Each of these

different labels expresses different treatment concepts, identities and value systems. Their friends and families develop a wide variety of ways, with which they devise their roles as supporters, victims, or accomplices of their loved one's suffering, coping, and recovery. Users of psychiatric services are facing interdisciplinary teams of nurses, psychiatrists, psychologists, social workers, occupational therapists, physiotherapists, patient's advocates, advocates, volunteers and peer-specialists who are supposed to work together and share responsibilities. The growing amount of diverse approaches with their different concepts of providing help and support, and the new roles that are taken on by users, their friends and families, require that all participants take a close look at their own roles, limitations and opportunities inherent in the relationships being formed. Only if we all engage in a constant dialogue we might achieve some clarity in this complex situation and benefit from its opportunities. But in order to achieve this, a new culture of communication needs to be established, developed, learned and experienced in new settings.

The "First Vienna Trialogue" was established after the World Conference for Social Psychiatry in Hamburg in 1994 by a small group of people representing users, relatives and professionals. Since then, Trialogue meetings are being held twice a month with 10 to 40 people in attendance. In the beginning, the meetings were only publicized verbally, followed by newspaper ads and announcements within user- and professional organizations. Trialogie is an *open group* - everyone interested in participating is welcome. It was our experience from the start that users formed the largest share of regular participants, followed by family members and friends and professionals (social workers, psychologists, nurses, patient's advocates, guardians, psychiatrists). As an open group, the number of attendants and the compositions of members from the three groups vary each time, and there is a mix of regulars and of those who drop by to see what the group is like. During the time of the group's existence the venue of meetings has changed a couple of times. Besides financial considerations, we strived towards finding a place outside psychiatric institutions, unaffiliated with a particular self help organisation and apart from therapeutic or family relations thus offering a "*neutral ground*" that does not offer an advantage or a privilege for any of the participating groups. For the same reason we prefer a rotating system of different members in the role of moderator to a model of professional moderation.

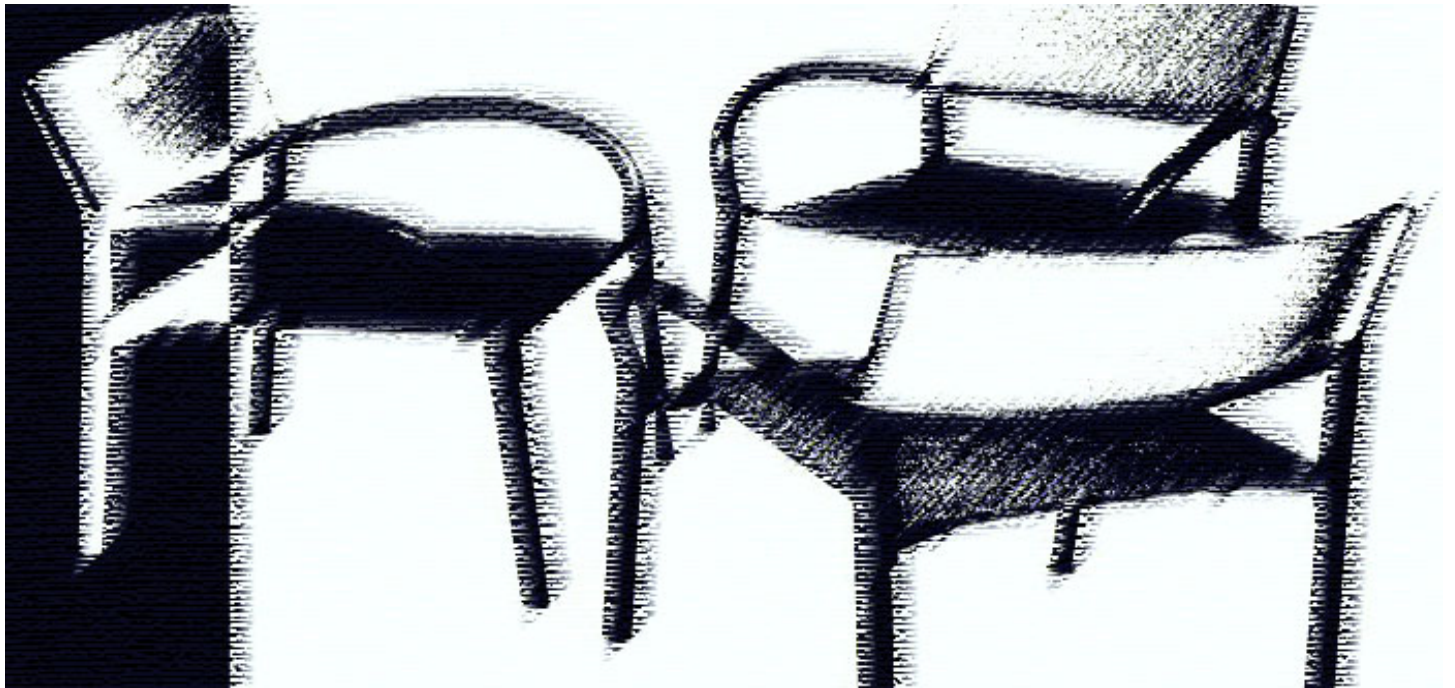
A role model for the "First Vienna Trialogue" was the psychosis seminar in Hamburg. Currently, over hundred



of these seminars can be found in Germany, some of them using different names

such as "exchange of experiences with psychosis" or "From dialogue to Trialogue" and some in Switzerland and Austria. As a result of a meeting of many different members of such groups a team of people began to evaluate the results of the psychosis seminars and published a guideline (Bock Th, Buck D, Esterer I (2<sup>nd</sup> edition 2000)).

We hope that the published accounts of our experience (Amering, Hofer, Rath, 2002), which we reported in a trialogic format, succeed in demonstrating how new, different, extraordinary and unusual this type of encounter is. We wanted to emphasize the unique personal and professional learning opportunities it engenders as well as highlight the difficulties that can arise when you engage in a trialogue as a whole person, start to accept the different members of the group as equally entitled experts, and try not to avoid relevant conflicts of interest. However, when we encourage taking trialogue serious we also point out all the fun that it brings. "*There is much laughter within the Trialogue, which is seen as a powerful remedy*" is one



important conclusion by a mother talking about her experiences as a triologue group member.

Priebe und Bock describe in their 2005 publication in a well established psychiatric journal characteristics, history, and possible benefits of psychosis-seminars and triologue groups. From experience and from the few data on Psychosis Seminars in Germany it looks like:

- Many participants are characterized by a lot of experience, often over many years.
- Main benefits for carers stem from gaining knowledge, sharing experience and being able to discuss concrete issues they struggle with within their family with persons, who know similar situations from their own experience, but with whom they are not intimately entangled through emotional and biographical bonds.
- Consumers benefit from respect for their psychotic experiences and a chance to make sense of these and other experiences in their personal social and biographical context.
- Professionals value not only the opportunity to gain new insights into the experience of psychiatric problems, but also review their role and their practices in new and comprehensive perspectives.
- Many attendants share the wish to improve current psychiatric practices and advance the concepts of mental illness and health.

The European Familie's Organisation EUFAMI in 2003 recommend triologue groups also for outside German

speaking countries. An experiment with a Triologue in Turkey in 2006 during a Congress of the World Psychiatric Association went very well and colleagues from as far as Trinidad and Tobago felt encouraged to follow up on the concept of Triologue in their home country.

Looking at example of topics covered by Triologue groups does lend credit to the idea that people all over the world might benefit from such exchanges:

- Stigma and discrimination.
- Work and social integration.
- Power, powerlessness, and empowerment.
- The family doctor as a triologue partner.
- From dialogue to triologue – where are the professionals?
- The “good” psychiatrist – users’ and relatives’ perspectives.
- When help has more unwanted than wanted effects.
- Diagnosis as a trap – being put in a box.
- Religion and Psychosis.
- False hopes for recovery and healing.
- Day clinics – why so few?
- Clinical and field trials – experimenting with patients.
- Silent users – who is helping them?
- From aftercare to prevention – easy access to early help.

Last year a woman and a man attended a Triologue by mistake of entering the wrong room. During the group

exchange about a specific psychotic experience of one of the participants the woman used a chance to talk about her hurtful experiences with her sister, got very emotional and was supported by the group. At the end of this particular Trialogue group she and her husband thanked the group and expressed that they had not yet encountered a social environment that granted them such freedom of expression and thus such relief for a big problem that had been waiting to be formulated and shared for a long time.

The above example illustrates the exceptional nature of the communication possible within the Trialogue framework and its opportunities to reach out to people outside the psychiatry-subculture. More specifically, the experience gained in Trialogue groups is extremely useful for people who want or need to engage into policy activities that need the participation of all three groups represented in trialogue, like serving on quality control boards of psychiatric services, in advisory groups for planning and evaluating psychiatric services, in anti-stigma and anti-discrimination initiatives and in all sorts of other much needed advocacy activities.

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## La Implantación del sistema de atención en la Comunidad de Madrid (España)

Desarrollo del Plan de Atención Social a personas con enfermedad mental grave y crónica 2003-2007.

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*WAPR: En España, la reforma psiquiátrica se realizó con retraso respecto de otros países de Europa. La responsabilidad de los servicios en España opera de manera descentralizada, y el desarrollo de servicios de rehabilitación ha sido creciente pero desigual. Algunas comunidades de España han logrado sin embargo un desarrollo notable en cuanto a implantación de servicios de rehabilitación para los ciudadanos, con modelos distintos según las necesidades y condiciones planteadas por la demografía y distribución geográfica de la población.*

*La Comunidad de Madrid es un ejemplo notable de implantación efectiva de un modelo social de atención, complementario a la atención que se presta desde los servicios de salud mental. La atención en los servicios de salud mental asegura la accesibilidad al tratamiento, atención en situaciones de crisis, atención a personas de evolución desfavorable en hospitalizaciones de “media estancia” y cuenta con programas de continuidad de cuidados. Coordinadamente, los servicios sociales han creado una red de centros y servicios de apoyo, que ofrece programas especializados de rehabilitación, apoyo a la integración social, al acceso al trabajo, programas de apoyo residencial y de intervención en el domicilio de la persona.*

*Para dar una idea de su crecimiento, si en 1995, para una población de unos 5 millones de personas, los programas y recursos desde servicios sociales de rehabilitación y apoyo comunitario disponían de 418 plazas, en 2003 disponían de 1269, en la actualidad (septiembre de 2007) el número de plazas asciende a 4.234 plazas y se prevé que a final del 2007 se creen 968 nuevas plazas con lo que la red de atención social y apoyo a la rehabilitación alcanzará un total de 5.202.*

*WAPR: ¿Cual es la historia de la implementación de la PSR en Madrid?*

Los antecedentes del Plan se remontan a hace casi 20 años, con el inicio de la reforma psiquiátrica en España y en la Comunidad de Madrid, con la gran transformación conceptual que ello representó y la adopción del modelo de atención



Abelardo Rodríguez y M<sup>a</sup> Jesús Sanz.

comunitario. En aquellos tiempos la Consejería entonces responsable de Asuntos Sociales asumió el compromiso de desarrollar recursos de atención a personas con enfermedad mental grave. De allí nació un programa que empezó a desarrollar una red de recursos de manera desigual. Se hacía imprescindible consolidar esta implicación para desarrollar en un tiempo breve una red de recursos sociales diversificados que complementara los de la atención sanitaria para disponer en Madrid de una red integrada y descentralizada que facilitara el mantenimiento en condiciones de calidad de vida a las personas de este colectivo. Esta idea recibió el apoyo político y presupuestario para hacerlo posible, apoyo que se ha concretado de una manera muy significativa en los últimos cuatro años en el “Plan 2003-2007 de

Atención Social a personas con enfermedad mental grave y crónica” que ha llevado a cabo la Consejería de Familia y Asuntos Sociales del Gobierno de la región de Madrid.

*WAPR: ¿Cual ha sido la filosofía de partida para el Plan?*

La apuesta por el modelo de atención comunitario, para ayudar a las personas a mantenerse en su propio entorno, con estrecha coordinación entre nuestra red de servicios sociales especializados y la de los servicios sanitarios, y apostar por metodologías de intervención contrastadas por la experiencia empírica y que en la literatura hayan demostrado su eficacia y su impacto positivo en la mejora de la calidad de vida de las personas. Sobre estos pilares se ha consolidado el modelo de intervención psicosocial y de tipología de recursos apostando por un conjunto diversificado de centros y recursos (Centros de Rehabilitación Psicosocial, Centros de Rehabilitación Laboral, Centros de Día de soporte social, Equipos de Apoyo Social Comunitario, Residencias, Pisos supervisados y plazas en Pensiones) que básicamente han pretendido responder a las necesidades psicosociales fundamentales de las personas, que son elementos fundamentales de su calidad de vida: la mejora de la integración, funcionamiento y soporte social, el apoyo a la inserción laboral, el apoyo residencial y el apoyo a las familias.

Luego hemos complementado a los centros que realizan estas funciones específicas con los llamados de *Equipos de Apoyo Social Comunitario (EASC)*, que trabajan en el entorno social de las personas con dos grandes misiones: apoyar la vinculación a los recursos de las personas que tienen muchas necesidades pero usan los recursos de manera irregular, que son las personas que suelen tener más necesidades y menos atención reciben. Y en segundo lugar, como complemento a los recursos residenciales, queremos apostar por lo que en la literatura se denominan *supported housing* (vivienda con apoyo), para que las personas se mantengan donde vivan o donde deseen vivir, teniendo en cuenta que la mayoría de personas con enfermedad mental desean vivir o con su familia o en su propia casa. Los Equipos ayudan a hacer esto posible, mejorando la capacidad de funcionamiento en el domicilio, la convivencia familiar, intentando que no tengan necesidad de buscar otras alternativas, y recurriendo a otros modos de residencia solo en situaciones imprescindibles. Viene a ser una adaptación a la situación de Madrid de modelos que en la experiencia empírica han demostrado ser eficaces, como son al modelo *asertivo comunitario*, la experiencia de Stein y Tess, que es un intento de llevar a la máxima coherencia la atención comunitaria, trabajando más allá de los centros, ofreciendo ayuda práctica desde equipos multiprofesionales en el propio entorno de la persona.

En Madrid, hemos adaptado esa experiencia y, desde lo social, usamos estos equipos de apoyo para reforzar y complementar los denominados Programas de Continuidad de Cuidados de los servicios de Salud Mental, que son el eje vertebrador de la atención a las personas con enfermedad. También hay un programa específico de atención a personas con enfermedad mental sin hogar. Y más recientemente hemos adoptado otras estrategias, como algunos recursos de atención diurna y residencial de apoyo a los procesos de reinserción de las personas enfermas mentales sin hogar..

Consideramos que estamos en línea con las recomendaciones europeas sobre atención a las personas con discapacidad en general y con enfermedad mental en particular, hemos tomado en cuenta las propuestas de la Convención de Derechos de Personas con Discapacidad, aprobada en diciembre de 2006, respecto del apoyo en el medio habitual, la no institucionalización, y la participación en el medio social. Lo que significa que seguimos las mejores directivas posibles, no solo desde el punto de vista técnico, sino también desde el de las políticas generales.

*WAPR: La Comunidad de Madrid ha experimentado un gran crecimiento en los últimos años desde una situación de partida de una red de servicios sociales muy limitada. ¿Cual ha sido la estrategia a la hora de implantar los servicios?*

La primera cuestión fue obviamente que había que tomar conciencia del problema e incluir éste en la agenda política. Este proceso se produjo como resultado de un cierto tiempo de actividad de actores de la sociedad civil como asociaciones profesionales, asociaciones familias de afectados, y también de los técnicos de la Comunidad de Madrid. Las acciones necesarias requerían un planeamiento importante con repercusión en los presupuestos de la Comunidad.

Una vez que se tomo la decisión política de realizar las inversiones necesarias, se planteó la conveniencia de operativizar esta mediante un Plan, aprobado en mayo de 2003 por el Consejo de Gobierno de la Comunidad de Madrid que estableció de manera muy concreta los plazos de tiempo y las intervenciones que se habrían de acometer, tanto desde el punto de vista técnico como presupuestario.

La estrategia técnica, una vez abierta la posibilidad de crear los recursos, se fue operativizando teniendo en cuenta por un lado las ratios que queríamos alcanzar de cada tipo de recurso, y por otro una lógica de descentralización y territorialización, de manera que se tratamos de situar los recursos y servicios cerca de los lugares de residencia de las personas.

La idea era que cada distrito territorial tuviera sus propios recursos de atención social. Ahora mismo estamos completando en cada zona una red amplia y diversificada de recursos tanto de atención social y rehabilitación en régimen diurno (Centros de Rehabilitación Psicosocial, Centros de Día de soporte social, Centros de Rehabilitación Laboral y Equipos de Apoyo Social Comunitario) como de atención residencial (Residencias comunitarias con supervisión de 24 horas y de pequeño tamaño entre 20 y 30 plazas cada una), Pisos supervisados con 4 plazas cada uno ubicados en viviendas normalizadas y supervisión periódica, así como plazas de alojamiento en Pensiones o pequeños hostales)

*WAPR: ¿Que factores relacionados con las características de la población atendida han aparecido como relevantes en el diseño e implantación del Plan?*

Cuando se diseñó el Plan se tuvieron en cuenta las características y necesidades de las personas que padecen enfermedad mental en general, según las experiencias disponibles hasta ese momento, y las necesidades percibidas desde las propias fuentes de información de nuestros Servicios Sociales y de Salud Mental. Luego el Plan ha sido evaluado cada año, tenemos algunos datos relacionados con las necesidades percibidas desde los centros y va apareciendo un perfil de usuario/a tipo que utiliza los servicios y aparecen algunos datos.

Podríamos definir el perfil prototípico del usuario de los servicios desde nuestra experiencia; una persona de una edad sobre los 30/35 años, el 90% viven con su familia, mayoritariamente al cuidado de sus madres, de clase media baja, y nivel de estudios medio bajo. Respeto del género, el 60% de los usuarios de servicios son varones, y en algunos servicios, como los de rehabilitación laboral esta desviación alcanza el 70%.

Este último es el dato que nos ha parecido de momento más llamativo. Consideramos que esto tiene que ver con circunstancias diversas relacionadas con las diferencias de género. Es posible que en el caso de las mujeres enfermas, las familias, incluso los profesionales de los servicios que derivan a nuestra Red, estén influidas por estereotipos de rol clásico de la mujer que hace vida de familia y demanda menos incorporación, por ejemplo, al trabajo. Creemos que habrá que combatir esta doble discriminación de las mujeres y tratar de impregnar al sistema de sensibilidad a la perspectiva de género.

Respecto a tendencias relacionadas con multiculturalidad, inmigración u otras circunstancias, de momento no detectamos tendencias especiales. Se debe tener en cuenta que somos un recurso de tercer nivel y el peso del fenómeno de la inmigración en Madrid es

relativamente reciente. Creemos que en el futuro este reto será mayor; ya hemos percibido que las personas de origen magrebí/islámico plantean nuevas situaciones a los servicios, debido a la posición en su cultura de la mujer y al hecho de que gran parte de los profesionales de nuestros servicios son de hecho mujeres.

Otro factor es la emergencia de nuevas patologías como los trastornos graves de personalidad, que generan gran alarma social, para los que aun no tenemos buenas respuestas, y que en la práctica vienen a competir en sus necesidades por los espacios que se han diseñado específicamente para personas con trastornos psicóticos graves.

Otro problema que habrá que abordar es el de la creciente psiquiatrización de la vida diaria, que tiende a convertir en trastornos psiquiátricos toda clase de nuevos problemas personales y sociales en esta sociedad compleja, plural y globalizada, lo que deberá ser cuidadosamente analizado en el futuro.

*WAPR: Una característica del modelo de atención en la Comunidad de Madrid es la de la existencia de una red de servicios de Salud Mental y otra de Servicios Sociales especializados para personas con enfermedad mental.*

Efectivamente, es una particularidad de nuestra Comunidad que tiene que ver con la historia del desarrollo de nuestros servicios que no obedece a otra razón en particular.

Hay que tener en cuenta en Madrid que los servicios actuales son el resultado de la evolución y la integración de servicios preexistentes con formas de funcionamiento y culturas profesionales diferentes, de manera que la evolución ha ido delimitando cuales son las funciones y las competencias de cada uno de los sistemas. Los problemas relacionados con la autonomía, la integración, la inserción laboral, la participación o evitar la marginación han sido en núcleo fundamental de la intervención del sistema de servicios sociales, y han justificado, en Madrid como en otros lugares, la implicación de los servicios sociales comunitarios en la ayuda a personas con problemas de salud mental.

Lo cierto es que este tipo de colaboración y complementariedad entre la atención sanitaria y social también existe en otros modelos de atención como el británico, en el que existe una extraordinaria coordinación entre los servicios de salud mental y los servicios sociales comunitarios, que es el modelo que queremos en Madrid. En este modelo la coordinación entre los actores intervinientes de las dos redes debe formar parte de la cultura profesional más básica, no solo del sistema, sino de cada uno de los profesionales que intervienen.

En la actualidad contamos con más de un mecanismo de coordinación: una comisión técnica de los responsables de los servicios centrales que se reúne mensualmente y que trabaja en la planificación como en los problemas que puedan venir del nivel inferior, también existen coordinaciones institucionales al nivel de responsables de las distintas áreas.

*WAPR: ¿Cuales han sido a vuestro juicio los principales éxitos y las principales dificultades pendientes para el modelo de Madrid?*

El *Plan de Atención Social a personas con enfermedad mental grave y crónica* sobre el que trabajamos actualmente desde la Consejería de Familia y Asuntos Sociales de la Comunidad de Madrid, que es continuación de acciones anteriores, se inició en 2003 y finalizará a finales de 2007, y ha sido un gran esfuerzo que en si mismo ya puede ser considerando un éxito. Se han puesto en marcha casi 4000 nuevas plazas, lo que ha permitido pasar de una red de centros y recursos con 1269 plazas en Mayo de 2003 a una red que contara a final de este año 2007 con un total de 5.202 plazas. Esta red de atención social esta conformada por un conjunto diversificado de centros y recursos (Centros de Rehabilitación Psicosocial, Centros de Rehabilitación Laboral, Centros de Día de soporte social, Equipos de Apoyo Social Comunitario, Residencias, Pisos supervisados y plazas en Pensiones) que cubren las distintas necesidades sociales de estas personas en los ámbitos de la rehabilitación psicosocial y el apoyo a la integración social, la rehabilitación laboral y el apoyo al empleo, el soporte social y apoyo comunitario y la atención residencial, sin olvidar el asesoramiento y apoyo a las familias. Toda esta red de recursos esta descentralizada y territorializada y trabaja en coordinación con la red sanitaria de Servicios de Salud Mental que son los responsables del tratamiento y seguimiento de las enfermos mentales y son la puerta de entrada y derivación a la red de atención social dependiente de la Consejería de Familia y Asuntos Sociales en el marco del citado Plan..

En la actualidad estamos realizando un proceso exhaustivo de evaluación a todos los niveles, y hasta que no terminemos este análisis no se podrá conocer una respuesta concluyente sobre sus luces y sombras. Sin embargo una de las impresiones más satisfactorias ha sido que ha funcionado la coordinación a todos los niveles con los servicios de Salud Mental. Esto inicialmente constituía un reto importante que creemos ha sido superado. La evaluación final incorporará la perspectiva de los profesionales, de las empresas que han gestionado los servicios, de los servicios de salud mental y de los usuarios y sus familias.

Ahora, como un reto próximo, está la definición de un nuevo programa estratégico que permita la continuación y la consolidación de los objetivos ya alcanzados, y nos proporcione instrumentos para poder afrontar los nuevos retos que puedan ir surgiendo, que podrían tener que ver con la inmigración, la perspectiva de genero o las nuevas patologías.

Otro elemento que podemos considerar un éxito viene del reconocimiento que estamos recibiendo desde otras Comunidades Autónomas, que nos invitan a compartir nuestra experiencia y nos hacen sentir que el trabajo realizado en Madrid puede servir como una referencia para los profesionales de otras comunidades, pero también para los responsables de la planificación.

Una dificultad que hemos abordado a medida que el Plan se ha ido desarrollando es el de las personas con dificultades de adherencia a los servicios digamos “regulares”. Se han creado equipos especiales, los *Equipos de Apoyo Social Comunitaria* con la función de acercarse a los lugares donde estas personas están para comenzar a trabajar con ellas y buscar su acercamiento a los recursos, ya sea a un centro de día o a un dispositivo residencial.

*WAPR: ¿Como están incorporando los servicios en su cultura la perspectiva de los usuarios?*

Nuestra intervención trata de la vida de las personas y no podemos hacerlo al margen de ellas. La perspectiva de los usuarios de los servicios está presente al menos de dos maneras: una, en la definición de los objetivos individuales que se persiguen mediante el Plan Individualizado de Rehabilitación, que es el instrumento particular que dirige el proceso de rehabilitación y atención de cada persona individualmente, que se establecen consensuadamente con los usuarios; y dos, teniendo en cuenta la satisfacción de los usuarios con los servicios a la hora de evaluarlos. Disponemos de mecanismos de captación de información que incorporan ambas perspectivas en la evaluación que estamos haciendo con la colaboración de la Universidad.

Desde hace muchos años utilizamos un cuestionario muy sencillo de satisfacción que mide resultados a través de 20 ítem cuatro áreas: satisfacción con el trato profesional recibido; satisfacción relacionada con las actividades y organización de os centros, actividades, etc., satisfacción con las instalaciones, y por ultimo satisfacción en la relación de convivencia con otros usuarios. Lo consideramos un indicador global interesante que nos indica si vamos por buen camino, especialmente con los dos primeros ítem, las puntuaciones de satisfacción van en torno a 5 sobre 6.

En los centros hay una lógica, que ya existe y que habrá que potenciar, de implicación de los usuarios mediante asambleas, y otros mecanismos mediante los cuales participan

activamente en el establecimiento de normas de convivencia, y de modos de resolución de problemas.

En la Comunidad de Madrid existen 22 asociaciones de familiares de enfermos mentales (sobre todo con esquizofrenia) que se agrupan en la Federación Madrileña de Asociaciones Por Salud Mental (FEMASAM) a las que apoyamos y subvencionamos, asimismo existe una asociación específica que agrupa a personas con diagnóstico de trastornos bipolar, pero no existe aún ninguna organización amplia y general de usuarios que reúna ya las características adecuadas para ser interlocutora, asumiendo explícitamente y consensuadamente la voz de los usuarios. En la orientación actual que persigue que la persona esté en el eje de las políticas, y sea participante absoluta de las políticas, consideramos muy deseable una asociación que pueda representar la voz de los usuarios autoorganizados.

*WAPR: En función de la experiencia en la aplicación de estas políticas y técnicas de intervención en la Comunidad de Madrid, ¿que hallazgos particulares habéis encontrado en la experiencia de Madrid que puedan resultar interesantes?*

De momento, tendríamos que esperar a ver que información nos ofrece la evaluación que estamos realizando, pero un aspecto interesante de la experiencia de Madrid viene de los mecanismos de coordinación con los servicios sanitarios de Salud Mental. Este Plan puede afirmar que ha puesto en práctica una forma de coordinación entre dos grandes agencias públicas (salud y servicios sociales) para atender eso que se vienen a denominar espacio socio-sanitario: dos redes de servicios que trabajan coordinadas sobre criterios técnicos para la atención global a un colectivo de personas con necesidades sociales y sanitarias como este de la personas con trastornos mentales graves..

Otro aprendizaje es que hemos dejado de sentirnos en la segunda división en relación con las experiencias internacionales para sentirnos en la primera línea en cuanto a metodología, calidad, tipología de recursos. Es posible que no hayamos alcanzado en nivel cuantitativo de recursos de otros países con mayor trayectoria y experiencia, pero en cuanto a calidad técnica, resultados, calidad de equipos profesionales, nos sentimos al mismo nivel. Es un orgullo para nosotros, un país que viene de situaciones recientes de desventaja comparativa en este campo. Es verdad que quedan aun muchos retos. Sería muy importante completar de manera real una red de servicios mínimos y lograr que, para los ciudadanos, no haya diferencias de oportunidades de acceso a los servicios en el territorio en función de los recursos de que se disponga.

En Madrid se ha logrado un modelo que cuenta con un grado de consenso y de apoyo social y político muy amplio, que constituye una red de utilización pública de servicios con fácil accesibilidad, y en condiciones de gratuidad para los usuarios.

Otro aspecto interesante de Madrid es haber logrado un modelo con participación de la iniciativa privada en la gestión de los servicios, pero con unos niveles de calidad y estándares profesionales totalmente homogéneos y compartidos en todos los dispositivos, para constituir una verdadera red pública, con un seguimiento monitorización y coordinación muy exhaustivos por parte de los responsables públicos. Una red de centros y recursos de apoyo social amplia y coordinada y que ofrece una atención gratuita y de calidad a los usuarios.

En el caso de Madrid, se ha dado una circunstancia que no es habitual en el mundo de la atención a la discapacidad, en el que lo usual es que la Administración se implica secundariamente para tratar de coordinar y armonizar recursos preexistentes nacidos de la iniciativa particular. En Madrid, la Administración tomó la iniciativa para dirigir el desarrollo de los servicios que han constituido la red de servicios. Y otra razón de satisfacción es respecto de la calidad técnica de los más de 800 profesionales, con gran implicación y dedicación, y con un gran espíritu de colaboración, más allá del servicio o de la empresa para la que trabaja cada uno. Cada vez que se abre un centro, los nuevos profesionales visitan y conocen los demás centros de parecidas características. Hemos buscado todos los mecanismos posibles para evitar el autismo de cada centro y para optimizar la cultura de Red. También hemos podido contar con unas empresas sociales con gran profesionalidad y vocación de servicio público.

Otro gran reto pendiente es el de la lucha contra el estigma. Hemos elaborado un plan en colaboración con la Universidad, que recoge experiencias internacionales, y que constituirá un nuevo campo de trabajo a partir del año próximo, en coordinación con los servicios de salud Mental. Sabemos que es un campo difícil porque la experiencia de los últimos años ha sido negativa: por el momento las actuaciones que hemos realizado no han conseguido reducir los problemas relacionados con el estigma, y los medios de comunicación no han reaccionado de la manera que deseábamos a medida que hemos ido implementando más y mejores servicios comunitarios para los ciudadanos con problemas de salud mental. Es un reto pendiente.

R. Guinea. para el Boletín de WAPR

## Meaningful daily occupations – a central task in occupational therapy for people with severe mental disorders.

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Occupational therapists working in mental health have the important task of supporting people with severe mental disorders to attain as satisfying a life as possible. The main focus of this support is the provision of opportunities for meaningful daily occupations. Occupation in this sense denotes not only work, but meaningful activity in multiple domains, including leisure activities, self-care and household chores, opportunities for self-reflection, as well as many other kinds of “doing” that occupies peoples’ time. It is widely recognised that people with severe mental disorders, as citizens of society, have a right to meaningful daily occupations; some countries make this right explicit in their human rights legislation. However, persons with severe mental illnesses continue to be marginalised from mainstream society and excluded from meaningful daily occupations. In addition, this group has many unmet needs, including inadequate living conditions, a generally poor quality of life, low self-esteem, and few social contacts. It is the belief and the intent of the discipline of occupational therapy that by addressing meaningful daily occupations, many of these needs may be met.

Occupational therapists throughout the world are involved in the prevention of mental illness, social support, treatment and rehabilitation of the mentally ill at all levels of severity. The intervention programmes may be implemented in psychiatric hospitals, life skills and day centres, community clinics, in the home and in workplaces.

Recent research within occupational science and occupational therapy has shown that there is a relationship between meaningful and valued occupations and perceived health and well-being (Kirsh, 2000). Actual *doing*, such as being engaged in chosen activities or gainful employment, has been found to be related to improved health and well being as reflected by both objective ratings and subjective



perspectives. However, the way the ‘doing’ is *perceived*, in terms of satisfaction, value, and meaning, has been even more consistently and strongly related to health-related factors (Eklund & Leufstadius, in press).

Purposeful activity is the cornerstone and the major tool of intervention in occupational therapy. It is central to the profession’s philosophy that occupational therapy activity engages the mentally ill person in meaningful occupation in order to maintain occupational performance and quality of life (De Witt in Crouch & Alers, 2005). It is therefore of utmost importance for occupational therapists to be able to identify what kind of occupations are stimulating and engaging for a client. Client-centred practice is a current accepted standard of service delivery for occupational therapists working in all areas and reflects



a process by which the client and the occupational therapist work together as mutual partners in order to find the best solutions for the client. Though consensus exists as to the central importance of client centredness, a number of barriers can compromise this practice. The development of rapport and communication has been a challenge in working with people with severe mental disorders. They may appear to be unmotivated to participate in occupational therapy and say they find most things meaningless. While the mental illness itself may have caused an impaired capacity, the environments that surround persons with severe mental illnesses are full of stigmatising messages that, in turn, affect self-identity. The interactions between person and environment influence the performance of purposeful activity. Especially in such cases, a structure for how to identify features of an occupation that make it meaningful might be useful.

Persson et al (2001) proposed such a structure, stating that for an occupation to be perceived as meaningful, it must possess one or more of three identified value dimensions: the concrete, the symbolic, and the self-rewarding. An occupation imprinted with concrete value becomes meaningful because it brings tangible rewards, such as payment, a product, or a new skill. Meaning can also spring from occupations that render symbolic value at the personal, cultural or universal level e.g. as a useful member of the society. Occupations linked with self-reward value are perceived as meaningful because they bring joy and excitement. These types of values may serve as a checklist when communicating with a client in order to find ways to a meaningful daily life. If none of these values can be identified for a certain occupation, it should be abandoned. When exploring meaningfulness and purpose in life a narrative approach is a useful tool in the occupational therapy process.

Meaningful and satisfying daily occupations are also associated with a richer social network, with feelings of being in control of one's own life situation, and with better self-esteem. Thus, several links have been shown between meaningful occupations and positive and desired aspects of people's status. The direction of these relationships has not been established, however, and it is possible that persons who perceive better well-being and quality of life have more energy and motivation for participating in daily occupations and also tend to be more satisfied with those occupations. Most likely the relationship is dynamic – satisfying occupations lead to well-being, and perceptions of health and well-being trigger engagement in occupations. Such a process constitutes a benign cycle, and the best way of launching it is to provide opportunities for meaningful daily occupations, where the issue of meaning can be addressed in terms of concrete, symbolic and/or self-reward value.

Intervention by occupational therapists is most effective as part of a multidisciplinary team approach. In developing countries where there is often a shortage of trained professionals, occupational therapists are still able, due to their versatile and intensive training in the field of mental health, to use activities that are culturally accepted and available to meet the goal of helping their clients resume life roles and engage in occupations that will lead to fuller and more satisfying lives. An effective occupational therapy programme must contain "elements of practicality, concrete problem-solving for everyday challenges, low-key socialisation and recreation, engagement in attainable tasks and specific goal orientation" (Liebermann et al. in Kaplan and Sadock, 2000 p. 3227). As an example, a balanced intervention programme could consist of the following activities that could be undertaken individually or in groups:

- personal care/self independence and assistance in the family's daily tasks including child and home management or budgeting where appropriate
- psycho-education including illness education, stress management, social skills training
- creative activity groups to explore and develop hobby or leisure pursuits. Learning the skill of using leisure time is very important
- health promotion activity including a focus on exercise, sport, and healthy lifestyles, all of which promote fitness and wellness
- sensory integrative programmes which may be effective in treating the positive symptoms of most severe mental illnesses
- work integration practices including supported employment, vocational assessment and counselling.

Employment on the competitive market is a valued area of daily occupations in most cultures. Research has shown that most people with severe mental disorders wish to have a job, but rates of employment amongst this group continue to be very low. Employment brings a number of advantages, such as a better economic situation, more social contacts, more structure to the day, and perceived higher social status (Strong, 1998). Therefore, competitive jobs and job-like daily occupations are an important target for occupational therapists who work with people with severe mental disorders. Work integration has become an important area of focus, and a range of programs, services and work initiatives have developed to promote this goal (for example, work adjustment programs, transitional employment, consumer businesses and social enterprises). Supported employment has gained recognition as an evidence-based practice and in particular, the Individual Placement and Support model has demonstrated favourable outcomes in the literature. This model involves rapid placement into the competitive job market accompanied by individually tailored follow-up support. While integration into the workforce is a goal for many or most persons, there will undoubtedly be some who prefer to be productive in other ways. Thus, it is also important to help people engage in other types of occupations that may offer similar extrinsic and intrinsic rewards. For example, participating on advisory boards, taking part in planning meetings, and engaging in volunteer work might be occupations that provide opportunities for productivity and satisfaction. The extent to which such occupations gratify needs for self esteem and self actualisation is an issue for future occupational therapy research.

‘Functioning’ from an occupational therapy perspective is much broader than the absence of symptoms. Optimal functioning is linked to well-being, quality of life and the person’s self-efficacy and mastery in choosing,

organising and performing those occupations he or she finds useful and meaningful in various living environments. Occupational therapists are concerned with encouraging and enabling the person to live life fully by addressing issues such as inclusion, reasonable accommodations and equal opportunities in the contexts where they live, work and play, despite the presence of some residual symptoms of the illness (Duncan, in Crouch & Alers, 2005). Thus, many occupational therapists have taken on active advocacy roles in creating and promoting just and inclusive environments.

The move of the profession of occupational therapy into an evidence-based framework has provided a much more scientific, realistic, holistic and client-centred approach to the intervention of the person with a severe mental disorder. At the same time the occupational paradigm within which the profession originated and which provides expert knowledge of activities contained with our everyday occupations, has not been lost. This is an essential framework for understanding and addressing the needs of the severely mentally ill person.

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## Report of WPA Regional Meeting 2007 in Seoul, Korea.

The meeting was held in Lotte Hotel World in downtown Seoul through Apr.18 –21, 2007 under the theme of 'Science and Human' organized by Korean Neuropsychiatric Association (KNPA). The organizing committee was directed by Dr. Young-Cho Chung, president of KNPA and co-chaired by Dr. Pedro Ruiz. Dr. Jun Soo Kwon chaired the scientific committee with 21 international and local members. The meeting was successful with 1,666 participants including 467 from 39 nations all around the world beyond Asian-Pacific Region. Among them are 43 Japanese, 2 Iranian, and 18 Taiwanese. This meeting tried to integrate recently developed biological aspects of psychiatry and psychosocial, humanitarian aspects for the future that academic activities were plentiful with 298 research posters, 6 plenary sessions, 30 symposia, and 11 ISS symposia. The Scientific committee selected 20 from poster presentation and gave US\$500 travel award. Participants enjoyed welcome reception with Korean traditional music and modern B-boys performance. Gala dinner was just like Traditional Costume Festival with volunteers who wore national costumes of their country followed by Korean folk dances and marshal art.

Along with WPA Regional Meeting, there were two satellite meetings. One was Asian Young Psychiatrists Meeting organized by Dr. Tae-Yeon Hwang of Yongin WHO Collaborating Center. Dr. Norman Sartorius, Dr. Tsuyoshi Akiyama, Dr. Hwang and 40 young psychiatrists enjoyed symposium, poster and oral presentation. This will be going on with network between young doctors through other regional meeting. Another is World Association for Psychosocial Rehabilitation (WAPR) Regional meeting on Apr. 20. This is the first regional meeting in Asia and more than 300 mental health professionals including psychiatric nurses, social workers and clinical psychologists joined the meeting.

Even though this was a regional meeting in Asia, its magnitude, contents and programs were comparable with international meeting that all the participants congratulated the successful and enjoyable meeting in Seoul. For KNPA, this meeting demanded much time and energies of the

members to organize, but gave a good opportunity to draw attention from the world to the academic achievement of KNPA and provided momentum to collaborate with other WPA members for research, education and exchange clinical experiences.

Dr. Tae-Yeon Hwang, Director of Mental Health of KNPA and Director of WHO Collaborating Center for Psychosocial Rehabilitation, Yongin Mental Hospital

## October 10th. WFMH World Mental Health Day.

[www.wfmh.org/2007material.htm](http://www.wfmh.org/2007material.htm)

The 2007 World Mental Health Day Campaign, to be celebrated on October 10<sup>th</sup>. will bring attention to transcultural mental health services and treatment.

According to WFMH data, *there are approximately 6.5 billion people living on planet Earth. Within that number, there are more people living outside their country of origin than at any other time in history. One person out of 35 is an international migrant — 3% of the global population.*

Experience shows how increasingly we can find dramatically different languages, religions, family relationships and values, as well as views on health care and treatment wherever we go, including in our own respective countries. Culture may influence many aspects of mental health, including how individuals from a given culture communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery. Cultural and social influences are not the only determinants of mental illness and patterns of service use, but they do play important roles.

WFMH offers key material in english, french, spanish, russian, chinese and japanese languages, available to be downloaded from their website [www.wfmh.org/2007material.htm](http://www.wfmh.org/2007material.htm), including a technical document and some tips on how to promote the Mental Health Day.

## Campaign “One million for Disability” Brussels 4 October 2007: Massive outdoor gathering .



The European Disability Forum (EDF) calls to gather On 4 October 2007, in a massive and festive outdoor gathering will take place in Brussels, Rond Point Schuman, from 13h to 15h. It will be the focal point of the “1million4disability” campaign and the opportunity to make ourselves visible as citizens in their own right and to make ourselves heard.

A delegation will meet the President of the European Commission, the President of the European Parliament and the EU Portuguese Presidency to call for a European non-discrimination legislation in favour of disabled persons.

More than 1000 participants are expected to join the gathering : delegations of persons with disabilities from all over Europe, disabled persons, their families and friends from all the regions of Belgium and neighboring countries, EU and national officials, civil society representatives and many others.

The campaign “One million for Disability” was launched on 23 January 2007.

The European Disability Forum (EDF) is a European nongovernmental organisation including 130 national and European organisations. Since 10 years, all together we have been working to protect and promote the rights of disabled persons in Europe.

### World Day of persons with dishabilities. Message from WAPR President .

On the occasion of the World Day of Persons with Disabilities.

- Because it is estimated that there are more than 200 million disabled persons in the world and 50 million of them are citizens of European countries
- Because full citizenship of people with disability is still a demanding issue in many countries
- Because mental disorders and related disabilities are affecting one out of four families
- Because the World Association for Psychosocial Rehabilitation has a long history of struggles for the human rights of the mentally disabled citizens,

We would like to join our voices and efforts with the European Disability Forum and all related National and European organizations, in the citizens’ outdoor gathering at Rond Point Schuman in Brussels, on October 4th, to make the voices heard, calling for EU measures to combat discrimination and promote full citizenship for persons with disabilities.



Professor Michael G. Madianos.  
President, WAPR

## WAPR represented at First World Congress of Asian Psychiatry.



WAPR organised a special session at the First World Congress of Asian Psychiatry that was held at Goa, India from 2-5<sup>th</sup> August 2007.

*WAPR stakeholders at 1 World Congress of Asian Psychiatry.*

Prof Madianos, President of WAPR was one of the invited guests at this congress. He delivered a key note address as well and chaired the WAPR session that was attended by a large number of delegates. Prof Deva, Prof Murali, Prof Mendis

and many other active members from WAPR Indian branch participated in this session.

This was a great opportunity for WAPR to get in to the main stream of Asian Psychiatry and proved a very successful attempt to bring the messages of WAPR on board.

## President & Secretary General WAPR visit 2009 Congress Venue

Prof Madianos and Dr Afzal Javed visited NIMHANS, Bangalore to look at the facilities at the conference venue for 2009 Congress. Prof Murali and his team were very enthusiastic in making the preparations for the next world congress. They also arranged a meeting of the local organising committee and discussions were held about the logistics and other matters related to the congress.

WAPR Indian branch also organised a scientific session in the evening where Prof Madianos and Dr Afzal Javed were the guest speakers.



# IASC Guidelines in Mental Health. Psychosocial Support in Emergency Settings.

[www.who.int/mental\\_health/emergencies/en/](http://www.who.int/mental_health/emergencies/en/)

Populations affected by emergencies frequently experience enormous suffering. Humanitarian actors are increasingly active to protect and improve people's mental health and psychosocial well-being during and after emergencies.

During the last 1.5 years, a taskforce gathering experts from many different Agencies and NGOs has tried to collect the experience able to reduce the significant absence of a multi-sectoral, interagency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another.

These guidelines reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners. The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being. In addition, the guidelines recommend selected psychological and psychiatric interventions for specific problems.

The Inter-Agency Standing Committee (IASC ) issues these Guidelines to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.

The final Guidelines embody agreement among 27 humanitarian agencies on the essential first steps towards protecting mental health and psychosocial support in emergencies in a useful and practical guide.

These intersectoral Guidelines are a key event in the development of this young field. Because they have the highest possible level of policy endorsement in today's humanitarian world.

The Guideline is available to be downloaded in PDF format from: [www.who.int/mental\\_health/emergencies/en/](http://www.who.int/mental_health/emergencies/en/)

[gencies/en/](http://www.who.int/mental_health/emergencies/en/)

The Guidelines were formally launched on Friday 14 September at WHO in Geneva.

The Inter-Agency Standing Committee (IASC) was established in 1992 in response to WHO General Assembly Resolution, which called for strengthened coordination of humanitarian assistance. The resolution set up the IASC as the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters. The IASC is formed by the heads of a broad range of UN and non-UN humanitarian organisations.

WAPR President Elect, Lulu Ladrido Ignacio, represented WAPR in this endeavor.



IASC Guidelines  
on Mental Health and  
Psychosocial Support  
in Emergency Settings

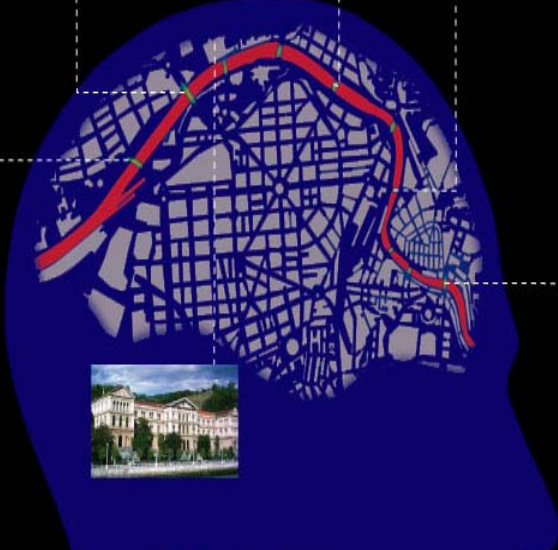


# Events

# WAPR

FEARP

www.fearp.org



Call for abstracts

**II Congreso FEARP**  
**WAPR European Regional Congress**  
**5-7 June 2008 Bilbao (Spain)**  
**www.fearp.org www.wapr.info**



**“Disability Rights and Social  
Participation:  
Ensuring a Society for All”.**

August 25-28 2007.  
Quebec Convencion Center.

[WWW..RIQUEBEC2008.ORG](http://WWW..RIQUEBEC2008.ORG)



**Boston Center for Psychiatric  
Rehabilitation.  
International Conference**

From Innovation to Practice:  
The Promise and Challenge of Achieving  
Recovery for All  
April 14-15, 2008.

[www.wapr.info/wapr\\_events.htm](http://www.wapr.info/wapr_events.htm)



**Mario Negri Institute**  
International Seminar

**Recovery from psychosis: What  
does it mean?**

Milano, Italy.  
**1 December. 2007**

[www.wapr.info](http://www.wapr.info)



1986 - 2007.

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

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