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## President's Report:

# I

## Indian Chapter Holds First National Congress

Although the Indian chapter of WAPR was founded in 1986 just after the founding congress of WAPR, this was the year in which it joined the trend of other national WAPR groups in having a national meeting to present the science, best practices, and advocacy we treasure. More than 400 participants came from all over India to Bangalore on February 21-23, 2002. The meeting was hosted by the National Institute of Mental Health and Neurosciences and organized very well by the organizing and scientific committees. We hope to get detailed description of this meeting from our Indian colleagues, so I offer first impressions.

The meeting was well-timed. The economy is more open and doing well, with an emphasis on individual and small group initiatives, on learning from one another and from abroad. Nongovernmental organizations have emerged in India to provide a host of services, and WAPR-India is a natural focal point for them to come together. The role of NGOs in helping government to take action is becoming more clear. The Erwadi tragedy (see *Bulletin* 13(3)) has stirred great attention in the media and a focus on community care. Residential services have grown, as have state inspections. Although there were complaints that every residence was suspected of being another Erwadi (one had had seven inspections in a few weeks!), visitors soon found that some excellent community programs were being offered. The problem of the quality of community living is world-wide. As this *Bulletin* goes to press the *New York Times* is exposing unreported premature deaths and neglect in adult homes in New York. WAPR chapters can help in many ways, especially by setting standards that will attract higher quality homes to seek certification as having met those standards.

Presentations featured Indian experts on all facets of psychosocial rehabilitation: cognitive and pharmacological approaches and integration, research reports and program presentations. The geographic scope was impressive, with reports from most Indian states. The meeting was very well-received, with at least three sites bidding to be the next meeting's venue.

Everyone associated with the Indian meeting deserves praise, but perhaps we should note here that the person praised most frequently by the participants was T. Murali. He has traveled tirelessly from NIMHANS to one place after another in India to stimulate the development of NGOs and community-based programs. Full details of the meeting can be obtained from him via email at [tmurali@nimhans.kar.nic.in](mailto:tmurali@nimhans.kar.nic.in).

## Sri Lankan Meeting Has Many Notable Landmarks

Dr. Nalaka Mendis, Professor and Chairman of the Department of Psychiatry at the University of Colombo and WAPR Vice President for South Asia, organized the "International Conference on Mental health and Psychiatry" on April 4-7th, 2002 to celebrate the 20<sup>th</sup> anniversary of Sahanaya, the National Council for Mental Health. Sahanaya has developed community based mental health services that evolved to include rehabilitation, clinical, educational and training programs. It was Sri Lanka's first Nongovernmental Organization devoted to mental health and predates the Regulation that recognizes it by 11 years. Twenty years later it still produces landmark firsts, which included:

- A prominent role for NGOs: This was Sri Lanka's first major international conference on mental health. Although many

people in government, academia, clinical work, and the general public very much wanted the meeting and turned out in the hundreds to support it, it had fallen to an NGO to catalyze the event and secure participation across the many sectors involved. This role for an NGO is one WAPR chapters find for themselves in many countries. Sahanaya provided the bridge between the government and its citizens, a partnership with the WHO as a forum for presenting the evolving mental health program for the region, and the first opportunity Sri Lankans working abroad have been welcomed home to provide professional contributions rather than just as tourists.

- An opening ceremony featuring three Cabinet ministers who obviously cared so deeply about the subject that they evidently had written their own speeches from personal and national experience with the civil war. The air of celebration was universal as Sri Lanka enjoyed the fifth cease fire in this decades long conflict that is reckoned to have taken 60,000 lives and caused countless injuries, including many from land mines. There was a strong sense that this would be the cease fire that would lead to a lasting peace, now being worked out.

- An international call for ending the distinction between mental and physical illness. This call from Prof. R.E. Kendell, past president of the Royal College of Psychiatrists, was developed within Britain in response to proposed revisions of the laws that provide for the care of those who cannot manage to take care of themselves. Many of these laws in the English-speaking world are similar and include the phrase "by reason of mental disease or defect" while the reality is that there are many reasons that some people cannot take care of themselves. Research has shown that what we have called mental and physical illnesses are not so different as to justify continuing the distinction. Removing the distinction would reduce stigma, end insurance discrimination, and have many other illnesses. Prof. Kendell's suggestion (for a full version, see Kendell, Re: The distinction between mental and physical illness. *British Journal of Psychiatry* (2001), 178, 490-493) is consistent with a recent court ruling in the USA that bipolar disorder is a physical illness. WAPR will consider, at the June Board meeting, a resolution calling for ending this distinction in the International Classification of Diseases.

-WAPR leaders met informally: As it happened, we had the South Asia vice president, the deputy secretary general, one of the two vice presidents, the national secretaries for Pakistan and Britain, many members of the Indian chapter, a Board member, two past presidents and the president meeting over three days to discuss what roles WAPR might adopt. The example of the conference of a NGO as convener and the basic WHO message: the burden of illness is great, effective, inexpensive treatments are available, and not enough is being done, was itself a charge for WAPR to do more.

-Sri Lankans welcomed home: Many countries have regarded those of their own who have gone to work abroad as particularly unwelcome. It has been frustrating, after having learned a lot and to have done state-of-the-art work in one's field, to discover one's needy native land has no interest in availing itself of what is freely offered. Sri Lankans showed they wanted to welcome everyone, including those born in Sri Lanka. There was a great sense of openness and easy communication that bodes well for the future.

## **World Health Organization Welcomed Comments on the Mental Health Global Action Programme – Issues Cost Report**

Past president Benedetto Saraceno praised (at the Sri Lankan meeting) the many people and organizations, including WAPR, for their thoughtful comments on the WHO proposed program (see *Bulletin* 13(4)). The comments are being synthesized into a new draft.

WHO is organizing a meeting for Ministers of Health to be held in Tunis on November 27 and 28, 2002. WAPR national associations are urged to verify that their countries will be represented and take the process forward. A new pamphlet (28 pages) on the program can be downloaded from the WHO web site ([www.who.int](http://www.who.int)) and is listed below among other WHO publications.

The urgency of the situation, and a good benchmark for comparison, is seen in the latest WHO report (published April 23, 2002), in which stresses WHO urges rich and poor nations around the world to stop neglecting care for people with mental health illnesses, which currently account for more than 12 percent of all diseases. Finding that resource shortfalls in the sector exist regardless of the country's wealth, the report, "Atlas: Country Profiles on Mental Health Resources," concluded that "all countries, large and small, rich and poor, need to give a much higher priority to mental health and take urgent steps to enhance their mental health services." The report is a country-by-country enhancement (112 pages), with new data, of the Atlas published last year, which profiled nearly 200 countries in six regions of the world, found that while mental health professionals are lacking in most parts of the world, in Africa and Asia the shortage was particularly acute, with less than one psychiatrist for every million people. Although doctor to patient ratios were higher for wealthier countries, such as the United States, the report showed that the number of professionals was still very low when compared with population size. For every 100,000 U.S. citizens, for example, there were some 10 psychiatrists, 1.6 neurosurgeons, and four neurologists. One in three countries of those profiled by WHO, including Mexico, India, and Pakistan, spent less than one percent of their general health budgets on care for people with mental illnesses. Forty percent of countries surveyed did not have a mental health policy, and one in four countries, including China, Nigeria, Thailand, Iran, and Turkey, had no legislation on mental health issues.

WHO publications (PDF files can be downloaded using Adobe Acrobat reader, which is free):

WHO/NMH/MSD/MDP/01

Atlas: Mental Health Resources in the World 2001

HO/NMH/MSD/MDP/01.1  
2001

Atlas: Ressources consacrées à la Santé mentale dans le Monde

WHO/NMH/MSD/MDP/01.1 Atlas: Recursos de salud mental en el mundo 2001

WHO/NMH/MSD/MDP/01.3

Atlas: Country Profiles on Mental Health Resources 2001 ( ; )

WHO/NMH/MSD/WHA/01.1

Mental Health: A call for Action by World Health Ministers

WHO/NMH/MSD/WHA/01.1

Santé mentale: Les ministres appellent à l'action

WHO/NMH/MSD/MPS/01.3

Mental Health Policy Project

WHO/NMH/MSD/MPS/01.3

Projet Politiques de Santé mentale

WHO/NMH/MSD/MPS/01.3

Proyecto de política de salud mental

WHO/NMH/MSD/MPS/01.3

Mental Health: Results of a Global Advocacy Campaign World Health Day 2001

Santé mentale: Résultats d'une campagne mondiale de sensibilisation Journée mondiale de la Santé 2001

Pamphlet

The Mental Health Story

WHO/NMH/MSD/02.02

The Department of Mental Health and Substance

Depencece

WHO/NMH/MSD/02.02

El Departamento de Salud Mental y Toxicomanías

WHO/NMH/MSD/02.02

Département de la Santé mentale et des Toxicomanies

WHO/NMH/MSD/02.1

mental health Global Action Programme mhGAP

WHO/NMH/MSD/02.1

Programa Mundial de Acción en Salud Mental mhGAP

WHO/NMH/MSD/02.1

Programme mondial d'action pour la santé mental mhGAP

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## WAPR Board Calls for Agenda Items

The board will meet on Saturday June 8 in Rome in conjunction with the meeting described below (see calendar). Anyone wishing to have items considered should forward these to [office@wapr.net](mailto:office@wapr.net). Items already on the agenda include how to go about choosing the 2005 Congress site, beginning the nominations process, future directions of the organization, etc.

## WAPR Committees:

### Cognitive Remediation Committee to Be Chaired by Alice Medalia

This is a new committee to track and make available to WAPR members the exciting new developments in cognitive remediation. Data from neuroimaging is confirming the clinical results that some practitioners have been able to obtain. The brain can be seen as being like a muscle. Properly used it seems able to develop new synapses and there is increasing evidence that, under some circumstances, new cell growth occurs. Dr. Medalia is a psychologist at the Albert Einstein College of Medicine in New York City who has been convening meetings on cognitive remediation for some years, typically attracting hundreds of participants. This year's meeting, cosponsored by AAPR, is included in the calendar below.

### Book by Social Services Committee Chairman Daniel Maltzman

(available free electronically): Nuevo libro uruguayo acaba de publicarse:

"VIOLENCIA Y PELIGROSIDAD EN LA SOCIEDAD DE HOY"

Reflexiones educativo-preventivas basadas en la experiencia de destacados profesionales de las áreas: jurídica, criminológica, médico-legal, psicosocial, educativo-pedagógica y sobre los derechos humanos. El libro cuenta con el Prólogo del Presidente de la Suprema Corte de Justicia, Prof. de Derecho Penal, Dr. Milton Cairoli Martínez. Y asimismo lo auspician las siguientes organizaciones: Facultad de Derecho; Uruguay Transparente; Instituto de Desarrollo Humano de la Asociación Cristiana de Jóvenes y la Fundación Konrad Adenauer.

Por mayor información y para poder acceder a la mencionada publicación agradecemos comunicarse con el Editor, Compilador y Co-autor: Dr. Daniel Maltzman (participante del INDES/BID- Mayo,2000), a través de los siguientes e mails: [danielclaudio@yahoo.com](mailto:danielclaudio@yahoo.com) y [danielmaltz@hotmail.com](mailto:danielmaltz@hotmail.com).

### WAPR National Secretaries: The following have been appointed:

**New Zealand:** Susan A. Harris, M.D. Taylor Centre, 308 Ponsonby Rd., Ponsonby, Auckland, New Zealand, 64-9-376-1054, fax 64-9-360-1651.

**Pakistan:** Prof. Dr. Haroon Rashid Chaudhry 83-Shah Jamal Colony, Lahore, Pakistan off. 9200572-81, fax 92-42-7572488, e-mail: pprc@wol.net.pk.

## September 11 - After Six Months

There has been great interest, six months after the World Trade Center attacks, in what we have learned from what happened. This tragedy was one in which mental health effects were seen from the start to be likely. Financial resources available to provide help have been, to say the least, generous. There has been a great deal of outreach to potential victims of the assault, which have been reckoned as existing in widening circles from the sites, but perhaps numbering as many as 2.5 million people. Knowledge obtained from previous disasters has been mobilized and hardly a week passes in New York City without new data emerging and attempts to draw lessons for the future. For example, as we have learned to depathologize the grieving process for the first six months, should we continue to use the one-month criterion for making a diagnosis of post traumatic stress disorder?

WAPR and its American Association (AAPR) are, of course, very much interested in minimizing the development of chronic mental illness resulting from the tragedy. As mental health professionals and citizens, we have wanted to help however we can. Martin Gittelman will offer both a pre-conference institute and a workshop on September 11 at the Rome conference (see calendar). Zebulon Taintor spoke on the social psychiatric implications of the disaster at the World Association for Social Psychiatry and general considerations ("Addressing Mental Health Needs" Chapter 14 in *Terrorism and Public Health* Barry Levy and Victor Sidel (eds), New York, Oxford University Press (in press) (texts available by writing to office@wapr.net). For a whole series of reasons, there have been virtually no reports from those first on the scene. Yet a WAPR member was the first psychiatrist and has offered the following account. Antonio Abad, M.D., was working in the New York City court clinic a few doors away when the planes struck and rushed over to see how he could help. He was pressed into service and stayed on the site for two weeks without leaving it. He was wearing his identification from NYU/Bellevue and recognized as a city worker around whom the *ad hoc* team could form.

## Mental Health Report From Ground Zero by Antonio Abad, M.D.

### I. INTRODUCTION

Due to the need of emergency mental health services at the World Trade Center maximum-security area after the terrorist attack of September 11, the New York City Mayor's Office of Emergency Management (OEM) and the United States National Disaster Medical System (NDMS) requested and approved the services of an *ad hoc* mental health team composed of clinicians from various hospitals and agencies. This *ad hoc* mental health team, based at the Stuyvesant High School and eventually composed of more than 100 clinicians, including civilian volunteers and members of City agencies and nonprofit organizations, collected a large number of behavioral observations and provided a multitude of psychiatric interventions during the first two weeks after the September 11 disaster.

### II. BRIEF DESCRIPTION OF BEHAVIORAL OBSERVATIONS AND CLINICAL INTERVENTIONS PROVIDED BY THE MENTAL HEALTH *AD HOC* TEAM

No major psychiatric emergencies were identified during the first few hours after the catastrophe within the maximum-security perimeter of the so-called "Ground Zero" area. However, most members of the search and rescue (S&R) personnel were very distressed. Many refused to leave the rescue area during collapse alarms, because they wanted to continue looking for their missing partners, their badges or their helmets. A large number of rescue workers were also shocked by the findings of corpses and body parts.

Since early morning on September 12, "spotting" teams trained to identify distressed individuals recognized dozens of rescue workers displaying signs and symptoms of extreme exhaustion, anxiety, psychomotor retardation and agitation, and other forms of reaction to acute stress, in addition to a few cases of psychosis and mania. Most of them had been working uninterruptedly on the site during the previous 24 hours. Many reported intrusive disturbing images of the prior day's event. Some of them were dysphoric, although others displayed an extremely constricted range of affect. Many reported lower thresholds for the startle reflex, and others experienced feelings of depersonalization and derealization. As the day went by and more body parts were found, more extreme forms of reactions to stress appeared to be affecting the majority of Ground Zero personnel; therefore, after examining a variety of psychoeducational documents the team identified a very helpful one-page leaflet from the Red Cross that explained to the rescuers that their experiences were normal reactions, and described how to deal with them. This leaflet also offered excellent advice on what to do in case of future emotional problems for them and their families. After printing on this document the telephone numbers of all the major hotlines, thousands of copies were distributed, first to individuals displaying objective signs of distress, and later on to all the participants in the rescue and support operations. Eventually, all civilian volunteers working at Ground Zero received this document before September 15, in addition to receiving supportive and engaging interventions. When reviewing the list of common normal reactions to a disaster with recipients of the leaflet, our clinicians found that almost 100 percent of the rescue and support personnel recognized three or more of the symptoms described, and the majority recognized more than four. Notably, these findings were similar among support personnel who stayed at the Stuyvesant High School and had not participated in the S&R operations.

The number of people spotted with obvious signs of acute stress progressively increased during the first three days after September 11. Most rescue and support personnel had not slept at all, or only for a few hours during the previous three days. Some of these individuals were clearly psychotic or manic, others disoriented or experiencing difficulties making decisions. Notably, only a few of these cases were brought in by their peers or supervisors. On the contrary, most of the cases were “spotted” by the mobile mental health teams in the resting areas around Ground Zero. These teams engaged them to come to the school for rest, massage, food, and supplies. Once there they were very receptive to supportive interventions.

Over the next few days until September 16 the team identified many individuals displaying extreme signs of distress. These included civilian volunteers not involved in rescue operations, but also logistics personnel and clinicians. By then, many members of the mental health team also experienced high levels of stress and there was a clearly noticeable high distress level among our clinicians after spending a relatively short period of time at the Stuyvesant School clinic.

Search and rescue personnel showed still more new psychiatric symptoms within the first two weeks after September 11. The most notable change was the increased frequency of reported flashbacks and nightmares, as well as signs of increased arousal, difficulty concentrating, feelings of unreality, emotional numbness, moodiness, memory problems, and disorientation to time. Many also reported insomnia or being unwilling to close their eyes to sleep, in order to avoid horrible intrusive images, flashbacks and nightmares.

As a result of the relative deficit of psychiatric services for freelance civilian volunteers, as compared with those received by FDNY, NYPD, and military personnel, who had their own mental health teams, there was increasing concern regarding the civilian volunteers. When interviewed more than 90 percent still endorsed three or more signs of acute distress listed in the inventory included in the Red Cross leaflet. Simultaneously, due to decreased concentration, difficulty making decisions, and perhaps denial, rescue and security personnel acknowledged that they tended to forget to follow safety procedures such as wearing hard hats and masks in clearly signaled areas.

By September 18, mental health personnel from official agencies were still not available at the site, with the exception of NDMS staff and a few members of the NYPD mental health personnel. Accordingly, the *ad hoc* team reinforced their clinical activities, including supportive therapy, psychoeducation, and massage therapy aboard The Spirit of New York, a tourist boat converted into a respite center, Stuyvesant High School, and the morgue at the American Express building. By September 24, the few remaining credentialed civilian volunteers were exclusively restricted to operating on board The Spirit of New York and were transported in and out of the area by boat every eight hours. All of them received psychoeducational information prior to their arrival to Ground Zero. The last freelance civilian volunteers had already left the area and services previously provided at Stuyvesant High School were totally discontinued. The American Red Cross finally assumed the coordination of the mental health and massage therapy teams on board the Spirit of New York, and the NDMS mental health team would continue providing supportive services at the morgue and at three NDMS stations at Ground Zero.

## **SUMMARY OF CLINICAL OBSERVATIONS**

- **Due to security clearance problems, there were generalized levels of exhaustion and sleep deprivation among civilian volunteering personnel at Ground Zero, which peaked on day three.**
  - **Generalized high levels of signs and symptoms of stress, affecting equally rescue and support personnel, progressively increased during the first five days after the disaster.**
  - **Acute psychiatric emergencies requiring evacuation to the hospital started to occur on the second day after the disaster and continued until the fifth day.**
  - **Transfers to the hospitals affected exclusively civilian volunteers involved in search and rescue.**
  - **Diagnoses of individuals requiring transfer to the hospital included psychosis, mania, extreme anxiety, adjustment disorder with mixed disturbance of emotions and conduct, cognitive impairment due to persistent stress, and early onset PTSD.**
  - **Individuals endorsing early onset PTSD symptoms were mainly involved in search and pathology tasks. Many of them continued working in spite of severe disturbances of their emotions and conduct.**
  - **There was a persistent high level of stress affecting security and rescue personnel evidenced by internal preoccupation, lack of concentration, and failure to comply with safety procedures.**
  - **Mental health personnel presented also presented with rapidly developing signs and symptoms of stress.**

## **SUMMARY OF CLINICAL INTERVENTIONS**

- **The first interventions required were informal supportive interactions.**
  - **Evacuation to the hospital as EDP (Emotionally Disturbed Person) started on day two, peaked on day three, and was no longer needed after day six.**
  - **Psychoeducation was the most frequent intervention, provided to approximately 10,000 members of the**

initial rescue and support personnel.

- Mobile “spotting” teams conducted identification of individuals in need for supportive interventions or evacuation.
- Referrals to phone hotlines were the most frequent, followed by referrals to ambulatory mental health services. The Emergency Room was the least frequent referral destination.
- Debriefing was the least frequently used intervention as compared to other more conventional forms of supportive therapy. However, all individuals treated by the team were provided with follow-up referrals.
- Massage therapy was a critical element of the mental health activities, as well as coordination of other support services.
- The *ad hoc* mental health team was required to provide services such as coordination with official agencies and provision of logistical support, safety precautions education, and other preventive medicine activities.
- Registry of high-risk personnel for future clinical and research follow-up.
- Group debriefings for medical and mental health personnel.

#### SUMMARY OF IDENTIFIED SYSTEM PROBLEMS

- Civilian volunteers provided most of the mental health services at the so-called “Ground Zero” area during the first two weeks after the disaster.
- Limited access to civilians due to security reasons and delayed credentialing processes caused a serious shortage of staff, which contributed to high levels of distress and exhaustion among civilian volunteers, including clinicians.
- Delayed and limited deployment of mental health teams provided by federal and nongovernmental disaster relief organizations.
- No organized official psychiatric personnel were available until the seventh day after the disaster, except for the NYPD and HSC teams.
- Official mental health services were unable to meet the demands at the site, as evidenced by their consistent requests to the *ad hoc* team to continue providing services after their deployment.
- The civilian *ad hoc* team was required to provide coordination among official agencies and civilian volunteers.
- High-risk civilian volunteers left the area without registration, psychoeducation, and follow-up referrals, as compared with government personnel.
- Nongovernmental disaster assistance agencies did not provide significant mental health services at Ground Zero during the first two weeks after the catastrophe.

#### IV. CONCLUSIONS

During the first two weeks after September 11, the mental health *ad hoc* team performed a large number of clinical interventions involving the majority of rescue, security and support personnel working at Ground Zero. These activities included handing out more than 10,000 psychoeducational documents. The team also directly provided supportive interventions or debriefed more than 1,500 individuals, facilitated the evacuation of hundreds in urgent need for treatment and rest, and referred many more to mental health facilities citywide. Additionally, follow up of a cohort of 500 individuals involved in rescue, support and medical services at Ground Zero during the first week after September 11 is currently conducted for clinical and research purposes.

However, in spite of the presence and assistance of all the relevant disaster relief agencies, there was a delayed and limited deployment of organized mental health services at Ground Zero by federal agencies and nongovernmental disaster relief organizations. Therefore, it seems that it is imperative to create a contingency plan capable to deal with the mental health needs generated at the “Ground Zero” of any possible major catastrophe in the City of New York ensuring the effective integration of the available mental health resources. This plan requires the appointment of official mental health teams ready to deploy immediately after a catastrophe of this magnitude and the availability of contingency plans applicable to a disaster area even larger than Ground Zero’s 16 acres.

In summary, the training of authorized mental health teams prior to a contingent catastrophe, as well as the development of clinical and psychoeducational protocols appear to be urgently needed by governmental and nongovernmental agencies in order to ensure the most comprehensive response.

#### ABSTRACT

**Debido a la urgente necesidad de servicios urgentes de Salud Mental para el personal de rescate y logístico en el area de máxima seguridad afectada por la catástrofe, las agencias gubernamentales municipales y federales aprobaron la utilización de un equipo improvisado compuesto por mas de cien voluntarios civiles. Este equipo recogió un gran número de observaciones clínicas e implementó numerosas intervenciones durante las dos primeras semanas después del 11 de Septiembre. Estas intervenciones incluyeron psicoeducación de aproximadamente 10.000 voluntarios y terapia individual a más de mil personas. Asimismo el equipo facilitó la evacuación de cientos de personas y refirió muchos mas individuos a centros de Salud Mental. El despliegue de equipos oficiales gubernamentales o de otras agencias, como la Cruz Roja, fue limitado y lento. Este factor, unido a limitaciones de acceso para civiles, motivó una carencia parcial de personal de Salud Mental. Debido a estas razones y a la falta de una adecuada coordinación de la repuesta por parte de agencias gubernamentales, parece necesaria la creación de equipos entrenados y provistos de protocolos clínicos y psicoeducativos capaces de enfrentarse a las necesidades generadas por otras posibles catástrofes. Una cohorte de 500 individuos involucrados en las tareas de rescate y apoyo será estudiada por veinticuatro meses para evaluar la morbilidad psiquiátrica en esta población y para investigar la eficacia de psicoeducación para la prevención de secuelas psiquiátricas entre voluntarios civiles.**

The World Trade Center (WTC) tragedy responses were featured also in the American Association for Psychosocial Rehabilitation awards given at the luncheon at the UN (for security reasons postponed from December) on March 13, 2002, but giants in our field we recognized as well: (from the AAPR *Bulletin*):

Anand Pandya accepted the Tom Levin award on behalf of Disaster Psychiatry Outreach and the more than 700 volunteers it mobilized to deal with WTC victims and their families. He praised all involved for “the network, the web, the safety net they have created, which will need constant attention and reinforcement.”

Margot Adler and Naomi Wetherall represented National Public Radio in receiving the media award, which did so much to decrease violence and bias towards Muslims by emphasizing its tolerance and strengths, as well as helping listeners to explore “our dark sides, the bigotries we all carry.”

Jack Victor received the Alexander Gralnick award for reintegration of disabled persons, for pioneering work in links between mental and physical aspects, and implementing community and family based rehabilitation. Jack pointed out that he and Bill Anthony had worked together two decades ago as directors of NIMH rehabilitation research and training centers. The World Rehabilitation Fund (WRF), from which he just retired, had started work with WAPR in the Philippines more than a decade ago. He stressed moving to socioeconomic integration of people with disabilities and the mental health needs of those with physical disabilities, especially combined trauma such as has been experienced in the Sierra Leone civil war, WRF’s next big project.

Bill Anthony got the Alice Fordyce Award for founding the Boston University Center for Psychiatric Rehabilitation (a WAPR collaborating center) and editing the *Journal of Psychiatric Rehabilitation*, among many other achievements. He described four empirically-based stages in psychosocial rehabilitation’s evolution. First, defining the need for the field in the 1970s in the mental health context of irrelevant diagnoses, ineffective treatment approaches, inadequate community support, and poor outcomes. Second, defining the person in need of rehabilitation as suffering the consequences of impairment: disability, inability to function, disadvantages, poverty, discrimination, etc. Third, defining the field of rehabilitation: goals, skills and support the person wants, and showing that these determined outcome more than diagnosis. Fourth, defining the new vision for the field, growing beyond the catastrophe of mental illness. Courtenay Harding’s (her NYT *Times* Op-Ed piece from Sunday, March 10 was distributed to everyone) research showed recovery was more common than thought. It is not a cure, but the vision we are working towards. He pointed out that a society and as individuals are determined in large part by the stories we chosen to live, tell, and pass on to future generations. The rehabilitation story should be of growth, laughing loving, living people developing and moving on with their lives, not a tale of deterioration, pathology, and lack of hope.

E. Fuller Torrey received the Irving Blumberg award for his efforts to improve treatment quality, support families, and decry the criminalization of mental illness have been to all I know. He commented on the gulf between the next breakthroughs in research (building on imaging, micro rays, proteionics, molecular mechanisms) and “the treatment we’re giving, 250,000 in jails and prisons, victimization, violence, getting worse with managed care which is managed cost with mangled care.” He noted that funding system incentives are not to provide care or rehabilitation, but rather as little care as possible. The funding system in New York City and State is thought to be more disordered than the people we serve. He suggested programs be reimbursed by the number of people holding part time or full time jobs, quality of life, or other positive measures with decreased funding for each person in jail or newly homeless.

## **Calendar of Events: 2002**

**May 26-30: ARAPDIS (WAPR cosponsored): II Congres Internacional: La rehabilitacio psicosocial integral a la comunitat i amb la comunitat. Barcelona, Spain. Associacio ARAPDIS - Centre Documentacio, Docenia i Recerca C/ Providencia, 17, 08024 Barcelona. Tel ++ 93 415 467 (24h) Fax++932189307. Email:congres2002@arapdis.org www.arapdis.org/congres2002\*.**

**May 30-31: WAPR Slovenia: Second Slovenian Congress on Psychosocial Rehabilitation: Community Psychiatry in Slovenia, CANKARJEV DOM, Ljubljana contact Vesna Svab vesna.svab@guest.arnes.si \***

**June 5-8: Forensic Mental Health - Working Together to Respond to Crisis and Promote Change. Organized by Gerald Landsberg at NYU. Contact: email: gl1@nyu.edu.**

**June 7: Cognitive Remediation in Psychiatry, organized by Alice Medalia, Ph.D. and Montefiore Medical Center will hold its fifth annual meeting at the UJA-Federation of New York, 130 East 50<sup>th</sup> Street, New York, NY. Contact: telephone 718 920-4736, e-mail: amedalia@aol.com.**

**June 6-8: WAPR Regional Conference: Psychiatric Rehabilitation Challenges and Controversies Rome, Italy. \*\***  
From the conference organizers, Drs. Angelo Barbato and Antonio Maone:

“We want to discuss some *hot* topics:

C *Atypical antipsychotic drugs: are they cost/effective ?*

- *Evidence-based rehabilitation: does it exist ?*

C *Schizophrenia: is this definition still useful ?*

C *Early intervention in psychoses: road to recovery or dangerous illusion ?*

C *Empowerment of consumers/empowerment of relatives: conflicting goals ?*

The Conference program will include: lectures, plenary sessions, discussion groups, workshops, poster sessions, and satellite symposia. The Conference languages will be Italian and English with simultaneous translation in the plenary sessions.

Registration fees	Before 30/4/2002	After 30/4/2002
Doctors/Psychologists, non-WAPR members	150 °	180 °
Doctors/Psychologists, WAPR members	120 °	150 °
Others, non-WAPR members	90 °	120 °
Others, WAPR members	60 °	90 °

*Conference venue: Centro Studi e Ricerche ASL Roma, Piazza Santa Maria della Pietà 5, Roma. Information: Tel ++39-06-85232453; ++39-02-64442512; e-mail: maone@tin.it or dirba@tin.it All contacts are for registration and program submissions. See the WAPR web site for more details.*

The conference will be held in a congress center on the grounds of the former Rome Mental Hospital, which has been closed in 1998. Accommodation for all the participants is available in the residence attached to the congress center. The nice location in a beautiful park adds to its symbolic meaning. We will be able to offer very low cost rates: about 50 EUR for a single room and 75 EUR for a double room. Moreover, we will have a number of dormitory style rooms with shared bathrooms as low as 20 EUR per person.

This regional meeting will be WAPR's major meeting in 2002. The WAPR Board will have its annual meeting in Rome in conjunction with the meeting. The full program of the Rome conference will be found at [www.wapr.net](http://www.wapr.net).

**August 1 2: WAPR South Africa\***

**National Conference: Psychiatric Rehabilitation. Port Elizabeth, South Africa**

**For information, Email: uys@nu.ac.za**

**August 24-29: WAPR cosponsored with World Psychiatric Association Section on Rehabilitation\***

**presentations at World Congress of Psychiatry. Yokohama, Japan details on WPA web site, <http://www.wpanet.org>. Section chair is Robert Cancro. Email: : rc31@nyu.edu**

**October 5-6: WAPR Hungary\***

**Pomaz, Hungary. Contact Dr. Ida Kosza at [kosza@mail.datanet.hu](mailto:kosza@mail.datanet.hu)**

**November 28-30: WAPR Philippines\***

**Manila, Philippines Contact Dr. Lourdes Ignacio at [ignacio@ibahn.net](mailto:ignacio@ibahn.net)**

**\*WAPR president will participate meeting**

**\*\*WAPR International Board**

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**MEMBERSHIP:** Join your national chapter of WAPR (see list on website), use the form on the web site: <http://www.wapr.net>, or this one:

## MEMBERSHIP APPLICATION FORM -FORMULAIRE D'ADHESION-SOLICITUD PARA HACERSE MIEMBRO

Please type or print legibly and mail this application form to:  
Veuillez ecrire lisiblement ou dactylographier et faire parvenir le formulaire d'adhesion a:  
Por favor, escribir claramente o dactilografar e enviar este formulario a:

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e-mail: office@wapr.net  
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Committee choices:

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\_\_Advocacy and Policy

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\_\_Cognitive Rehabilitation

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**\_\_ Rehabilitation & Law**

**\_\_ Rehabilitation & Economics**

**\_\_ Scientific & Research**

**\_\_ Social Security & other support**

**\_\_ Telerehabilitation**