

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

WAPR BULLETIN



GLOBAL FORUM FOR COMMUNITY MENTAL HEALTH

**1st Africa Regional Meeting:
Community Mental Health in Africa;
Sharing Experiences for Better Practice.
Uganda. 10th – 12th June, 2008.**

Volume 24, Sept. 2008.

www.wapr.info

TABLE OF CONTENTS/ Índice

Editorial:

- P. 3: “**Derechoa Humanos e Inclusion social . Rehabilitación e inclusión psicosocial en Argentina.** Prof. Roger Montenegro. WAPR Board at Large.

Collaborations:

- P. 5: “Community mental health in Kenya. A report ” M. Mucheru. WAPR Representative in Kenia.
- P. 7: Global Forum for Mental Health. Entebe Declaration.
- P. 8: La Situation Dramatique de la Santé Mentale au Maroc. Nadira Barkallil. Association Marocaine des Parents et Amis des Personnes en Souffrance Psychique, Rabat.
- P. 12: WAPR Debates. Changing the term Schizophrenia.
- P. 14: Apoyando a las organizaciones de Usuarios en España. R. Guinea. Dep. Secretary General WAPR.
- P. 17: USA Emergency Physicians—80% say Mental Patients Xtra-longwaits. M. Gittelman. Former WAPR President.
- P. 19: European pact for mental health and wellbeing.

Information and Events:

- Supporting Community Mental Heath in Spain.
- Development an a community mental health in Kyrgystan.
- WAPR meetings in United Kingdom, Bangkok, Boston, Bilbao, Salvador de Bahia.
- Bèla Gàlfi Award.
- Obituary: Roger Amiel, Kobus Jordaan.

WAPR Bulletin.

WAPR 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.

WAPR is not responsible for the personal opinions written and subscribed by the authors of the articles.

WAPR HEAD OFFICE.

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

EDITORIAL COMMITTEE (COMITÉ EDITORIAL)

Editorial Council (Consejo Editor)

Michael Madianos. WAPR President. Greece; Angelo Barbato. WAPR Immediate Past President. Italy; Zeb Taintor., USA; Lourdes Ladrido-Ignacio. Philippines; Afzal Javed, UK; Oliver Willson UK. Marianne Farkas, USA; Ida Kosza, Hungary.

Editorial Board (Equipo Editor)

Ricardo Guinea. Madrid. Spain (Director); Marit Borg, Drammen, Norway; José Uriarte, Bilbao, Spain; Ramon Blasi. Barcelona, Spain.

Special thanks to Paul Sidandi, Botswana.

ELECTRONIC DELIVERY (DISTRIBUCIÓN ELECTRÓNICA).

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

Derechos Humanos e Inclusión Social. Rehabilitación e inclusión social en Argentina.

Prof. Roger Montenegro.
Miembro del *Board at Large* de WAPR.

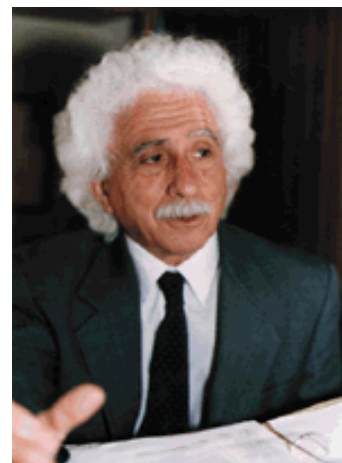
Los Derechos humanos son una de las mejores invenciones de nuestra civilización. Son instrumentos trascendentes para la vida social creados por los hombres. Son una herramienta esencial para evitar las catástrofes producidas por el hombre.

Los individuos que son, o son percibidos como enfermos mentales, sufren de una triple condición: su enfermedad, la estigmatización que causa su enfermedad, la complejidad de los sistemas de servicios desarrollados para servirlos.

Los derechos humanos en general, así como el de los derechos específicos de los enfermos mentales están estrechamente vinculados a las múltiples relaciones de poder y a los discursos generadores de la verdad que dichos poderes necesitan para funcionar.

Si repasamos la historia reciente, los años '60 llegan y se afirman cambios surgidos a raíz de las profundas reformulaciones críticas de la post guerra en Europa. Hay significativos aportes de las neurociencias, las psicoterapias, las reformas institucionales, de los movimientos de defensa de derechos de las minorías. Pero los setenta llegan con la dictadura militar en Argentina y otros países de América Latina, y pa sesar de las esperanzadoras transiciones democráticas de los '80, desde los noventa hasta la actualidad, prevalecen los esquemas socioeconómicos excluyentes basados en políticas neoliberales de ajuste fiscal y economías de mercado, con escandalosa concentración de riqueza y Estados empobrecidos, endeudados y dramáticamente sumidos en ineficiencia, corrupción y obsecuencia política

Un trabajo efectivo de cuestionamientos sobre derechos humanos y salud mental, debe partir del enfrentamiento claro de nuestras realidades sociales. Debe decirse que faltan políticas, programas y presupuestos para salud y educación, y que la



Dr. Roger Montenegro. WAPR.

situación esta agravada por el engañoso discurso de las dirigencias.

Se deben afirmar derechos empezando por el derecho de las personas a tener dificultades sin sufrir discriminación y/o marginación. Avanzar en la práctica en reconocimiento de los derechos de pacientes es pre-requisito del prestigio de nuestra práctica profesional, que esta estrechamente relacionada con defensa activa de los derechos de enfermos mentales.

La "Conferencia Regional para la Reforma de los Servicios de Salud Mental: 15 Años después de Caracas" (nov. 2005), ha evaluado recientemente los desarrollos producidos desde 1990 y ha lanzado los "Principios de Brasilia, Principios Rectores para el Desarrollo de la Atención en Salud Mental en las Américas" en los que declara como conclusión que debido a las mejoras muy limitadas, se debe llamar llaman a todas las partes involucradas a continuar trabajando firmemente en la implementación de principios

éticos, jurídicos, técnicos y políticos incluidos en la Declaración de Caracas para las Américas.

En nuestra práctica diaria, constatamos que se incumple el proyecto de transformación del modelo hospitalo-céntrico, custodial e internista, que faltan recursos humanos e infraestructura para dispositivos de internación parcial, hospital de día, de noche, que no se implementa el enfoque de redes.

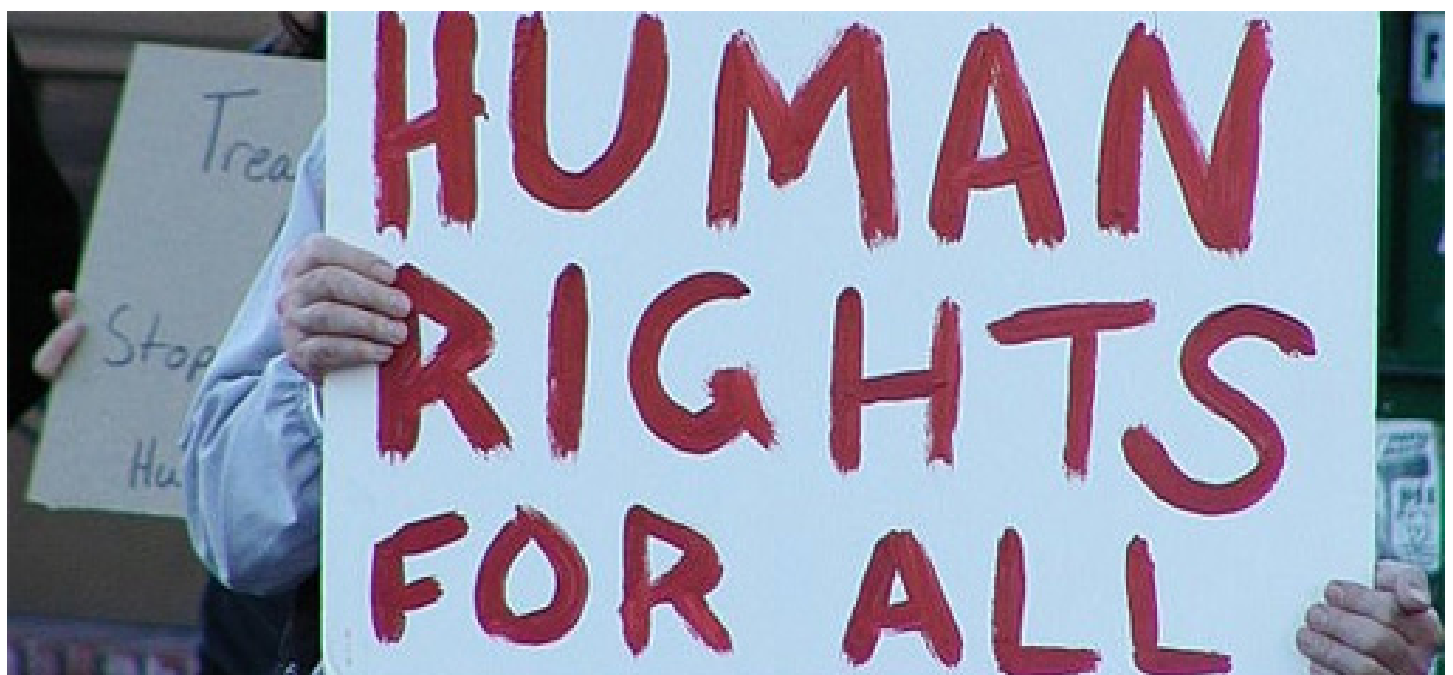
Para tener éxito en un proceso de desmanicomialización, debe efectuarse un trabajo de esclarecimiento en la sociedad, sobre la conceptualización que el imaginario social tiene sobre el padecimiento psíquico. Sólo es posible asegurar valores de salud mental apoyándose en movimientos sociales que afirmen valores de libertad, autonomía, solidaridad, participación democrática, no discriminación e integración de los ciudadanos a los intercambios sociales, económicos y simbólicos de la vida social y cultural.

En línea con estos conceptos, siempre trabajamos por la difusión de principios éticos y la defensa de derechos de pacientes, tanto desde sociedades nacionales de psiquiatría como desde el trabajo interdisciplinario intersectorial y desde el trabajo en ONGs (WAPR, WPA, APAL, etc.)

APAL publicó en 1998 la versión en español del libro “Médicos, Pacientes, Sociedad”, que contiene documentos de la Asociación Médica Mundial, la Asociación Mundial de Psiquiatría, la Organización Mundial de la Salud, las Naciones Unidas y el Consejo Europeo. Debería ser material de referencia para la práctica profesional .

La enfermedad mental torna a los que la sufren menos efectivos en la defensa de sus derechos. Por eso, hay grupos que defienden los derechos de los enfermos mentales. Trabajan activamente en red con OGs y ONGs de salud mental. Es recomendable para los profesionales de la salud mental que, aparte de respetar los derechos de los pacientes en su práctica profesional, los apoyen activamente. Participando en dichas ONGs es una buena forma de hacerlo.

Citando a Andreotti: “El poder desgasta al que no lo ejerce”. Con nuestros pacientes y sus familias estamos sosteniendo el ejercicio de dicho poder.



COMMUNITY MENTAL HEALTH IN KENYA A REPORT.

Dr. M. Mucheru (Kenyan Representative- WAPR)



Dr. M. Mucheru (Kenyan Representative- WAPR)

National level (Tertiary level)

The structures of this level of care are : The division of mental health at the Ministry of health headquarters, The Kenyatta National Hospital which houses the Nairobi university medical school; the Mathari Hospital which is the national referral and teaching mental hospital and the Moi Teaching and referral Hospital.

Provincial level (Secondary Level)

Each provincial hospital has 24-30 bed inpatient units and has a psychiatrist.

Each has access to a hospital based occupational therapy department for use in rehabilitation activities, an outpatient clinic and acts as a recipient of referrals from the districts it serves. The provincial psychiatric services are responsible for forensic work, supervision and training downwards to the district and community levels. They are also involved in training of other cadres of staff at the provincial level, the organization and planning of entire provincial mental health services. They provide a link between the national level and the community.

The District and Community level (Primary level)

District level

A District Mental Health Team consists of a psychiatrist or medical officer, a psychiatric nurse, a social worker, and an occupational therapist. They are then represented in the district health management team.

Community level

The community level has its base as the local health centre. It is usually staffed by a clinical officer who is the head of the team. In addition, there are a number of enrolled community nurses usually 2-5, a public health officer and family field health educators. They form a team that is not only responsible for both curative and preventative services but also for, identifying and appointing village health workers whom they then train. These village health workers have the specific roles of identifying, people who are sick in the community and referring them to the health teams and reintegration them back when they are recovered. They also help with demystifying mental health by providing information both formally and informally.

The Health centre staffs provides follow up for discharged patients from the district level and refer complicated cases to the district level. Medications available include chlorpromazine, phenobarbital, diazepam, phenytoin, amitriptylline and fluphenazine decanoate. They maintain registers of patients in their catchment areas who require regular medication such as depot preparations and anti epileptic medication. They often liaise with the village health workers in tracing defaulters. Continuing public health education for instance health talks that are given in the waiting areas of outpatient clinics, posters, home visits and attendance at formal administration meetings with the public such as chief's barazas. These are integrated to incorporate other aspects of general health.

COMMUNITY MENTAL HEALTH

Kariobangi Health centre is situated in one of Nairobi's slums started in 1984. It has 3-4 psychiatric nurses posted on a rotational basis from the Mathari referral hospital. It is run by the City Council and serves Nairobi East District. The nurses follow up patients discharged from the referral hospital and those attending the health centre as out patients. They plan the week's activities on Mondays and evaluate the same on Fridays. On Tuesdays a post graduate trainee in psychiatry and psychiatric nurses conduct the outpatient clinic. There are no health talks done at the clinic. On Wednesdays and Thursdays home visits are done by the nurses. Monthly reports are then forwarded to the Medical superintendent of Mathari Hospital. This facility is used for training of mental health professions for community mental health experience.

Limitations to service provision:

- Unavailability of psychotropics.
- Unaffordability of drugs since most patients are unemployed and lack social support
- Lacks of collaboration with NGO's dealing with HIV thus patients with psychiatric manifestations of HIV are not able to get ARVs which complicates management.
- Lack of counselling skills for the staff.
- Staff shortage thus not all patients requiring follow up get the services.
- There are various outreach programmes at Provincial and District levels carried out by psychiatric nurses.

There are other Community mental health clinics run by Basic Needs namely:

- Kangemi Health Centre – Nairobi West Division
- Lower Kabete Health Centre – Nairobi West Division
- Meru South – Eastern Province
- Mweiga – Central Province
- Mukurweini – Central Province.

Conclusion:

Community mental health is beginning to take root in Kenya possibly because of the decentralization of mental health services and integration into primary health care.

Recommendations:

- Outreach programmes at the secondary and primary levels of care would go a long way in destigmatising mental health by educating and providing accessible treatment to the community.
- Mental health campaigns during Mental Health Week, Nurses week etc so as to raise public awareness on mental health issues.
- Capacity Building for instance income generating activities for the development of sustainable livelihoods.
- Training and employment of staff at the community level would enhance service provision.
- Collaboration with other stakeholders would be vital to improve mental health services.

Advocacy by the Division of Mental Health to increase psychotropics availability at all levels of care.

Compiled by:
Dr. M. Mucheru (Kenyan Representative- WAPR)

BASIC DEMOGRAPHIC DATA:

Area: 582,646 sq kms
 Population: 32.8 million (UN 2005)
 Life expectancy: 48 years (male), 46 years (female)
 Age structure: 0-14 years: 41.1%
 15-64 years: 56.1%
 65 and over: 2.8%
 Population growth rate: 1.15% (2002)
 Birth rate: 27.61 births per 1000 population
 Death rate: 14.68 per 1000 population.

Administration: Kenya is divided into administrative units, from largest to the smallest- 8 Provinces, 107 Districts, Divisions, Locations, Sub locations and wards.

Health services: Provided at the level of National referral hospitals (2), Provincial hospitals (8), numerous district and sub-district hospitals, health centers and dispensaries.





Entebbe Declaration.

The Global Forum for Community Mental Health 1st Africa meeting held in Entebbe, Uganda, on 10-12 June 2008, has been attended by participants from the following African countries:

- Democratic Republic of Congo, Ethiopia, Ghana, Kenya, Malawi, Nigeria, Rwanda, South Africa, Sudan, Tanzania, Uganda, Zambia and has been organized on behalf of the Forum steering group by the following organizations: BasicNeeds, CMB, World Association for Psychosocial Rehabilitation, World Health Organization.

All the participants share the following considerations:

- It is time for African countries to move away from a mental health care system centered on few large isolated institutions towards a system centered on culturally appropriate community services available at local level, based on primary health care, social integration and consumers' empowerment, linked to all initiatives against poverty.
- Such move requires not only changes in health and welfare policies, increase and re-allocation of financial and human resources, strong input by World Health Organization, substantial modifications of professional attitudes and skills, utilization of evidence-based practices, but also the active mobilization of the civil society.

THEREFORE, THE FOLLOWING RESOLUTION IS APPROVED:

- All the participants note with pleasure the emergence of a movement representing users, consumers and survivors of psychiatry continent-wide.
- All the participants agree to commit themselves and their organizations to make every effort to build in their countries a coalition aimed at pushing towards the development and implementation of the communitybased model of mental health care, by identifying and addressing barriers that hinder such development, disseminating and promoting best practices, finding practical solutions to the emerging problems.
- All the participants agree that such coalition must be made by a network including all relevant stakeholders: users of mental health services and persons giving them psychosocial support; healthcare professionals; community leaders; local, regional and national government agencies, non-governmental organizations; public health agencies; traditional healers; spiritual leaders.

Secretariat Global Forum for Mental Health.
Mario Negri Institute. Via La Masa 19. 20156 Milano, Italy.
Tel ++39-02-39014591, Fax ++39-02-39014300 gfmh@marionegri.it

LA SITUATION DRAMATIQUE DE LA SANTÉ MENTALE AU MAROC

Nadira Barkallil

Association Marocaine des Parents et Amis des Personnes en Souffrance Psychique, Rabat.

S'il est une maladie qui est absente du débat public au Maroc, c'est bien la santé mentale qui évolue dans une faiblesse flagrante des moyens publics et dans un silence inacceptable quand on sait la souffrance des malades et celle de leur famille. En dehors des familles et des professionnels, la société et les hommes politiques ignorent tout des conditions de vie des malades mentaux et de leurs familles. Si la souffrance des malades est immense, celle des familles est indicible et l'une alimente l'autre, fragilisant encore plus les uns et les autres.

La santé est absente des priorités de l'Etat.

Au Maroc, la Santé publique partage avec l'Education nationale la marque profonde et douloureuse de la défaillance de l'Etat en matière de services sociaux offerts à la population, surtout aux groupes les plus pauvres qui ne peuvent avoir accès aux services privés. Par rapport à son niveau de développement économique, le Maroc consacre peu de ressources au bien-être de sa population : c'est ainsi que le rapport sur le développement humain dans le monde arabe montre que le Maroc se situe au 12ème rang pour son PNB/hab mais ses performances sociales sont inférieures à ses potentialités économiques puisqu'il descend au 14ème pour son niveau de développement humain, dépassé en cela par l'Egypte et la Syrie, pays plus pauvres économiquement mais qui consacrent plus de ressources aux besoins sociaux, santé et éducation, de leurs populations respectives². Ces chiffres n'appellent aucun commentaire supplémentaire ; bien plus, ils sont confirmés par les statistiques du PNUD qui a repris celles de l'OMS lors du classement des systèmes de santé dans le monde : notre pays est classé au 15ème rang arabe³ et au 151ème rang mondial pour la qualité de son système de santé telle que mesurée par deux indicateurs à savoir la réactivité/réceptivité⁴ et l'équité⁵.

La misère de l'infrastructure psychiatrique publique.



L'infrastructure psychiatrique nationale actuelle a été, majoritairement, mise en place pendant la période coloniale et peu de créations ont été réalisées depuis l'indépendance du pays en 1956 alors que les besoins se sont démultipliés.

L'infrastructure psychiatrique publique au niveau national comprend 1934 lits et les services offerts sont répartis en :

- 2 centres psychiatriques universitaires
- 7 hôpitaux spécialisés en psychiatrie
- 14 services psychiatriques intégrés dans les hôpitaux généraux
- 57 centres de santé urbains sur 557 soit 10% ayant des consultations ambulatoires
- l'absence totale de centres de santé ruraux bénéficiant de consultations psychiatriques.

Le Maroc ne dispose que de 1934 lits psychiatriques soit 0,8 lits psychiatriques pour 10 000 habitants⁶ alors que l'Egypte et la Tunisie en ont 1,3, tous trois étant loin derrière la France avec ses 12,06 lits. Les normes internationales recommandent 4,5 lits pour 10 000 habitants.

1.396 lits, soit 72.2 % sont localisés dans 7 provinces ou chefs lieux de région. 47 % des provinces ne disposent d'aucune structure psychiatrique.

Le déficit des ressources humaines

En 2001, sur une population de 6160 médecins de la Santé publique on dénombrait seulement 124 psychiatres, soit 2,01 %. A la même date, le secteur médical privé comptait, sur une population de 6.795 médecins, seulement 76 psychiatres, soit 1,11 %. Pour le personnel para-médical, sur une population 26.200 infirmiers et techniciens de santé publique, seulement 623 agents, soit 2,4 % travaillent dans les services de psychiatrie.

Concernant la répartition spatiale des médecins psychiatres du secteur public, celle-ci se présente comme suit :

- CHU de Rabat Salé, et la Wilaya : 19 psychiatres
- CHU de Casablanca et la Wilaya : 25 psychiatres
- Centre Hospitalier Régional de Marrakech : 7 psychiatre
- Centre Hospitalier Régional de Fès : 5 psychiatres
- Centre Hospitalier Provincial de Settat : 4 psychiatres

La très grande insuffisance des moyens humains dont nous disposons est encore plus remarquable à travers les comparaisons internationales :

Nous ne disposons que de 0,4 psychiatres pour 100 000 habitants soit un pour 250 000 personnes contre 0,9 , 1,6 et 20 respectivement pour l'Egypte, la Tunisie et la France. En plus, 60% des psychiatres publics sont concentrés dans 5 régions, abandonnant ainsi les malades mentaux du reste du pays à eux-mêmes et à leurs familles

Les chiffres du nombre d'infirmiers psychiatriques révèlent un moindre déficit du Maroc avec 2,2 infirmiers psychiatriques pour 100 000 habitants contre 2 et 0,2 pour l'Egypte et la Tunisie.

De ce fait, on observe :

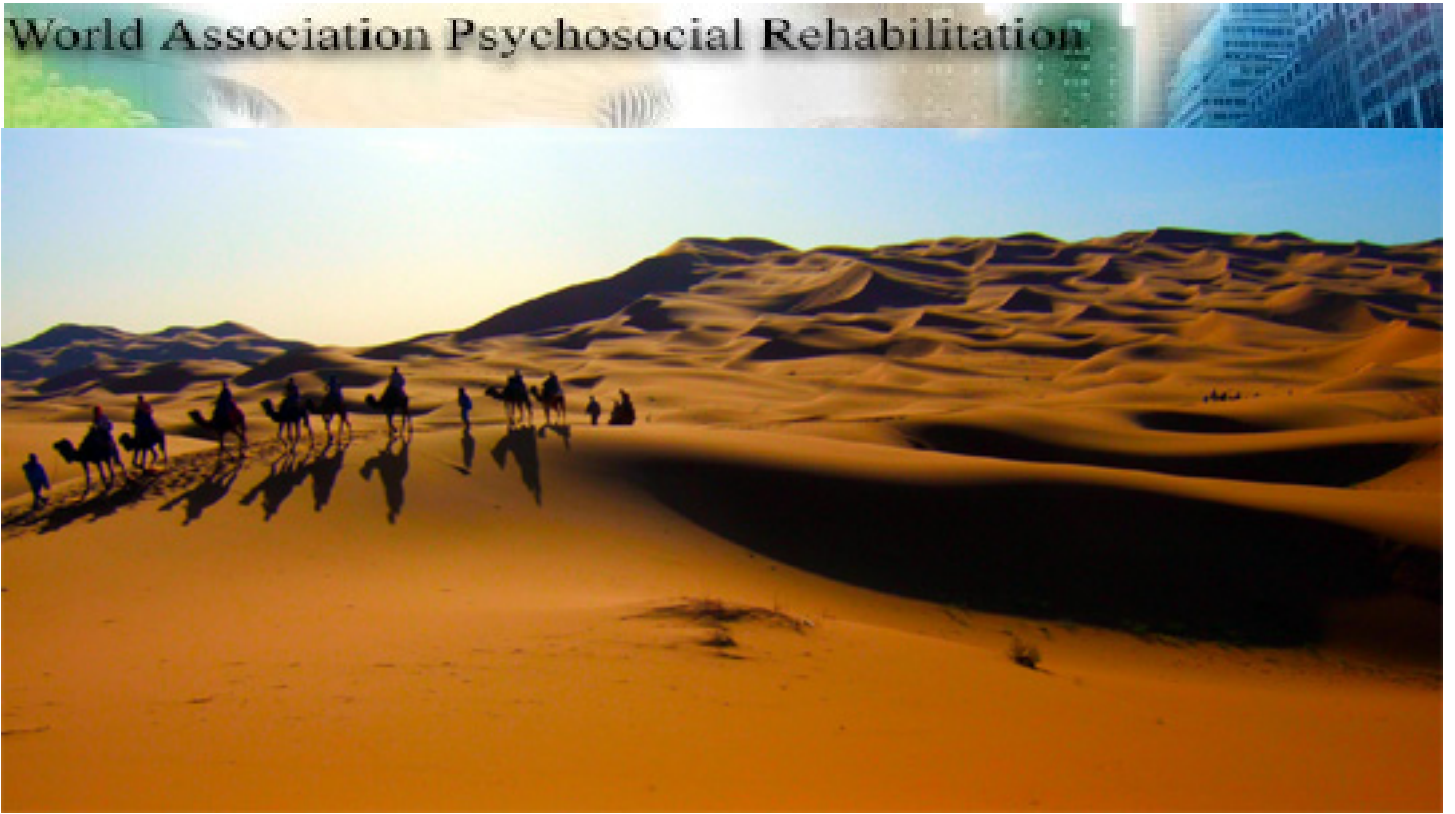
- que peu de malades mentaux sont pris en charge dans le système de santé publique puisque pour un ensemble de 3 millions de personnes touchées, dont au moins 500 à 600 000 atteintes de troubles lourdement handicapants, seules 142 000 ont fait l'objet de consultations en 2001, ce qui représente beaucoup moins de personnes si on considère qu'une même personne peut consulter plus d'une fois par an
- que l'offre hospitalière est faible puisque seuls 13 314 malades sont hospitalisés dans les structures publiques.

Une couverture médicamenteuse insuffisante.

L'État ne fait absolument pas face à ses responsabilités telles que définies dans le dahir 1-58-295 du 30 Avril 1959 qui lui impose de prendre en charge la couverture médicamenteuse totale des malades suivis dans le système ambulatoire public. Cette couverture médicamenteuse, outre qu'elle est faible, est caractérisée par les fréquentes ruptures de stock, ce qui se traduit par la rechute des malades suivis alors qu'un suivi continu est nécessaire pour que ces malades se stabilisent correctement. Si les médicaments offerts dans les circuits publics sont gratuits, quoique insuffisants, sur le marché privé les médicaments neurologiques sont alourdis par les prélèvements étatiques tant au titre des droits de douanes (2,5%) que du PFI⁷ (0,25%) ou encore de la TVA (7%) soit un total de ponction étatique de 9,75%. Les prix des derniers médicaments mis sur le marché

Rabat, Maroc.





marocain sont bien supérieurs à ce qu'ils sont en Europe ou dans les pays voisins.

Cette ponction étatique est inacceptable car :

- en plus de très peu agir en faveur des malades mentaux, surtout les plus pauvres, l'Etat n'a aucune gêne à renchérir le prix des médicaments.
- la maladie mentale nécessite un traitement qui dure souvent toute la vie causant un énorme fardeau pour les familles les plus pauvres
- l'Etat a exonéré de droits de douanes et de TVA les médicaments anti-cancéreux et anti-sida mais non pas ceux destinés aux malades mentaux
- de nouveaux médicaments performants sont apparus dans le monde mais ils sont chers et, de plus, à leur arrivée au Maroc, ils sont grevés par les prélèvements étatiques, ce qui les réserve à une minorité de privilégiés

Une couverture sociale qui vient juste d'être réformée

L'AMO vient de mettre fin à une situation d'exclusion des enfants d'assurés qui a duré pendant des dizaines d'années.

Actuellement l'AMO ou Assurance Maladie Obligatoire a ouvert de nombreuses possibilités pour les malades mentaux adultes chroniques puisque la loi 65-00, portant code de la Couverture Médicale de Base, stipule que :

- l'article 5 relatif aux bénéficiaires, que l'assurance maladie obligatoire couvre les membres de la famille qui sont à la charge du bénéficiaire et sont considérés comme personne à charge sans limite d'âge, « les enfants handicapés de l'assuré qui sont dans

l'impossibilité totale, permanente et définitive de se livrer à une activité rémunérée » ;

- l'article 9 relatif aux conditions de remboursement stipule qu'« en cas de maladie grave ou invalidante nécessitant des soins de longue durée ou en cas de soins particulièrement onéreux, la part restant à la charge de l'assuré peut faire l'objet d'une exonération partielle ou totale » ;
- l'article 116 relatif aux ayants droits de l'assuré, que ceux-ci comprennent entre autres, « leurs enfants handicapés, quel que soit leur âge, qui sont dans l'impossibilité totale ou permanente de se livrer à une activité rémunérée par suite d'incapacité physique ou mentale ».

Une nouvelle orientation publique mais peu de résultats

Face à cette situation psychiatrique alarmante, le Ministère de la santé s'est fixé dans le cadre du plan 2000-2004 un certain nombre d'objectifs, parmi lesquels :

- La modernisation et l'humanisation des services psychiatriques existants.
- L'augmentation de l'offre de soins par la construction de nouveaux services de psychiatrie intégrés dans les hôpitaux généraux n'en disposant pas et le renforcement de l'intégration de la santé mentale dans les formations de soins de santé de base.
- L'augmentation des achats et la gestion rationnelle de médicaments essentiels tels que les neuroleptiques, les antidépresseurs et les anti-épileptiques
- Le création d'unités spécialisées dans la prise en charge de l'enfant et de l'adolescent ainsi que de centres de réhabilitation des malades mentaux.

- Le développement, avec les partenaires sociaux, de la prise en charge des malades mentaux chroniques en situation socio-économique précaire.
- L'actualisation des textes régissant la psychiatrie.

A cet effet, dans le cadre de ce plan quinquennal 2000-2004, plusieurs actions ont été programmées :

- Développement de 200 unités de soins psychiatriques ambulatoires avec des consultations en pédopsychiatrie.
- Création dans quatre régions de structures psychiatriques pour les médico-légaux et les malades difficiles.
- Augmentation de la capacité hospitalière de psychiatrie de 3.000 lits pour adultes et 300 lits pour enfants et adultes
- Formation de 200 médecins psychiatres et 800 infirmiers spécialisés en psychiatrie
- Doublement du budget des médicaments et maintien de la gratuité des psychotropes tout en évitant les problèmes de ruptures de stocks.
- Renforcement des équipements spécifiques (20 électro-encéphalogrammes) et des moyens de mobilité (35 ambulances, 50 véhicules et 100 vélomoteurs) pour les consultations ambulatoires.

TRÈS PEU DE RÉALISATIONS ONT ABOUTI !!!!!!!

Les familles sont abandonnées à leur souffrance et à leur désespoir. Toute cette stratégie est restée sans effets et les familles sont encore livrées à elles-mêmes et recourent, parfois, pour les plus désespérées, à des pratiques peu défendables. Ces solutions familiales désespérées s'expriment ainsi :

Recours à la mendicité pour acheter les médicaments : il n'est pas rare de trouver à la porte des hôpitaux psychiatriques et des pharmacies voisines des malades qui vous supplient de leur payer un ou plusieurs médicaments de même, qu'en période de rupture de stocks publics, les familles et les malades pauvres viennent supplier les médecins et infirmiers pour les aider

Enfermement et/ou enchaînement des malades à domicile, le plus souvent sans soins médicaux, ce qui les rend encore plus violents ou agressifs contre eux-mêmes, ce qui se traduit par des suicides fréquents dans ces cas-là

Abandon des malades dans la rue, chose de plus en plus observable par tout un chacun

De nombreuses rumeurs parlent de camions payés par les familles désespérées pour ramasser les malades mentaux des zones rurales, les transporter et les abandonner dans des petites villes commerçantes comme Souk El Arbaa ou Sidi Kacem

Recours des familles à toutes les espèces de charlatans et de sorciers qui en extorquent des sommes parfois énormes, sans résultats et qui exposent les malades à toutes sortes de risques, dont le viol des femmes « possédées par les démons »

Recours à des abandons plus ou moins longs, voire définitifs, des malades dans des marabouts comme Bouya Omar

où toute une organisation commerciale s'est mise en place, au vu et au su des autorités locales et sanitaires. Exploitant le désespoir des parents qui paient pour l'accueil des malades dans certaines familles du village, sans aucun contrôle ni sur les conditions d'hébergement ni sur les conditions de vie et de sécurité, ces maisons offrent des services tellement insuffisants et inhumains que les malades enfermés toute la journée ou enchaînés sont honteusement utilisés dans des circuits de mendicité, de vols, de domesticité voire de prostitution.

De nombreux malades sans famille ou avec des familles qui ne peuvent plus les accueillir, pour des raisons diverses dont surtout la pauvreté, sont enfermés dans des centres sociaux du Ministère de l'Intérieur comme celui de Ain Atig, près de Rabat, ou celui de Tit Mellil, près de Casablanca, centres qui ne sont couverts par aucun psychiatre public alors qu'ils accueillent des dizaines voire des centaines de malades mentaux abandonnés.

L'insuffisance flagrante des moyens publics pousse les familles à ce désespoir. Deux simples exemples : lors des crises violentes du malade, les familles ne trouvent aucun secours ni du côté de la police ni de la Protection Civile pour l'emmener à l'hôpital et quand il arrive aux urgences, des dizaines de personnes attendent alors qu'il n'y a que quelques lits disponibles. Ce désespoir auquel l'Etat pousse les familles se traduit par une atteinte certaine aux droits civils, culturels et sociaux des malades mentaux qui est indigne de nous en ce début du XXIème siècle.

Al Balsam, association marocaine des parents et amis des personnes en souffrance psychique, créée en Juin 2005 à Rabat, interpelle l'opinion publique nationale et internationale pour lever le silence sur la maladie mentale au Maroc, une situation inacceptable aujourd'hui.

La présidente
Nadira Barkallil
nbarkallil@yahoo.fr

(Footnotes)

- 1.- OMS, Rapport sur la santé dans le monde, 2001, La santé mentale : nouvelle conception, nouveaux espoirs.
- 2.- UNDP-PNUD, Arab development report, 2002
- 3.- Responsiveness en anglais
- 4.- Fairness en anglais
- 5.- OMS, Mental health resources in the world, 2001.
- 6.- Prélèvement fiscal à l'importation.

WAPR Debates. CHANGING THE TERM “SCHIZOPHRENIA”.

WAPR Bulletin.

In the WAPR Board meeting in Bilbao, Spain, a initiative to reconsider the use of the term *schizophrenia* has been arised, supported by M. Madrianos, WAPR president. In the opinion of M. Madianos “This old term dating back in 1911 does not reflect any clinical or and nosological reality. However, it causes a lot of pain and suffering among those who are labeled and their families. Several users and families organizations are already trying to influence key professionals as allies in changing this term”

The initiative has been received with interest and has been followed by an e-mail discussion, which is the source for this non exhaustive report.

P. Deva, former WAPR president, supports the idea from Malaysia, but also opines that “...more important than a name change is a change in the quality of care the mentally ill receive and indeed the lack of the care they should receive even in the hands of psychiatrists”. In the same line, M. Gittelman from USA says : •”The idea of changing the term *schizophrenia* is OK but must always be paired with issue of improving treatment, living conditions and employment for people with mental illness”

J. Uriarte from Spain invites to carefully maintain the global consensus.

P. Sidandi from WAPR-Africa, suggests to seek for suggested alternatives endorsed by its justification, and reports that ”the discussion going on in Botswana at present is to change the media attitude to mental health services and stigma attached to mental illness, the mentally ill and mental health workers. One group have suggested that the name Lobatse Mental Hospital be changed to a less stigmatising one”.

O. Wilson, co-founder of WAPR, joins the debate and writes from UK “ I would support a name change but it will need a wide consensus including users & families as well as health professionals and yet must be sufficiently specific despite there being a range of these disorders and syndromes. Advancing research might make a nonsense of name change at this point in the not too distant future”.

Prof. H. R. Chaudhry says ”I strongly agree that we must change the term *schizophrenia* since it carries lot of stigma both for the patients and for families and carries negative prognosis. It is also a general impression that once patient diagnosed with



schizophrenia is always a patient of *schizophrenia*. I suggest the term *neurocognitive disorder* to replace the term *schizophrenia*, possibly it gives some biological understanding.

In the same line, M. Stark from Germany writes: “I strongly support the idea of at least to start with a discussion on that topic. Especially in Germany the term *schizophrenia* resembles the nazi terror which all these patients had to suffer. I had suggested in a former article on this matter the term *cognitive disorder* in relation to affective disorder under which also a broad variety of diagnostic subterms gather” but points out that a great consensus should be reached to proceed.

R. Guinea from Spain opines that ”*schizophrenia* is a old consensus term that indicates a group sf syndromes -not a unique one -, that the state of the art of psychiatry is is still not able to offer a definitive biological perspective of the aetiology and physiology of the psychotic states, and consequently that our diagnostic approach is too hazy. Guinea agrees on the idea that for the patient and the family it carries a lot of prejudices about bad prognosis, and suggests to consider a wide new consensus construct considering its relevance over psychosocial consequences (*psychosocial dysfunction syndrome*), without a particular reference to biological or aetiological causes”.

L. Barnaby, says that “just as in other parts of the world, the term *schizophrenia* is loaded with negative connotations and stigma. We in the Caribbean would certainly support moves to change the term via discussion and other appropriate means”.

In the opinion of Dr Russell D’Souza, from WAPR- Australia, “the important issue is the well-being of the patient and the supports / significant others that are the family. Even in developed countries as Australia we are at times having to manage patients who might fulfil the DSM criteria for diagnosis of Schizophrenia but with a list of provisional diagnosis given not only for the fears and risk of non adherence with treatment by patient and family but also Stigma associated with the named illness Schizophrenia even from other health professionals. In the developing world and in Asia this can be an issue that can impact of caseiness, treatment, rehabilitation and ultimately global function recovery and outcomes. I think this issue merits further dialogue and discussions including the views of the patient and the family”.

N. Shinfuku, AFPA President, reports from Asia: •”Please note that Japan has changed the Chinese character (*Split mind disease*) used to designate Schizophrenia to another Chinese character (*Coordination disorder of mind*). Stigma was one of major reasons for its change and “Family Association” was the driving force for its change. Other East Asian countries, China, Korea, Taiwan, have not changed the Chinese character (*Split mind disease*) which was translated from Germany to Japanese (Chinese) around 100 years ago. It will be important to know that *Schizophrenia* has been translated into many languages including non-european languages. Renaming schizophrenia in English will have far-reaching impact to other non-English speaking countries”.

N. Shinfuku also mentions M. Sato’s article *Renaming schizophrenia: a Japanese perspective* in World Psychiatry (february 2006) , where the author writes ”The new term for schizophrenia (*Togo Shitcho Sho*) refers to the vulnerability-stress model, and implies that the disorder may be treated and that recovery is possible if a combination of advanced pharmacotherapy with appropriate psychosocial intervention is used. In Japan, we use this model for the investigation of biological vulnerability for schizophrenia and in clinical practice”.

Zeb Taintor states “I favour dropping *schizophrenia* in part because of different usage across the Atlantic. Americans wonder why the French see the prognosis as poor until they discover that *first break* is not included. More and more we in the USA have adopted this usage and talk of *first break*”.

Madianos has announced an editorial article for the next issue of the Bulletin, motivating his initiative, and has stated that “the current debate on this issue, in the field of mental health although has not been extensively motivated, there are some voices discussing the need for change, of the term. I believe that the debate on this issue in our Association has just started”.

WAPR Bulletin.



APOYANDO A LAS ORGANIZACIONES DE USUARIOS EN ESPAÑA.

R. Guinea. Dep. Secretary General WAPR.

Las personas con enfermedad mental afrontan dificultades para encontrar un lugar digno en todas las sociedades. Existen barreras (como el estigma) que dependen de la incomprensión de la sociedad hacia su problemática, que deben ser removidos. El estigma social pone a las personas a la defensiva, les presiona para ocultar sus problemas, les aísla y les confunde y les hace sufrir por la incomprensión social. Otras barreras tienen que ver con las consecuencias de la propia enfermedad, sus síntomas y discapacidades: las sociedades deben asumir el reto de ayudar a las personas mediante tratamientos de calidad y medidas de apoyo social apropiadas.

En RPS, existe un gran consenso sobre que se debe apoyar a las personas con enfermedad mental para que puedan ejercer sus derechos ciudadanos de manera plena.

En España, la forma de practicar este apoyo ha ido evolucionando. En las fases iniciales de implantación de programas de RPS, se organizaron multitud de actos asociativos y científicos liderados por profesionales y familiares, donde la participación de los usuarios era meramente testimonial. El interés de estos eventos ha radicado en que los eventos tuvieron una calidad creciente y la sensación de inclusión y empoderamiento de los usuarios fue importante. Conciertos musicales en salas de la ciudad, campeonatos deportivos en instalaciones públicas, actos culturales y manifestaciones fueron numerosas y regulares.

Sin embargo, las formas más tempranas eran demasiado paternalistas. Se tomaba la palabra por ellos para explicar defender sus derechos, pero si contar con ellos y con muy escasa participación por su parte. El eslogan “nada por mi sin mi”, da la medida de la crítica que merecía esa posición desde los usuarios.

En la actualidad estamos viviendo una segunda época en la que los usuarios están tomando la palabra en primera persona. Las organizaciones de usuarios creadas bajo el cuidado de los profesionales o familiares están comenzando a tomar la iniciativa y a emprender acciones independientes. Los usuarios están buscando su propia voz y están apareciendo líderes que la transmitan a la sociedad de manera independiente, organizada y clara.

Los usuarios han expuesto su voz en espacios regulares en medios de comunicación nacionales (como la experiencia de

“Radio Nikosia”), han organizado actos científicos y académicos en la universidad (como las I Jornadas de Salud Mental en Trabajo Social”), gestionan sus propias redes sociales a través de asociaciones y clubes, y observamos en su participación ya mayoritaria en actos como el Día de la Salud Mental 2008 en Madrid.

Podemos anticipar que los movimientos de usuarios continuarán su desarrollo, y que su actividad incipiente será crucial para demostrar fehacientemente que la posibilidad de la recuperación de la enfermedad y de la participación ciudadana no es una nada de utopía, para recordar a los sistemas sociales y sanitarios que deben mantener su compromiso con las personas enfermas para que las oportunidades de recuperarse sean verdaderas oportunidades.

FEARP ha apoyado la creación de una red nacional de usuarios en España, auspiciando la celebración de reuniones durante los congresos nacionales. Estas iniciativas han permitido identificar los objetivos comunes y las dificultades que habrá que vencer.

Para ello será necesario que un número significativo de usuarios asuman de manera creciente y verdaderamente el reto de la participación y se conviertan en agentes activos de la sociedad civil.

R. Guinea.



Declaración del *encuentro de usuarios* del II Congreso FEARP de Bilbao (España).

En la reunión de Usuarios celebrada ayer en Bilbao, día 6 de junio de 2008, en el marco del II Congreso FEARP, que contó con la presencia de representantes de Asociaciones de Usuarios de Salud Mental, procedentes de varias Comunidades Autónomas, se debatieron distintos puntos y quedó claro que, si bien no existe total unanimidad respecto a todos los aspectos planteados- SÍ existe una clara voluntad de crear una plataforma que represente en primera persona al colectivo de usuarios de Salud Mental del Estado.

También se dio lectura a la declaración que se va a leer a continuación, propuesta por las asociaciones ADEMM (de Cataluña), Asociación Bipolar de Madrid y AVANTE (de Cádiz), a la que se han adherido distintas asociaciones, y que ya cuenta con el apoyo de diversas entidades nacionales, cuyo listado completo se leerá al final.

DECLARACIÓN

A partir de la iniciativa tomada a lo largo del año 2007 por diferentes entidades que trabajan en el ámbito de la salud mental, se han recogido las recomendaciones realizadas por la OMS y promovidas desde la Estrategia en Salud Mental del Sistema Nacional de Salud Mental de 2006, para impulsar la creación de una plataforma representativa de personas afectadas por enfermedades mentales. A partir de las distintas reuniones realizadas os transmitimos las siguientes consideraciones.

CONSIDERACIONES

1. Consideramos esencial que se consiga crear una plataforma que pueda representar a todas aquellas personas que tienen afectada su salud mental, sin hacer discriminación alguna por razones de diagnóstico, género o raza.
2. La representación de las personas afectadas por diferentes patologías psiquiátricas ha recaído hasta la fecha en organizaciones de carácter profesional y asociaciones de familiares de afectados.
3. La creación de la plataforma por parte de las personas afectadas por problemas de salud mental, supone una plasmación de los derechos humanos y de ciudadanía.

Además ofrecerá una visión más humana, realista y verdadera del afectado y de su entorno.

4. Creemos que la adopción de responsabilidades de carácter representativo por parte de los propios afectados es necesaria ya que contribuirá a una mayor comprensión de las diferentes dolencias, aportando una visión más humana, realista y verdadera del afectado y de su entorno y, por consiguiente, conducirá a un abordaje de calidad para con la persona.
5. Reconocemos que el esfuerzo para la constitución de una plataforma verdaderamente significativa y capaz de representar lo que se ha dado en llamar coloquialmente la “voz del usuario” necesita grandes dosis de esfuerzo y dedicación.
6. En el desarrollo de este proceso será necesaria la interlocución y el debate con diferentes agentes sociales, así como con entidades que en el ámbito de la salud mental cuentan con una mayor experiencia de trabajo.

Por ello, las Asociaciones abajo firmantes, nos hemos comprometido a realizar todos aquellos esfuerzos que, en función de nuestra capacidad operativa actual, nos permitan avanzar en la consecución de los objetivos descritos.

A través de esta declaración, invitamos a otras asociaciones sin ánimo de lucro, y dedicadas a luchar por la mejora de la calidad de vida de las personas afectadas por problemas relacionados con la salud mental, a adherirse a este proceso y aunar fuerzas que nos permitan un mayor grado de organización y eficacia.

A la vez, queremos agradecer el interés y apoyo desinteresado demostrado por diferentes organizaciones en el inicio de este proceso, en especial, a la UNED, Colectivo Orate, y a la FEARP por la invitación y la cesión de varios espacios en su III Congreso anual.

Asociaciones que se han incorporado a esta Declaración

Hierbabuena – de Oviedo (Asturias), Terraferma – de Lleida (Cataluña), AUSAM – de Murcia, Mundo Bipolar – de Madrid
ABBVS – de Bagés Solsonos (Cataluña), AFESOL – de Benalmádena (Málaga- Andalucía), y Asociación Alonso Quijano – Madrid

Como conclusión, consideramos que esta Declaración y el trabajo realizado en esta reunión de Bilbao, es un buen punto de partida para seguir recabando apoyos y aportando trabajo y esfuerzo, para la consecución de dicha Plataforma.

WAPR meeting at Bangkok, Thailand.

WAPR organised actively a participated in meeting the 11th ASEAN Congress held at Bangkok, Thailand from 25-29 August 2008. Prof Pichet Udomratn, WAPR ; the representartive in Thailand was the chairman of the organising committee and the meeting was attended by a number of WAPR Board members including Prof Lourdes Ladrido-Ignacio, Dr Afzal Javed, Prof Deva, Prof Murali, Prof Haroon Rashid Chaudhry, Prof Nalaka Mendis and Prof Shinfuku. Prof Russell D'Souza from Australian and New Zealand branch also participated. WAPR also organised few sessions at this meeting and participated in the scientific programme with a keen interest. The board members also had a meeting and discussed about the forthcoming World congress at India in 2009 and also the proposed regional meeting at Australia in 2010.

Prof Murali gave details of the arrangements about our 2009 Congress. I am pleased that the arrangements looks impressive and the local hosts are working very hard to make this event a real success. The organising committee has secured the support of the government, local professional associations including NGOs, users and carers groups, national mental health institutions & pharma industry. The issues about budget accommodation, local travel and other logistics appear to be progressing.

The board members are pleased to suggest the names of the distinguished speakers to the scientific committee for their consideration for the Plenary and key sessions. They are currently finalising these names and input from the Board will be highly appreciated.

The scientific comitee is ready to receive some input, abstracts for symposia, free papers and other presentations so that they can start working on the scientific programme.

The updated flyer will be ready by middle of Sept on the

Congress website and this will include the names of all the collaborating groups for this Congress along with some more details.

Second announcement will be ready by the end of the year and will have detailed information about hotels and other related logistic issues.

It was agreed that Asian Board members of WAPR will develop close collaboration with Asian Federation of Psychiatric Associations (AFPA) and plan some training and service provision projects in the region.

Our newly established **Australian & New Zealand Branch will host a regional meeting in 2010**. Kindly note this information and Dr D'Souza and Dr Umit will send us the details very soon. This will make our Association's presence felt in that region in a big way.

The discussions about **2010 WAPR Congress** also took place as interests have been shown by Philipines and Australian & New Zealand's branches for hosting this event. All the board members and national branches are requested to send any their interest / bids to the Board as early as possible.

Afzal Javed, WAPR Secretary General.

Supporting Community Mental Health. A meeting in Spain.

"85% of the mental health attention should be delivered out of hospitals", this could be the main conclusion of a meeting, revisiting the main concepts of community mental health and Psychosocial Rehabilitation. B. Saraceno, form WHO; I. Levav from Israel, presented the key lectures.

A. Desviat, A.F. Liria, F. Chicharro, P. Cuadrado, J.C. Casal R. Guinea and other delegates from Spain presented communication supporting community mental health principles and denounced the new "neo-liberal style" trend that is threatening to destroy the community network in Spain, favouring private business based health attention. Many scientific association have also denounced this trend, that has produced very poor standards of attention previously in other countries.



USA Emergency Physicians—80% say Mental Patients Xtra-longwaits.

M. Gittelman. Former WAPR President.

A survey by the American College of Emergency Physicians, released by USA Today, found that nearly 80% of 328 emergency medical directors at hospitals said that mentally ill patients sometimes wait four hours or more to be admitted. About 10% said patients wait more than a day on average: “It’s not unheard of for people to spend a night or even a couple of nights (in the ER).”

Such systemic delays are putting patients’ lives at risk: Mental patients treated within the mental health system have a high mortality rate—these patients’ lives are cut short by 25 years [1]

Mental patients prescribed some antipsychotic drugs have a high rate of life-threatening physical diseases—e.g., cardiovascular disease, stroke and diabetes. “Emergency medicine departments (EDs) are seeing increasing numbers of individuals who have attempted suicide.” [2]

Clearly such patients presenting in hospital emergency rooms are at very high risk of dying if left unattended.

The ramifications of such delays for mental patients who are at high risk are documented in a 107 minute surveillance video (June 19) of a woman who had been involuntarily committed—that is, she was forced into the hospital described in court documents as “a chamber of filth, decay, indifference and danger.” Esmin Elizabeth Green waited 24 hours to be helped when she fell from her chair at 5:32 a.m. and began convulsing. [3] She was left to die in plain sight of indifferent staff at Kings County Hospital. [4]

James Bentley of the American Hospital Association acknowledges that hospitals are closing their psychiatric units because of inadequate payments from government and insurers, unpaid costs for the uninsured and too few psychiatrists willing to work in hospitals. That creates a culture of neglect.

The conduct of the Kings County Hospital staff does not merely represent individual “bad apples.” The hospital staff indifference to human suffering has been shaped by an institutional culture and public policies that devalue the lives of some human beings—much as the photographs documenting Abu Gharib prison guards humiliating prisoners of war represented a culture that tolerates such depraved conduct.

References:

- [1] http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm
- [2] <http://grants.nih.gov/grants/guide/notice-files/NOT-MH-08-013.html>
- [3] <http://tinyurl.com/4bnnu7>
- [4] <http://ahrp.blogspot.com/2008/07/associated-press-reports-below-that.html>

Other references:

1. Colton CW, Manderscheid RW. Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Preventing Chronic Disease, 2006 Apr. Available from: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm.
2. The stated rationale for a suicide prevention initiative by the National Institute of Mental Health, is the claim, “Emergency medicine departments (EDs) are seeing increasing numbers of individuals who have attempted suicide.” See: Request for Information (RFI): Input on Public Mental Health

Research Questions for NIMH’s interest in Suicide Prevention Efforts in Emergency Medicine Departments, Notice Number: NOT-MH-08-013
Release Date: June 16, 2008 Response Date: July 25, 2008
<http://grants.nih.gov/grants/guide/notice-files/NOT-MH-08-013.html>
http://www.usatoday.com/news/health/2008-06-16-ERwaits_N.htm

From a surveillance camera: a dead woman ignored in a emergency room in USA





UK Branch meeting 2008.

WAPR UK Branch held its annual meeting.

WAPR UK Branch held its annual meeting on 10th May 2008 at Pendle House, Nelson. A large number of mental health professionals attended this meeting from nationwide. There were about 65 delegates who were present on this day. This is second year in row that this event has been held with collaboration of Lancashire Care NHS Foundation Trust. Dr Shahid Quraishi national president for WAPR welcomed the delegates and invited Professor Max Marshall to officially inaugurate the meeting. He in his inaugural speech expressed his views about new ways of working.

DR JS Bamrah chaired first session and Dr Jossane Holloway presented her lecture on rehabilitation in Forensic services. Dr K Mostafa chaired the second session and Dr M Arif discussed rehabilitation in Adult ADHD patients and Dr Currie spoke about outcomes in schizophrenia.

Last session was chaired by Dr Afzal Javed and Mr J Naess spoke about the need of reemployment of patients suffered a mental health event and Dr McCarron spoke about psychological intervention in psychosis and DR S Afghan emphasised the need of public education in order to tackle the discrimination. Dr SM Ahmnad closed the meeting .

Afzal Javed, Secretary General WAPR.



Development of a network of psychosocial rehabilitation in Kyrgyzstan.

Dr. Bolot Temirbekov. Nat. Secretary of WAPR in Kyrgyzstan. boltem75@gmail.com

To lead the analysis of development of a network of psychosocial rehabilitation in Kyrgyzstan follows on consecutive steps:

- The Law on the psychiatric aid and guarantees of the rights of citizens at its rendering, accepted by Legislative Assembly of the Jogorku Kenesh of Kyrgyz Republic from 25may1999.
- The National program “ Mental health of the population of the Kyrgyz Republic on 2001-2010” Creation of the Republican Center of mental health in structure of which branches of rehabilitation (2001-2006) have been organized, and a department diagnostic, medical and rehabilitation, educational technologies (2001-2004).
- Organization of cooperation in creation of the Rehabilitation Centers with NGO “Awakening” in Bishkek and NGO “Talgar” in Osh (2000).
- Digest of Development of the normative and legal acts adjusting stationary service in the Kyrgyz Republic (2004):
 - “Regulations about of psychosocial rehabilitation at the medical organization rendering to the psychiatric services”;
 - “ Regulations about rehabilitation branch at the medical organization rendering to the psychiatric services “

For the present moment I have finished development of the Program of social rehabilitation of patients with mental disorders “Jamaatca Kaytaruu” and to organize training courses “Rehabilitation in psychiatry “.

In the conclusion I would like to quote such kyrgyz a proverb “ If you superfluous houses, whether will become the among another’s? “. I for myself on this question have answered. Thanks you for I begin to feel a member of big family WAPR!



European Pact for Mental Health and Well-Being.

EU High Level Conference. Brussels June 2008

The participants in the EU high-level conference “Together for Mental Health and Wellbeing”, Brussels, 13 June 2008, have elaborated a consensus document where it is recognised that:

Mental health is a human right, and promotes learning, working and participation in society. The level of mental health and well-being in the population is a key resource for society and economy, that mental disorders are on the rise in the EU. Mental disorders and suicide cause immense suffering for individuals, families and communities, and mental disorders are major cause of disability.

The participants agreed that there is a need for a decisive political step to make mental health and well-being a key priority, that needs to be developed by involving the relevant policy makers and stakeholders, including those from the health, education, social and justice sectors, social partners, as well as civil society organisations, and that people who have experienced mental health problems have valuable expertise and need to play an active role in planning and implementing actions, and that there is a need to improve the knowledge base on mental health: by collecting data on the state of mental health in the population and by commissioning research into the epidemiology, causes, determinants and implications of mental health and illhealth, and the possibilities for interventions and best practices in and outside the health and social sectors.

A call for action has been made on five priority areas. Some relevant aspects of the them have important implication on Psychosocial Rehabilitation practices and policies:

Prevention of Depression and Suicide is an important target since mortality from suicide is very frequent among those with mental illnesses.

Taking care on Mental Health in Youth and Education is another important issue, since it is now recognised that up to 50% of mental disorders and disabilities have their onset during adolescence. Policy makers and stakeholders are invited to take action on mental health in ensure schemes for early intervention throughout the educational system, provide programmes to promote parenting skills, etc.

Workplace Settings plays a central role in the social inclusion of people with mental health problems, so policy makers, social partners and further stakeholders are invited to take action on mental health at the workplace in order to provide measures to support the recruitment, retention or rehabilitation

and return to work of people with mental health problems or disorders.

Stigma and social exclusion are both risk factors and consequences of mental disorders, which may create major barriers to help-seeking and recovery. Policy makers and stakeholders are invited to take action and support anti-stigma campaigns and activities such as in media, schools and at the workplace, develop mental health services which are well integrated in the society, promote active inclusion of people with mental health problems in society and involve people with mental health problems and their families and carers in relevant policy and decision making processes.

The reference context for the Pact is the EU-policy acquires on mental health and well-being that has emerged through initiatives across Community policies over the past years, together with the commitments which Member States of Ministers of Health made under the WHO Mental Health Declaration for Europe of 2005 and relevant international acts such as the United Nations Convention on the Rights of Persons with Disabilities.

The Pact brings together European institutions, Member States, stakeholders from relevant sectors, including people at risk of exclusion for mental health reasons, and the research community to support and promote mental health and well-being.

The pact invites the UE Member States together with further relevant actors across sectors and civil society and the European Commission and Member States, together with the relevant international organisations and stakeholders to:

- Establish a mechanism for the exchange of information;
- Work together to identify good practices and success factors in policy;
- Communicate the results of such work through a series of conferences on the Pact on priority themes over the coming years.

The Pact also invites the European Commission to issue a proposal for a Council Recommendation on Mental Health and Well-being during 2009, and the Presidency to inform the European Parliament and the Council of Ministers as well as the European Economic and Social Committee and the Committee of Regions of the proceedings and outcomes of this conference.

Bèla Gàlfi Award 2008 presented in Bilbao (Spain).-

I. Kosda presented the award to R. Guinea on behalf the Hungarian WAPR Branch.
Bilbao, June 2008.

Dr. Ricardo Guinea, WAPR Dep. Secretary General, has received the Bela Galfi Award, presented by Dr. Ida Kosza, WAPR Vice-president, on behalf the Hungarian Branch of WAPR. The award was presented in the closing ceremony of the I Regional European WAPR and IFEARP Congress in Bilbao.

I. Kosda justified the award on the activity developed by R. Guinea in the recent years for WAPR and for the Hungarian Branch. Guinea expressed his high appreciation of the award, and expressed his acknowledgment to the Hungarian Branch that is supporting Psychosocial Rehabilitation in difficult times due to the political and economical situation in Hungary, and also acknowledged all his colleagues in IFEARP Spain that have been supporting psychosocial rehabilitation and developing a terrific work in the last recent years.

Guinea has been the president of IFEARP, the WAPR Spanish branch, that was founded in 2001 and has been developing continuous activities. IFEARP supported the participation of Latin delegates in the "Latin Simposia" in WAPR New York world congress 2003 and Athens 2006. Has cooperated in training and scientific activities in Republic of Panama, Tunis and Brazil. IFEARP is also editing "Rehabilitacion Psicossocial", a website, a journal in Spanish with is available in the internet for free. Under the support of IFEARP more than ten new local organizations have been created. Another relevant activity has been the creation of an Observatory that pretends to follow the level of services and opportunities in Spain for those mentally ill.

In his acknowledgement, Guinea mentioned his colleagues J. Uriarte, J.A de la Rica, F. Villegas, R. Blasi, A. Garay, A. Vallespi and others that have been very active members in IFEARP and responsables for the success of the II Congress.



Boston University Conference. From Innovation into Practice: *The promise and challenge of achieving recovery for all.*

Boston, USA. April 13-15 2008.

Chaired by Marianne Farkas, WAPR Vice-President and William Anthony, Executive Director of the Center for Psychiatric Rehabilitation; the conference was celebrated, with the participation of Michael Madianos, WAPR President, Angelo Barbato, former WAPR President and Ricardo Guinea, Antonio Maone, amongst other significant WAPR panellists.

The programme covered a wide range of issues: centered on the idea of recovery as the overall target of the PSR process, including public health approaches, mobilizing families and spiritual supports, combating stigma and discrimination, vocation rehabilitation, processes and outcomes, tailoring services for cultural particularities of populations, developing state-wide consumers advocacy networks, shifting services into recovery model, integrating health and mental health, supporting students with psychiatric disabilities in high school, the shared responsibility approaches for mental health programmes, research and evaluation on consumer-operated programmes, supported employment, and others.

Over 800 participants attended the meeting, with a very high level of participation and a significant poster section.

Judi Chamberlin had a very relevant participation, and demonstrated the face of recovery and real participation in the improvement of ideas and services. In the same way, Pat Deegan showed the possibilities of the peer work with consumers, considered as the true specialist of the illness, and the way to overcome situation of misunderstanding between the professionals, users and relatives.

A very successful meeting.



***Encontro Latino-Americano de
Rahabilitação Psicossocial.
VI Jornada de Saude Mental
Universidade Federal da Bahia
Salvador de Bahia. Brasil. 11-13 sept. 2008.***

El encuentro se celebró a iniciativa de Ana Pitta de WAPR -Brasil, Antonio Rabelo y Domingos Coutinho, y con la participación de Michael Madianos, Presidente WAPR, Roger Monenegro de Argentina, Ricardo Guinea de España y otros distinguidos colegas de Brasil.

En el encuentro se celebró en el curso de la interesante evolución de la Reforma Psiquiátrica Brasileña, y la significativa expansión de las ideas, las políticas públicas, las acciones y los servicios de salud mental, en un esfuerzo nacional para experimentar y conseguir modelos de acción cada vez más eficientes para reconducir e incluir a las personas con enfermedad mental al lugar de vida de los ciudadanos: sus familias, el barrio, el distrito, la comunidad.

El encuentro elaboró los desafíos de la Rehabilitación en Brasil, la clínica de salud mental y la capacitación en la atención básica, el cuidado en salud mental en municipios pequeños, el trabajo cotidiano en los servicios comunitarios, la evaluación de los servicios de atención psicosocial y de los servicios de residencia terapéutica, la implementación de los derechos humanos y la inclusión social, diversas experiencias locales, y la Globalización y su impacto en la Rehabilitación Psicosocial.

El encuentro contó con la participación de representantes del movimiento brasileño de usuarios, que tuvo significativas intervenciones relacionadas con su perspectiva sobre los derechos humanos en los servicios de atención y sobre su concepto y propuestas para la inclusión social.

El encuentro dio testimonio de la vitalidad del desarrollo de la RPS en Brasil.

R. Guinea.



**I Congreso Regional
Europeo WAPR.
II Congreso FEARP.
Bilbao, España; junio 2008.**

El congreso se celebró en Bilbao los días 5-7 de Junio con la presencia de Michael Madianos, Presidente de WAPR y de Afzal Javed de UK, Marin Gittleman de USA, Ida Hosza de Hungría, Marit Borg de Noruega, Antonio Maone y Gabrielle Rocca de Italia, Edvard Hauff de Suecia y Rene van der Male de Holanda y Ricardo Guinea y Jose Uriarte de España, entre otros delegados de WAPR.

El congreso reunió a más de 400 asistentes con más de 30 ponencias oficiales y numerosas comunicaciones libres. Entre los temas destacados, se presentaron trabajos sobre perspectiva histórica y experiencias internacionales en RPS, la perspectiva de las familias y de los usuarios, intervención precoz, patología dual, perspectiva transcultural, trastorno de personalidad, y otros aspectos relacionados con la planificación en distintos ámbitos, validez epistemológica de los constructos teóricos usados en RPS o aspectos sociales de la enfermedad mental.

Durante el congreso se celebró el Seminario Avanzado WAPR, con presentación de diversas comunicaciones de los representantes de WAPR en Europa.

El congreso, que contó con el apoyo de la Universidad de Deusto, el Ministerio de Sanidad y otras organizaciones civiles locales y estatales, fue valorado como un gran éxito científico y de participación, y ratificó el camino recorrido en España en los últimos quince años. Con el apoyo de los organizadores, durante el congreso se celebró una reunión estatal de usuarios para estudiar el desarrollo futuro de sus modos de representación, que emitió un comunicado final.

La representación de WAPR felicitó oficialmente a JA de la Rica, presidente del comité organizador por el éxito del evento.

R. Guinea.



Events

WAPR

WAPR WORLD CONGRESS BANGALORE 2009

12 to 15 November 2009, Bangalore.
“One world: quest for integration”



www.wapr2009.org

ASEAN PACIFIC PSYCHIATRIC REHAB. CONFERENCE

6-10 October 2008. Singapore.

“Transforming Lives in Every
Aspect of Work”

6-10 October 2008.

www.apprc.com.sg



Obituary.



Kobus Jordaan.

WAPR Board Member Representing Consumers.

This summer Kobus Jordaan passed away. For people that have not been so lucky to know him: Kobus was a man around sixty years of age and his immediate impression that comes with his appearance is gentleness. He was not only a kind- and modest person but also strong willed and dedicated with a strong passion for his work i.e. to improve mental health conditions for people on local, national and international level from consumer perspective.

At the IX World Congress of WAPR in Athens 2006 he has been elected on the Board of Directors of WAPR, the World Association for Psychosocial Rehabilitation. Together we have occupied two consumers seats. Working together with him was an extremely pleasant and rich experience.

To the people that know him well I would like to share my deepest sorrow and sympathy.

René van der Male
Consumer representative
WAPR Board of Directors

Obituary.



Roger Amiel.

WAPR Co-Founder.

C'est avec une grande tristesse que nous avons appris le décès de Roger Amiel.

Né en Egypte, il a étudié la médecine à Paris. Comme psychiatre il s'est intéressé l'influence des conditions de travail sur l'homme et sur celui qui souffre de troubles mentaux. Il enseigna la psychiatrie à Paris, à Bruxelles et à Nice. Il travailla avec Paul Sivadon et dirigea un hôpital de jour à Paris.

Roger Amiel faisait partie de ceux qui mettent en pratique leurs convictions professionnelles. Il appartenait à une génération de psychiatres français qui, après la guerre eut à cœur de transformer un dispositif de soins encore essentiellement centré sur l'hôpital, en un réseau de proximité assurant des soins intégrés et continus. L'hôpital de jour qu'il contribua à mettre en place était géré par la mutuelle de enseignants.

Roger Amiel a participé à la réunion d'Helsinki sur la réhabilitation psychiatrique en 1971. Il organisa ensuite à Paris avec le Pr. Louis Avan (inventeur d'un dispositif informatisé pour « traduire » les textes en Braille), une conférence internationale pour des professionnels de santé africains et européens. Il a apporté par la suite une contribution déterminante à la préparation du congrès fondateur de l'AMRP/WAPR à Lyon et Vienne en France en 1986. Il n'a pas ménagé

ses efforts pour édifier dans la foulée la branche française de l'association, participer à l'organisation des cours supérieurs de Yaoundé et Abidjan, pour aboutir au congrès de Paris en 2000.

Son expérience professionnelle dans le domaine de l'insertion sociale des malades mentaux et de l'influence du travail sur la santé, nous a beaucoup aidés. Mais c'est sa connaissance de la vie des associations internationales, son réseau d'amitiés professionnelles et personnelles, sa connaissance de l'Afrique et de l'Amérique du nord, qui a apporté des garanties supplémentaires au succès de notre entreprise.

La nouvelle de son décès a créé une vive émotion et un courant de sympathie dont témoignent de nombreux messages.

La disparition de Roger Amiel est une perte immense pour l'association. Il aura également profondément marqué, par son militantisme pour des soins meilleurs et un respect des droits des malades mentaux, une génération de psychiatres francophones.

C'est un ami qui nous a quitté et qui va beaucoup nous manquer.

Jacques Dubuis. Former WAPR Président.

Roger Amiel directed Day Treatment and rehabilitation programs for the French National Teachers Union (MGEN) and was a founding member of the WAPR.

Along with his contemporaries he understood that among the best methods to promote integration and reduce stigma was vocational training and the availability of paid work. Teachers who suffered from mental illness and could no longer work in the classroom found opportunities to continue employment in another capacity.

He attended our first organizing meeting in Finland in 1971; a meeting which called for action to organize what would later become the World Association for psychosocial Rehabilitation. Later he helped to organize our first Congress in Lyon and Vienne, France.

Born on the African continent (Egypt), he was sensitive to the needs of those with mental illness in all parts of the globe. He helped to raise funds and to organize an Advanced Institute in Douala, Cameroun to strategize with African leaders the best way to organize psychiatric services with limited funds and personnel.

He will be sadly missed.

Martin Gittelman. WAPR Former President.



1986 - 2008.

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

Membership Application/Formulaire d'Adhesion/ Solicitud para hacerse miembro

Please type or print legibly/ Veuillez ecrire lisiblement on dactylographier / Por favor, escribir claramente o dactilografar:

WAPR Head Office
Dr Stelios Stylianidis, Treasurer, WAPR.
EPAPSY, 61 Grammou str, 151 24 Maroussi, Athens, Greece, Grèce, Grecia.
Tel: 0030 210 6141350, 6141351 Fax/Telecopier: 0030 210 6141352.

Name/Nom/ombre _____
Address/Adresse/Dirección _____

Telephone/Téléphone/Teléfono _____ Fax/Telecopier _____
E-mail _____

Check type of membership for which you are applying/Cochez la classe d'adhesion appropriée/Marque que tipo de miembro desea usted ser:

- Regular/Ordinaire/Ordinario: 50 USD _____ ()
- Sponsoring/Parrainage/Padrinazgo: 1000 USD _____ ()
- Organization/Organisation/Organización: 150 USD _____ ()
- Students, Consumers, Families/Estudiants, Usagers, Familles/Estudiantes, Consumidores, Familias: 25 USD _____ ()
- Reduced fee/ Cotisation reduite/Cuoto reducida (enclose letter with rationale/inclure letter d'explication/ incluir carta de justificación:

Amount/Montant/Cantidad _____

Donation/Don/Donación:

Amount/Montant/Cantidad _____

Interest in Psychosocial Rehabilitation/Centre d' Interêts en readaptation psychosociale/Area de interés en rehabilitación psicosocial:

All money directed to WAPR should be sent by bank transfer to the following bank account/Tous les paiements addresses a l' AMRP doivent être deposes sur le compte à l' adresse suivant compte/ Todos los envíos de dinero para la AMRP deberán que ser enviados a esta cuenta:

EUROBANK: WAPR-HELLENIC BRANCH: SWIFT EFGBGRAA

EURO: IBAN: GR1402600020000620201157792

USD: IBAN: GR7102600020000641200035217