



World Association for Psychosocial Rehabilitation

BULLETIN

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PSYCHOSOCIAL REHABILITATION AND PRIMARY CARE PSYCHIATRY

Although most references to psychosocial rehabilitation are associated with the efforts to rehabilitate the severely and chronically mentally ill, there are also persons with less severe emotional problems in primary care who need rehabilitation. Primary care psychiatry refers to the recognition, diagnosis and treatment of mental illnesses in primary care settings,

Primary care psychiatry, a long-neglected area, has recently come into focus with the launch of the ICD-X Primary Health Care Version and the WHO education kit to appraise primary care and health care workers of the practice and management of these problems.

In primary care, patients with emotional problem may be functioning, but not entirely at their optimum level. Many with anxiety and depressive symptoms are often related to difficulties in relationships and coping skills. Marital, family or occupational problems often are recurrent due to lack of coping skills and personality difficulties. These may require not just brief counselling and low doses of medicine, but also longer-term rehabilitation to improve and strengthen coping skills. This is often done in group settings on a day basis where cognitive, behavioural and psychotherapeutic techniques may be used. Life-style problems with emotional reactions that are repetitive and persistent, and patients with alcohol and substance abuse may also benefit from this.

Skills in conducting such rehabilitative programmes may be taught to primary care doctors and allied professionals for use in primary care centres. In Parts of South Africa, such groups are routinely included in follow-up clinics for psychiatric patients in over 300 rural hospitals and clinics of orange Free State with good outcome.

Primary care psychiatry is still a relatively new concept in developing countries. Before it becomes established as a routine in many practices, there is a need to include psychosocial rehabilitation for selected primary care patients who need them in that setting.

Professor M.P. Deva,
President - WAPR.

**VII Congress of the World Association for Psychosocial
Rehabilitation will be held in Paris in the year 2000**

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EDITORIAL

JUST BEFORE HAMBURG

Within a month we will again have the privilege to meet as an association in the beautiful Hanseatic city of Hamburg. From words received today, our VI Congress promises to be a milestone. President of the Congress, Prof. Michael Stark, informs me that more than 800 abstracts have been received from 53 countries. He also notes that there will be sizable delegations from South America and Eastern Europe; he hopes for a substantial participation from France, especially taking into account the fact that, as is announced elsewhere in the *BULLETIN*, our VII Congress will take place in Paris in the year 2000.

Interested participants are urged to register immediately for the 30 training sessions and workshops.

Let's make sure that we utilize the Congress not only to enrich our knowledge, but also to create new links, increase solidarity, and to bring to bear efforts that will revitalize our association.

On another vein, I am pleased to report that we have been able to develop the first entry, specifically dealing with work disability caused by mental illness, into the database section of GLADNET (Global Applied Disability Research and Information Network on Employment and Training). This is an information sharing and research instruments developed in close collaboration with the International Labour Organization (ILO) in Geneva.

The first entry is in French (the other languages utilized being English, German and Spanish) and deals with the legislation, terminology and successful programs that exist in Quebec, Canada. It can be accessed at the following internet address: <http://www.gladnet.org>

With the cooperation of the members of WAPR's Committee on Mental Illness, Work & Employment, it is hoped to significantly increase the number of countries whose programs will be described on GLADNET.

Gaston P. Harnois, M.D.
Editor

Gro Harlem Brundtland Secures Top Job at WHO

(The Lancet, Jan. 1998)

Gro Harlem Brundtland was nominated on Jan. 27, 1998 to head WHO for the next 5-year term. "The health dimension has not had enough attention from world leaders. That has to change; I see it as my first priority", said the former Norwegian Prime Minister.

The 58-year-old doctor was one of five candidates to appear before the 32-member WHO Executive Board. She finally emerged as their choice by securing 18 votes in the fourth ballot, compared with ten votes for Sir George Alleyne (WHO, the Americas), and four votes for Uton Muchtar Rafei (WHO Western Pacific).

Educated in Oslo, Norway, and Harvard, USA, Brundtland held successive posts in government medical services before becoming Minister of Environment in 1974. Five years later, she became Prime Minister, and was re-elected three times. During her tenure, she chaired the World Commission on Environment and Development, which led to the 1992 Earth Summit in Rio de Janeiro, Brazil.

Speaking after the Executive Board announcement, she emphasised WHO's duty towards the developing world. "If we're to live up to the aim of the WHO constitution - to secure the highest attainable health for everyone - we have to unite in our combat against poverty. People in developing countries carry over 90% of the burden of disease, yet they have access to only 10% of the resources that are used for health."

Brundtland indicated that four areas in particular required renewed effort:

- To put health at the top of the political agenda;
- To help countries establish primary health-care services available to all their citizens;
- To be better prepared to respond to emergencies;
- To renew the "management style" at WHO through reform to make maximum use of its concentration of talent. Everyone working for WHO must have a "clear and ambitious mandate", she said.

Brundtland will take over the post on July 21, 1998; her appointment has to be endorsed by the World Health Assembly in May.

Proposed WHO's World Health Declaration

(From WPA NEWS First Quarter 1998)

An especially important meeting of the WHO Executive Board took place in Geneva on 19-28 January 1998, at which WPA was formally represented. Dr. Gro Harlem Brundtland, former Prime Minister of Norway, was nominated to become the fifth WHO Director General (and the first woman in this position) in the 50 years of the Organization's existence. The Board also considered a new global health policy, **Health for All in the 21st Century**, and on the basis of this a **World Health Declaration**, both proposed for adoption by the World Health Assembly this May. The draft **Declaration** starts as follows:

We, the Member States of the World Health Organization (WHO), reaffirm our commitment to the principle enunciated in its Constitution that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; in doing so, we affirm the dignity and worth of every person, and the equal rights, equal duties and shared responsibilities of all for health. We recognize that people's health and well-being are the ultimate aim of social and economic development. We are committed to the ethical concepts of equity, solidarity and social justice and to the incorporation of a gender perspective into our strategies. It is imperative to pay the greatest attention to those most in need, burden by ill-health, receiving inadequate services for health or affected by poverty. We emphasize that health improves when social and economic inequities are reduced.

Later it states: *We recommit ourselves to ensure universal access to health services that are based on scientific evidence, of good quality and affordable. And further: We recognize that in working towards health for all, all nations, communities, families and individuals are interdependent. As a community of nations, we will act together to meet common threats to health and to promote universal well-being.*

African Region

Opening Address by Dr. Sherif, Principal Medical Officer, Palapye Primary Hospital, for a workshop on the evaluation of the Botswana Mental Health Action Plan

Mr. Chairman, Ladies & Gentlemen,

It gives me great pleasure and I am honoured to welcome you to Palapye which is the power house of the nation. Palapye is one of the rapidly urbanized village in Botswana with its major industries such as the morupule colliery The BPC (Botswana Power Corporation), the railway, and other mushrooming large and small industries and business enterprises.

The concept of mental health encompasses the notion of the optimum development and functioning of the individual allowing the realization of aspirations and satisfaction of needs as well as the ability to change or cope with the environment within the context of family, cultural, social, and community parameters. Mental health is an integral component of health in general but its promotion extends beyond the health field.

Health is not just the absence of disease, but is a state of physical, mental, and social well-being. Clearly, we have no reason to think that mental well-being is less important than physical. Indeed, a well developed mental life is what distinguishes human beings from other life forms, and attention to this aspect of our lives must not be ignored.

Mental health and well-being must be seen as a broad concept. It is not confined to the activities of health care professional but involves community groups, educators, social services, the legal profession, families, and others. The formulation of a district or hospital mental health service policy must be done within the context of social, cultural and overall government policy and, in particular, general health policy. To consider this, one might review the objective of **HEALTH FOR ALL BY THE YEAR 2000** by considering each of the components of this objective.

Mental health service has got a broad spectrum of activities, ranging from cure of disease to promotion of mental health. These activities can be conceptualized as a frontier of efforts dealing with a range of overlapping targets in the mental health field. This spectrum of activities includes the following:

Cure - This is where the complete termination of mental disorders and the returning of the individual to normal health is sought.

Care - These activities focus on the reduction of discomfort and disability rather than cure. Such an activity character-

izes the treatment of mental disorders where symptoms and their disturbing qualities are mitigated and the individual returned to acceptable levels of social functioning. Disability is reduced or eliminated, and the issue of cure is generally not addressed. Improvement is the hallmark of progress.

Rehabilitation - Activities which aiming both at maximizing the opportunities of the individual for recovery, and attempt to minimize the disabling effects of chronic conditions..

Prophylaxis - The prevention of relapse in recovered persons is the primary focus of activity at this level.

Primary Prevention - This effort is aimed at the prevention of first occurrences of illness. It involves three main notions: the reduction of environmental hazards and stresses, the development of support systems and other resources, and the development of coping or managing abilities.

Mental Health Promotion - This is a broad concept aimed at enhancing mental health through integrated actions at different levels of activity that influence health, and the factors that influence health. The activities here include prevention, but are broader and deeper so as to include biological, environmental health, and sociological issues. It provides a possible source of criteria from which agreed upon priorities can be established, and activities across the entire effort spectrum in mental health can be monitored.

The range of activities, from Cure, on one hand, to Mental Health Promotion on the other, as well as a clear identification of the range of problems, challenges, and needs within the components of the spectrum can help clarify the relationships and priorities of our mental health service activities, and their respective importance in helping a country more realistically towards its ideal model of service in the mental health field.

It has been shown that in both developed and developing countries about 20% of people attending outpatient clinics do so as a result of a disorder of primarily psychological etiologies - most of these being psychosomatic conditions. Less than a quarter of these are correctly diagnosed as psychological problems. These patients thus become an expense and a burden to the clinic through unnecessary investigations, overuse of medication and constantly returning to the clinic for treatment. It is thus imperative that in the longer term general health staff become skilled in the recognition, assessment and treatment of mental health problems that require non-drug interventions, such as counselling and referral would be necessary only in certain cases.

A practical and sound approach to rural mental health care which could have significant impact, would be the shift in responsibility for dispensing medication from the CPN to general clinic staff. It appears that there is reluctance to take on a mental health function. Mental health problems are seen as different and bothersome. There is also fear of violence from mentally disturbed patients.

However, when mental health problems are demystified through training & experience, general nurses feel confident of their skills & are more sympathetic to mental patients. In a recent follow up of programs in 6 countries (WHO collaborative studies) in which general nurses were trained in basic mental health care, a year after the training the participants' knowledge of and attitude towards mental health were significantly improved from initial levels (e.g. Palapye Hospital). The training process formalized the recognition by the health workers that treating mental disorders is an integral part of their work. It might be necessary to reclassify certain medications so that nurses are able to dispense and prescribe drugs.

We need to evaluate our CNMS in respect of:

1. What are our successes and how much time we allocated on promotive and preventative mental health care.
2. Have we got emergency mental health care at the clinic or primary level.
3. How many default cases have we got in a month at the periphery and how can we follow them?
4. Are our compliance rate high or low and how can we monitor our patients.

If a mental health care is constantly available at all level of health facilities, the problems of inabilities of the CPN to travel because of lack of transport would be alleviated. Moreover patients will not default and end up in a relapse situations. Staff could provide initial care for emergencies, which at present not trained for, resulting in delay of transfer due to lack of transport. Our CMHS (Community Mental Health Services) need to involve programmes of public awareness of mental health issues, such as the negative effects of stigmatization, programmes in the school, the building of support system for the mentally ill, mentally handicapped and their families, campaigns against drug and alcohol abuse.

TRADITIONAL

Mental disorders are traditionally perceived as a battlefield for invisible forces - God, local spirits, dead ancestors, sorcerers and enemies. Evil represented by the disease is always the effect of another evil. Any therapy which hopes to succeed must eradicate both evils - for this an experienced healer is needed. Rituals are a source of peace, love and fertility. therefore for an effective mental health service traditional medicine must not be underestimated or rejected out rightly by modern medicine. Besides the cultural affinity between the patient and the healer, the fact that both belong to the same community where the healer commands more authority, helps to make the patient and their families more secure due to their counselling abilities.

CHILDHOOD PSYCHIATRY

Emotional, behavioural and learning problems may be manifested at all ages in children. The need for early

intervention with regard to children with developmental disabilities is of increasingly universal relevance. Childline etc. There is generally under-detection of childhood psychopathology. (poor school performance juvenile delinquency etc) we do not need to have an approach or service developed in the context of Europe or North America. The approach may vary appropriately across cultures. What is required is an approach and programmes reflecting the situation and functions of indigenous cultures.

URBANIZATION

The way of life in this modern day has weakened many of the traditional supports and amenities we used to have such as the extended family, the small towns, the life time job (agric) and the stable marriage which are comforting during a crisis.

ALCOHOL & DRUG ABUSE

The major causes of illness, injury, disability & death in adolescents are often traceable to maladaptive behaviour such as the (consumption of alcohol, drugs and intentional injuries, suicidal or homicidal.

AIDS EPIDEMIC

The AIDS epidemic has put a great challenge and burden to CHM because of its neuropsychiatric manifestations of MV related illnesses such as acute confusional state, ADC (AIDS Dementia Complex), bacterial, fungal, viral, protozoal CNS infections, CNS malignancies and its psychosocial consequences such as panic, anxiety, depression, suicidal intent and psychosis. Any community-based AIDS care, if it does not involve the CMHS, will not reach its target.

It is now my pleasure to declare the national mental health seminar officially open,

Thank you.

Submitted with permission by Dr. Paul Sidandi,
WAPR Vice President, African Region

There is an urgent need to reverse the trend whereby our society has identified the issues of madness and alienation as being somehow the sole concern of psychiatry.

Pat Bracken and Phil Thomas (in an article entitled "A new debate in mental health" published in Open Mind, January/February 1998)

European Region

AUSTRIA

VOCATION AND MENTAL HEALTH

On December 5, 1997, the WAPR Austrian Branch held its annual meeting in Vienna, supported by Prof. Dr. E. Seyfried (WAPR Committee on Mental Illness, Work and Employment) who initiated and headed the panel discussion, and by Dr. Ida Kosza, WAPR Vice President for Eastern Europe.

"Psychoziale Arbeit" (Psychosocial Work), the journal of psychosocial services in Vienna, reported this meeting in its first issue of 1998 as follows:

"Unemployment - probably the very topic of our recent times: not only does it concern all levels of society, it also (and first and foremost) concerns those people who, in addition to unemployment, are impeded by mental illness.

Therefore, last December the Psychosocial Services of Vienna, in cooperation with WAPR Austria (Primaria Dr. Marion E. Kalousek in charge of the Socio-Psychiatric Ambulance Leopoldstadt and promoting the Austrian secretariat of WAPR) organized a meeting on the topic 'Vocation and Mental Health'.

Renowned experts had been invited to discuss this subject with those immediately concerned, their relatives and with professionals of other organizations.

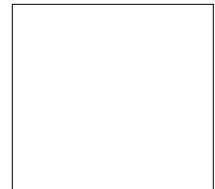
The participants were provided with the very latest data and facts on the recent labour market situation in Europe, and the U.S. economic experts reported on the latest trends in employment policy - Gerhard Höhle, director of the Wiener Geschützten Werkstätten (Vienna Sheltered Workshops - Vocational Rehabilitation and Training Center) critically reflected on the concepts of *Work vs Employment* (working for a living) from the viewpoint of a vocational rehabilitation facility for mentally ill people.

The meeting was conducted by a panel discussion where questions from the floor were answered by Dkfm Dr. N. Geldner (Austrian Institute for Economic Research), Univ.Prof.Dr. D. v.Eckhartstein (University for Economics and Trade, Vienna), H. Fritz (Austrian Labour Exchange, Dept. Rehabilitation), Gerhard Höhle (Vienna Sheltered Workshops) and Dr. H. Nalis (Intermediate Psychosocial Day Centers)."

FEATURE ARTICLE

MENTAL HEALTH ISSUES AMONG THE INDIGENOUS PEOPLES OF THE WORLD

Alex Cohen, Ph.D.
 Coordinator, World Mental Health Project
 Department of Social Medicine
 Harvard Medical School



Relatively little research has examined directly the mental health status and treatment needs of the indigenous peoples of the world. This is both unsurprising and remarkable. Unsurprising, first, in that the needs and rights of indigenous peoples have been historically of little concern to those larger and more powerful nations that moved across the globe in search of wealth. Remarkable, however, in that during that same period there has been no lack of knowledge of the brutalities to which the indigenous peoples of the world have been, and continue to be, subjected. Sixty years after Columbus landed on an island in the Caribbean, Bartolomé de las Casas, a Spanish friar, published *The Devastation of the Indies* in which he documented the atrocities committed by the Spanish in their conquest of the New World. Three hundred years later, as the European powers were colonizing much of Asia and Africa, the British House of Commons published a scathing report on the consequences of contact - e.g., loss of land, introduction of diseases, and genocide - for indigenous people. Neither document resulted in greater beneficence on the part of imperial powers toward indigenous peoples. Indeed, in the second decade of the 20th Century, W.H.R. Rivers - a British psychiatrist and anthropologist - stiff felt it necessary to argue that the depopulation of Melanesia was not the result of deleterious native customs but was the outcome of the introduction of infectious diseases, the harmful repercussions of the importation of alcohol, opium and firearms, and the inappropriate modification of traditional housing and clothing. Even at the end of the 20th Century, as documented by Amnesty International and Cultural Survival, as well as dozens of local groups in the Indigenous Movement, injustices against indigenous peoples continue throughout the world.

Given the traumas and dislocations that indigenous peoples have experienced, we may assume that they suffer from high rates of various neuropsychiatric and behavioral problems. While relatively little data exist

concerning the mental health status and treatment needs of the indigenous peoples of the world, what we do know points to great unmet needs. Throughout the Western Hemisphere, indigenous peoples suffer from high rates of alcoholism and suicide. The same can be said of the peoples of the Pacific Islands and Northern Russia, as well as the aboriginal groups of Taiwan. Furthermore, we can safely conjecture that dislocation, epidemics, depopulation, and subjugation have put indigenous peoples everywhere at high risk of depression and anxiety. Finally, it seems safe to assume that poor health status and lack of access to public health programs and medical care would produce relatively high rates of epilepsy and mental retardation among indigenous peoples.

According to estimates, there are 5,000-6,000 distinct groups of indigenous peoples, living in over 70 countries, their population totalling between 220-300 million (or about 4-5 percent of the world's population). One should not, however, make the mistake of assuming that this population is homogeneous. While it may be true that indigenous peoples share a close attachment to their land, commonly lack statehood, are subject to economic and political marginalization, and are the objects of cultural and ethnic discrimination, they also exhibit a tremendous heterogeneity in lifestyles, cultures, social organization, histories, and political realities. It is impossible, therefore, to impart a full sense of the worlds in which they live in the space of a short article. Nevertheless, it is critical to this discussion to offer several broad generalities in order to convey an understanding of the contexts in which the mental health of indigenous peoples is shaped.

The most important factor in the history of indigenous peoples has been the Western economic expansion and development that began a little more than 500 years ago and continues to the present day. The effects of this were disastrous for the indigenous peoples of the

world. First, the introduction of smallpox, diphtheria, influenza, and measles resulted in terrible epidemics. For example, in what has been called the "great dying" in the Caribbean and Middle and South Americas, population decreases among many peoples reached 90 percent and above. This scenario of epidemics following European expansion was repeated in the Pacific Islands, Australia, and Siberia. Second, the European expansion brought with it an economic system that sought lands and markets to exploit. This resulted in enormous pressures on indigenous peoples to protect their lands and ways of life in the face of usually overwhelming forces. In brief, indigenous peoples became "victims of progress"- meaning that they were generally slaughtered, dislocated or disenfranchised when standing in the way of plans by larger forces to exploit natural resources,. And while the methods today are not are brutal as those in the past, indigenous peoples continue to be seen as impediments to economic development because they do not wish to relinquish their lands for exploitation. Third, the legacy of violence against indigenous peoples is appalling. One need look no further than the slaughter of American Indians and the African slave trade to get a sense of the forces to which indigenous peoples have been subjected. But while the mass killings are generally no longer the rule, they do continue. For example, during the Guatemalan civil war, an estimated 75,000 Mayan Indians disappeared or were killed; another 300,000 fled their homes and sought refuge in other countries.

As stated at the outset, it seems reasonable to expect that the mental health of indigenous peoples has suffered as a consequence of the social and historical forces to which they have been subjected. Nevertheless, the lack of empirical data and the inherent difficulties of conducting cross-cultural psychiatry mean that any discussion of this topic must be considered impressionistic and preliminary. Several trends are obvious, however. High rates of suicide have been reported for American Indians and Alaska Natives, Australian Aborigines, the people of Micronesia, and the Northern Minorities of Siberia. Even more widespread are problems of alcohol and substance abuse. Epidemiological research among several groups of indigenous peoples in North America have shown that they suffer from high rates of depression - although it must be noted that we have very little sense of intratribal variations.

The creation of a knowledge base - including epidemiology, as well as cultural beliefs and attitudes - is an essential step in the development of programs that address the mental health status and treatment needs of indigenous people. That being stated, however, I

would maintain that it is not THE most critical step. Above all else, we must place mental health problems within the contexts by which they are shaped. If this is not done, we run the risk of medicalizing what are primarily social problems. That is, what does it mean to treat cases of depression with psychotropic medications while not addressing the cluster of problems - poverty, genocide, poor health, disenfranchisement, and loss of ancestral lands - of which depression is only one element? This is not to say, however, that psychotropic medications, and other forms of psychotherapy, should not be made available to indigenous peoples. Rather, it is to say that the social and psychological worlds are so interdigitated that one cannot hope to effectively address one without addressing the other.

This presents two great challenges to the mental health field. First, it questions the viability and effectiveness of narrowly defined professional roles under circumstances that call for a multifaceted approach to alleviating human suffering. Second, it demands that mental health professionals relinquish their priority to define "problems," and, therefore, the form that solutions will take. In other words, while mental health professionals might see depression, suicide, and alcohol abuse as the problems, communities of indigenous peoples might define mental health problems as landlessness or loss of the ability to shape their present and future lives in accordance with cultural beliefs and traditions.

In conclusion, I would suggest that addressing the mental health problems of the indigenous peoples of the world calls for mental health professionals to redefine their own roles and embrace a true community psychiatry. This means, first, asking the community to define its mental health priorities, second, working with communities to address inequities in their social worlds, and, finally, all the while attending to those individuals who are suffering from mental disabilities.

This article is excerpted from a report on the mental health of indigenous peoples that was prepared under the auspices of Nations for Mental Health, Division of Mental Health and Prevention of Substance Abuse, World Health Organization.

Cont'd from Page 5 AUSTRIA

An inspirational meeting to the participants? No, indeed not - when it comes to considering the existing/non-existing "possibilities" for mentally ill people within the labour market right now. In times when recession is still not overcome, unemployment rate is THE prime topic for the government - people in power to employ personnel tend to vote even more for the well-educated, easily exploitable (= young and ambitious), flexible and cheap employees - another warrant for economic success.

No inspirational meeting to the participants? But no, it was! Grasping all the cold figures exchanged, facing the hard facts discussed meant also facing the reality of the most times unconquerable demands mentally ill people meet in their pursuit for work to make a living on their own.

And this indeed inspires conviction and determination not to relent in supporting and encouraging the users, yet again to find and to open up one more of the existing governmental/municipal programs for training and work and certainly not to lose focus on the fact that vocation in our society is a prerequisite to well being and vocational rehabilitation is one of the main and effective ways to help restore mental health.

*Primaria Dr. Marion E. Kalousek
WAPR Austriae*

Nouvelles de France et de la Francophonie

L'AMRP à Paris en l'an 2000

Le VIIème Congrès de l'AMRP aura lieu à Paris en l'An 2000 en Mai. Un thème s'impose donc pour ce congrès celui de la "**RÉHABILITATION à l'aube du 3ème Millénaire**" c'est dans ce cadre que l'on pourrait mettre particulièrement en évidence la nécessité d'encourager la diversité de l'offre en préservant l'équité face à cette offre.

Nous partons du constat que la mondialisation ne se limite pas aux échanges économiques mais concerne également les idéologies, les pratiques pour le meilleur et parfois le pire. La désinstitutionnalisation se poursuit sous l'influence de facteurs tant thérapeutiques qu'économiques; largement répandue dans les pays industrialisés, il y a au contraire dans les pays peu

développés, une nécessité de trouver des alternatives à une fonction de soins et de protection par l'asile qui n'ont parfois jamais existé. Comment les professionnels, les familles, les usagers et les élus doivent-ils réagir lorsqu'il s'agit de faire face au clivage qui classe d'un côté ceux qui rapportent et de l'autre ceux qui coûtent ? Quelles sont les différentes visions de la réhabilitation à travers le monde ? Quelles sont les pratiques qui s'en inspirent non seulement pour alléger la souffrance et contribuer par des soins à une guérison éventuelle mais aussi à améliorer l'insertion de ces malades en développant de multiples types d'intervention de soin et d'assistance; au logement, au travail à la vie quotidienne. La réhabilitation suppose l'articulation des soins avec la prise en compte de la situation législative et sociale et son objectif doit dépasser les niveaux d'intervention centrés sur la personne pour tenter d'agir sur l'environnement.

Enfin, il conviendra de prendre la mesure pour les malades des risques qu'ils courent dans la communauté où la protection est souvent faible et parfois inexistante et de la nécessité pour la société de créer pour eux et avec eux des espaces qui leur permettent de conserver la maîtrise de leur vie tout en construisant un quotidien satisfaisant.

En attendant, rendez-vous à Hambourg!

G. Vidon, M. Habib, R. Ontoniente et N. Attali (NHA com.) Mettent tout en oeuvre pour organiser un conseil scientifique et tout ce qui est nécessaire à la réussite d'une telle entreprise. Rejoignez-nous à l'Assemblée Générale Extraordinaire de la branche française qui se tiendra:

Le samedi 25 avril à Paris à l'Hôpital Sainte-Anne
(Contacter G. Vidon, Tél: 01.43.46.53.73)

Mais bientôt également une autre occasion pour préparer le congrès nous sera donnée par les premières rencontres nationales du Comité Français pour la Réhabilitation Psychosociale qui se tiendront à Angers:

Les 3 et 4 décembre 1998

avec comme objectif de dresser un état des lieux de la réhabilitation psychosociale en France.

Au sortir des années 90 quel constat ? Quelles avancées ? Mais aussi quels obstacles ?

À l'aube des années 2000, quels objectifs et quels enjeux ?

Avec le congrès d'Angers le Comité Français pour la réhabilitation psychosociale (CFRP), branche française de l'Association Mondiale pour la Réadaptation Psychosociale (AMRP), souhaite associer l'ensemble des acteurs, usagers, professionnels, décideurs, familles, au mouvement de transformation profonde des perspectives d'existence et des pratiques de soins, mais aussi des mentalités touchant à la vie des personnes souffrant de troubles mentaux.

Le congrès d'Angers est organisé par l'Association Angevine de Recherche en Psychiatrie (AARP).

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Region of the Americas

PAHO'S MENTAL HEALTH PROGRAM EXECUTIVE SUMMARY

The objective of the Program on Mental Health of the Division of Health Promotion and Protection of the Pan American Health Organization, which was examined by the Subcommittee on Planning and Programming in April 1995 and by the Executive Committee in June 1996, is to provide technical cooperation to the countries in activities related to mental health and psychiatric care. The Program has three components: (1) the promotion of mental health and primary prevention of psychiatric disorders; (2) the control of psychiatric disorders; and (3) interventions on the psychosocial aspects of health and human development.

The Program's technical cooperation priorities and strategies arise from a regional situation analysis and the interpretation and implementation of the policies of PAHO's Governing Bodies. The analysis reveals that, notwithstanding the definition of health

adopted by the Member States and the intrinsic importance of mental health, this area generally receives inadequate support from the governments and is undervalued by society, in spite of the overwhelming current/future needs. By way of illustration, in 1990 five out of the world's 10 leading causes of disability were psychiatric in nature; by the end of the century some 88 million adults in Latin America and the Caribbean will have experienced some form of emotional disorder; and more than 11 million will suffer from affective disorders by the year 2010.

The implementation of the Initiative for the Restructuring of Psychiatric Care, launched with support from PAHO/WHO Collaborating Centres and regional and international agencies, relies on a number of strategic approaches: the transfer of services and knowledge to the community, the expansion of treatment alternatives for patients and their families, the preservation of human rights, the provision of more humane care, the update of mental health legislation, and the inclusion of patients and family members in the management process.

In addition, the Program has begun to foster activities to promote the mental health and psychosocial development of children. This has been done under the umbrella of a regional interagency plan of action that has two chief components: the promotion of early childhood development and the reduction of violence against children.

To be able to fill leisure intelligently is the last product of civilization

Bertrand Russell

Dates for your Diary

1998

**Rehabilitation in social enterprise: Contradictions and convergencies of health and environment policies compared to a labour market in transformation
Caorle (Near Portogruaro) Venice
March 26-28, 1998**

Information: Registration Office
Cooperative L'ARCO
Viale Isonzo, 11
30026 Portogruaro, Venice

Following an International Symposium on Schizophrenia to be held April 3-5, 1998, WAPR Pakistan Chapter is organizing an

**ADVANCED INSTITUTE ON
PSYCHOSOCIAL REHABILITATION
April 6, 1998
Lahore, Pakistan**

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Danubian Psychiatric Association
**18th Danube Symposium
of Psychiatry
PSYCHIATRY IN DANUBE COUNTRIES AT THE
DAWN OF 21st CENTURY**

**June 4-6, 1998
Zagreb, Croatia**

Information: Prof. Dr. Miro Jakovljević
Organizing Committee, 18th Danube Symposium of Psychiatry
University Psychiatric Clinic
Clinical Hospital Centre Zabgreb
Kispaticeva 12, 10000 Zabgreb
Croatia
Tel/Fax: +385 1 2333-043

**INTERNATIONAL CONFERENCE OF THE
PSYCHIATRIC HOSPITAL OF HAVANA
PSYCHOHAVANA 98
October 9-23, 1998
Habana, Cuba**

Information:
Dr. Eduardo B. Ordaz Ducungé
Presidente, Comité Organizador
Fax: 537-45-1512

*Organized by the Mental Health Department of Trieste Regional
Study Center of Friuli Venezia Giulia*

International Franco Basaglia Congress

**LA COMUNITÀ
POSSIBILE
TRIESTE, OCTOBER 20-24, 1998**

Information:
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Interest in Psychosocial Rehabilitation / Centre d'intérêts en réadaptation psychosociale / Area de interes en rehabilitacion psicosocial

Vlth Congress of the World Association for Psychosocial Rehabilitation

Hamburg, May 2-5, 1998

**Challenges and Demands of Psychosocial
Rehabilitation in a Changing World**

TRAINING SESSIONS & WORKSHOPS

Tutorial sessions of 2, 4 or 6 hours provide an exclusive and extensive learning experience on various topics. There will be continuing education credits available.

You must register in advance, indicating on the registration form which tutorial you would like to participate in. We advise you to book as early as possible because space is limited. We suggest that you list a number of tutorials in the order of your priority to ensure that you will be able to participate in one that serves your interest.

Cost: 2 hr. sessions = 50,00 DM
4 hr. sessions = 100,00 DM
6 hr. sessions = 150,00 DM



Saturday, May 2nd

Training with schizophrenic patients (2 hrs)
Cognitive-behavioural therapy in schizophrenia (4 hrs)
Symptom management training (4 hrs)
Leadership strategies for the rehabilitation team (2 hrs)
Psychopharmacotherapy and psychosocial intervention (beginning & advanced level) (2 hrs)
New neuroleptics and antidepressants. Their advantages in psychosocial rehabilitation (2 hrs)
How to organize a low cost psychiatric day rehabilitation programme for developing countries (2 hrs)

Sunday, May 3rd

How to assess quality of life in mental disorders (2 hrs)
The five minute speech sample (FMSS) (4 hrs)
Neurocognitive deficits relevant to psychosocial rehabilitation in schizophrenia (4 hrs)
An update on research strategies in psychiatric rehabilitation (2 hrs)
Human structural milieu therapy for psychiatric patients (4 hrs)
Integrated treatment for severe mental disorder and substance use disorder (4 hrs)
Hearing voices - A training for professionals to embark on a new perspective (2 hrs)
Techniques of psychosocial rehabilitation for developing countries (2 hrs)
Coping orientated treatment in schizophrenia (4 hrs)
Psychoeducation for families and persons with mental illness (2 hrs)
Psychopharmacotherapy and psychosocial rehabilitation (2 hrs)
Interactive approaches to training staff and developing programs (2 hrs)
Early intervention with psychotic disorders (6 hrs)
Drugs and CBT for persistent positive and negative symptoms (6 hrs)

Monday, May 4th

Management of mental illness and disability: Treatment and rehabilitation - a seamless integration of hospital and community programs (6 hrs)
How to organize a rehabilitation program with minimum resources: The role of community systems (4 hrs)
Replacing mental hospitals - rehousing vs. rehabilitation (6 hrs)
Self care and the vulnerable therapist: Counteracting the occupational hazard of vicarious traumatization (2 hrs)

Tuesday, May 5th

Family-focused intervention for patients with bipolar disorder (4 hrs)
Working with the families of schizophrenic patients: The essential skills (4 hrs)
Small family care homes (2 hrs)

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D-20308 Hamburg

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