28th. APRIL; MEETING & BOARD MEETING IN MANCHESTER, UK

WORLD ASSOCIATION for PSYCHOSOCIAL REHABILITATION

Volume 32. June. 2013

www.wapr.info
WAPR BULLETIN Nº 32.

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WAPR Bulletin.
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Greetings from president’s office & welcome to the june edition of WAPR Bulletin!

Dr. Afzal Javed,
President WAPR

I am pleased that WAPR work is getting more strength day by day and we are receiving a lot of input from our board members and national Branches.

We had a Board meeting in April 2013 and was attended a by a large number of Board members from all around the world.

Board members were pleased for the reports submitted by members. This certainly showed a keen interest of our members in the functioning of WAPR. It was noted with great pleasure that many branches and individual members are engaged in different projects in different areas of mental health and rehabilitation services.

Opening of new branches (Iran, Indonesia and Romania) was a real success. It was also noted that interest has been expressed for possible new branches in Bosnian, Qatar, Paraguay, Colombia, Kenya, and South Africa.

The information about WAPR Action Plan 2012-2015 was updated with details about many actions taken for the plan. A great progress has been made in establishing links with many other organisational and associations working in the field of mental health (WHO, WPA Section on Rehabilitation, World Association for Social Psychiatry, World Federation for Mental Health, Pacific Rim College of Psychiatrists, Royal College of Psychiatrists UK & Australia & New Zealand, European Federation of Associations of Families of People with Mental Illness(EUFAMI),ISPS, International Club House, International association of Occupational Therapists, European Mental Health, International association for Women’s Mental Health).

It was noted that the new website and Bulletin have attracted a lot of interest. The site is very impressive and effective. Feedback certainly showed that more people are now getting interested in WAPR and are contacting the office bearers about different quarries. Well done Marit & Ricardo!

Board agreed to allocate funds (up to 3000 US Dollars) for projects in each region. It was agreed that Regional Vice President in each region, in consultation with Deputy Vice Presidents and regional WAPR branches, will develop programmes / projects in different areas of psychosocial rehabilitation (like education, training, service provisions, manpower development, Awareness for Patients, families and carers). It was proposed that each region will complete one project during this triennium.

As per constitutional clause, the Board approved formation of standing committees (Congress committee, Nomination committee, Membership committee, Publication committee, Constitution committee & Ethics & Review committee) and agreed on the names of the chairs of these committees. President will co chair these committees with an another Board member and all the co-chairs will submit terms of reference /
activity plan for their respective committees as soon as possible.

As per suggestions from the President, seven Task Forces (Task Force on Users & Carers involvement in Treatment and Rehabilitation Planning, Task Force on Ethics & Human Rights for persons experiencing mental illness, Task Force on Curriculum & Training – particularly focusing on recovery, Task Force on issues relating to Professionals’ Burnt Out, Task Force on Rehabilitation programmes for Adolescents & Young Children, Task force on Preparing guidelines for PSR Services in low Income countries, Task Force on Asia-Pacific Projects Development and Dissemination and Task Force on developing WAPR statement on impact of violence, terrorism and unlawful killing on mental health) were constituted with a special objective to prepare WPA statements / guidelines. The chairs of the Task forces were requested to submit their suggestions to the Board and Board was also asked to suggest names of persons who may be able to assist the chairs for formulating their reports.

If any Board member is interested to be a part of any Task force, kindly send his / her name to me so that I can forward these names to the respective chairs of these Task Forces.

Looking at the increasing violence, terrorism and disasters & its impact on mental health, it was agreed to form a task Force / special committee to formulate recommendations and suggestions for establishing the role of WAPR in its management and prevention.

While expressing thanks to Milan Congress organisers, it was emphasised that WAPR congresses should generate more money for central funds so that we can organise different activities of the association in a more effective way. Budget for 2012-15 was also presented & also approved having allocated funding for regional projects, Secretariat expenses and board meeting expenses.

I am also pleased that we are having a number of meetings, conferences and sessions at International conferences during this year.

Thanks again for all your support and I do hope that we will continue with our work for WAPR and its mission.

Afzal Javed

Greetings from the Editorial Team.
Marit Borg.
WAPR Bulletin Editor.

The World Association for Psychosocial Rehabilitation (WAPR) was established in 1986 in France. The growth of WAPR during the years has reflected the increasing importance of preventing psycho-social problems and promotes community inclusion and citizenship. Human rights work, anti-stigma programs, community mental health development, empowerment and recovery have been central issues. Today, WAPR is recognized as a non-governmental organisation with consultive status with the WHO, the United Nations (UN) Economic and Social Council, and the International Labour Office. Moreover, it also maintains relations with the European Commission and the African Rehabilitation Institute.

24th May 2013 the General Assembly of the World Health Organization passed the Mental Health Action Plan 2013-2020. This is a very important policy document for global and local mental health. The WHO document recognizes the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. The action plan emphasizes to “strengthen advocacy, and develop a comprehensive mental health action plan with measurable outcomes, based on an assessment of vulnerabilities and risks, in consultation with and for consideration by Member States, covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community». For more information: http://www.who.int/mental_health/mhgap/consultation_global_mh_action_plan_2013_2020/en/

WAPR has a consultive status in WHO and we are now in the process of creating a network of “WAPR/WHO Plan of Action advocates” in each country. We will give more information about these activities in the next issue of the Bulletin.

We are happy to share this year’s second edition of the WAPR Bulletin with you. Anne Markwick writes a paper about Recovery Orientated Practice – Practicing with backbone and heart. A paper on Community Mental Health Service: An experience from Lille, France is presented by Jean Luc Roelandt and colleagues. We have a story about Irene’s Journey of Recovery and Tae-Yeon Hwang offers a report about Anti-stigma Movement and Human Rights of the Mentally Ill people in Korea. A Report from Paraguay is presented by Eva Insfrán and Anne Grethe Klunderud inviters to a debate about the WHO Global Mental Health Action Plan 2013-2020.

Marit Borg.
Recovery Orientated Practice – Practicing with backbone and heart

Dr Anne Markwick
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Many practitioners are talking about Recovery but there are lots of different ideas and beliefs about what it means in relation to professional practice. In my experience, practitioners, although often curious about Recovery orientated practice are equally uncertain regarding how to go about it. Some hope for the best that good intentions are enough. Others fear the impact of introducing Recovery to people who are already ‘stuck’ within the system. A few perceive Recovery as a step too far. That said the time has come to face up to what Recovery orientated professional practice entails and to confront the challenges of working in this way.

It is not my intention here to examine Recovery as a concept nor to go over its history or the anxiety about service colonisation of the concept. Rather this article tries to build on the Recovery movement without judgement or critique and to genuinely inquire into what it offers us as practitioners. It is not proposed as an end in itself but as a snapshot; a moment in time, which demonstrates where the journey so far brings us to, and a call for further progress. It is a clarion call to practitioners to face head-on the challenge to practice in a new way. We should not underestimate the size of this challenge. It requires us to stand away from our professional expert position and to learn how to be tolerant of our own anxiety and uncertainty. This requires self-reflection and considerable personal insight on the part of the practitioner. Familiar territory for some but by no means all of us.

Many practitioners are talking about Recovery but there are lots of different ideas and beliefs about what it means in relation to professional practice. In my experience, practitioners, although often curious about Recovery orientated practice are equally uncertain regarding how to go about it. Some hope for the best that good intentions are enough. Others fear the impact of introducing Recovery to people who are already ‘stuck’ within the system. A few perceive Recovery as a step too far. That said the time has come to face up to what Recovery orientated professional practice entails and to confront the challenges of working in this way.

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The changing emphasis required for Recovery orientated practice has entered the literature recently
Glen Roberts and Sheila Hollins (2007) suggest that a Recovery orientation in practice requires a greater emphasis on coaching, education, mentorship and facilitation and a reduced reliance on treatment. This is supported by my own experience. Conversations I had with Recovery-orientated professionals during my own Doctoral research highlighted areas of practice they felt was characteristic of this positioning. These characteristics tended to be focussed not on treatments and clinical interventions but on how they used themselves within the relationship and how they paid close attention to the person, rather than symptoms and problems. There was an increased focus on building, or re-building people’s self-mastery and sense of shared ownership and genuine learning together. I learned a lot from these conversations. They helped me to understand that Recovery orientated practice is more than simply being kind, approachable and sensitive. Of course these qualities are vitally important, just not enough alone. Effective Recovery orientated practice, like effective coaching requires ‘heart,’ a concept I have borrowed from Mary Beth O’Neill (2007), balanced with what she describes as ‘backbone’. Practicing with heart means staying engaged with the relationship and reaching out with compassion and empathy. Practicing with ‘backbone’ means being prepared to both develop ways of managing ourselves as we relinquish control and live with our own anxiety and also to work purposively with the other person in service of their development towards self-mastery and resilience even when this might be uncomfortable. The professional expertise is used not in knowing what the person should be aiming for but in sensing when they are ready to face the next step in the journey, especially when it might be hard for them to see it for themselves. Heifetz et al (2009, p.29), who describe adaptive change, refer to the ‘productive zone of disequilibrium’. Too little discomfort and I have no motivation to change. Too much discomfort and the anxiety becomes unbearable. The professional role seems to be to work purposively with the individual to enter together and to stay in the productive zone and then, also together, to find a way through. It is not to take the person to where discomfort is unbearable, but neither is it to prevent them from entering the productive zone, despite the challenges it entails.

If we shy away from this challenging work, we must face the possibility that we not only fail to contribute to the person’s self-mastery but we also run the risk of actively contributing to the problem; we become focussed on maintenance rather than growth. Imagine if you broke your arm. The plaster cast is initially necessary to help the healing process. Imagine if you became anxious when the time approached to have the cast removed. You are worried about the arm being vulnerable and the pain and strain involved in re-strengthening it. If the cast were left on to prevent your anxiety, this would only be storing up greater problems for later. Better, then, for the professionals to work with you to manage your anxiety and to support you during the challenging period and develop personal strategies as you regain your self-mastery. Similarly we must have the courage to ask ourselves whether mental health professionals, despite well-meant intentions, might occasionally shy away from those moments that require backbone balanced with heart in our practice. Thus inadvertently storing up problems for later and contributing to increased dependence, a focus on maintenance and the potential for the person to become stuck in the system. We must also face our own motivations that might be at work in these situations. If we feel rewarded by someone’s reliance on us then it is important that we face up to this and work to find other rewards. One aspect of Recovery orientated practice that practitioners were unanimous about in my research was that working in a Recovery orientation was far more rewarding than any other way they had experienced. It was not felt to be without its challenges, but by far the most rewarding way to practice. Similarly none of the practitioners I spoke to felt that had completely mastered Recovery orientated practice. Rather they saw themselves as work in progress, with a determination to learn and develop. They were all...
striving to stay true to their strong value base and belief system as they journeyed toward this orientation, in partnership with the people they were working with. There are perhaps parallels here between the Recovery journeys people with a lived experience describe and the journeys the staff embark on towards new ways of practising. I am not suggesting that they are the same or that professionals can know how it feels to have a lived experience. Rather I recognise how each journey requires empowerment, self-belief, learning to problem-solve and making choices, and each relies on being supported in new ways and taking a few calculated and well-managed personal risks. In my experience practitioners who see these parallels are also able to apply this insight to their practice and feeling the reciprocity that is a feature of practicing in a Recovery orientation.

**Recovery orientated practice**

There is a growing body of literature, which starts to examine what Recovery orientated practice is. Described by Davidson (2009, p. 33) as ‘work in progress’ the literature too is on a journey. From what literature there is, helpful themes emerge including changing the balance of power (Shepherd et al 2010), the development of hope inspiring relationships (Repper and Perkins 2003) and a need to go the extra mile (Topor 2001) for example. As a backdrop to these however, I believe there has to be purposiveness to our practice. We should be clear what our actions are intended to be in service of, to the other person. We should strive to remain very present in our relationships and to develop our ‘reflection in action’ ability (Schon 1995, p30). This is about applying conscious attention to our own thoughts and actions, in the moment, alongside how we might be receiving and interpreting the words and actions of the other person. It requires us to pay effortful attention, to remain curious and stand away from our assumptions and to delve into our own motivations and intentions. As practitioners we are more familiar, perhaps, with examining the motivations and potential barriers to change from the perspective of the other person. How often do we ask ourselves about our own motivation for certain actions and choices or what potential barriers come from within us? If I have an overriding need to be seen as caring and kind, for example, then my ability to practice with backbone could be compromised. I am not suggesting that practicing with backbone is never kind and caring but if it is not my usual way of practicing then being perceived this way might be my fear.

‘People took very good care of me but they didn’t really have any expectation of my taking good care of myself..... But things really started to change when I had a change of psychiatrist and a change of CPN. [They] had expectations of me. High expectations. I used to go to professionals with a whole list of things that I couldn’t do and they started to expect me to come with some solutions and they explored those solutions with me.’ (Munt 2009)

Practicing in a Recovery orientation requires us to ‘out’ the fears and beliefs that limit our ability to focus on what the other person requires of us in service of their self-mastery. It requires us to surface what might be our own hidden motivations and to confront their potential impact. Owning our place in the relationship is arguably as important as any clinical intervention that might be prescribed.

**Professional tolerance of discomfort**

The Heifetz et al (2009, p.29) ‘productive zone of disequilibrium’ which is that generative space of possibility, applies as much to professionals as it does to the person receiving services. Working in this zone requires us to actively strive to maintain our sense of self and our relationships, despite being pulled by the forces of our own fear and anxiety and that of others. If we don’t achieve this then we risk simply reacting; losing our own sense of presence and internal balance and simply responding in an automatic, unthinking way (O’Neill 2007).

**Holding the space of Creative Tension**
Practicing with the balance between ‘backbone’ and ‘heart’ I have framed in my own research as ‘holding a space of creative tension,’ where practitioners perform a careful balancing act between compassion, empathy and kindness and the encouragement and promotion of self-mastery and self-determination. At the heart of this way of practicing lie belief and curiosity. Remaining curious enables practitioners to avoid assumption and complaisance. In a Recovery orientation, practitioners need to hold their professional expertise lightly and walk alongside the person as an equal, valuing them as the experts in their own lives. Curiosity allows the practitioner to find out about the unique qualities of the person, their life and their hopes and aspirations, as well as their distress and how it impacts on their life. Belief is often referred to as ‘holding the hope’ but in my experience this can cause us to focus on encouraging the other person rather than surfacing our own beliefs. If I as a practitioner harbour a belief that certain people do not have the potential for personal growth and development or an improvement in their quality of life then this belief will undoubtedly contribute to this being the case.

“We must ourselves believe that everyone can grow within and beyond the limits of their problems if we are to foster this belief in others.” (Repper and Perkins 2003, p.77)

In order to foster hope, practitioners need to believe in the person, their strengths and their ability to regain self-mastery. This belief needs to hold firm even when the person may have little belief in himself or herself and we must beware unwittingly offering invitations into positions of despair perhaps based on well-intentioned protective instincts. Belief can also refer to the need for professionals to hold a belief that things can get better and to communicate that belief authentically.

From my research, it seems to me that the components of creative tension are: ‘straight talking’ about the challenges ahead; ‘tough love’ or backbone - being prepared to be challenging when it is appropriate and required; ‘panning for agency’ which involves bearing witness to the person’s self-righting efforts, however small they might be and ‘letting go’ of the need to control and take responsibly for the person’s Recovery. The role of the practitioner then becomes ‘holding the space of creative tension’. This might sound rather linear and in a fixed order
whereas, in reality, practitioners employ the facets in a variety of orders and combinations (diagram 1). This is not offered as a rigid framework; rather it is more of a guide, which can serve as a reminder of the facets of Recovery orientated practice. It also reinforces that the most effective practice is not always the easiest option for practitioners who need to develop the resilience and courage needed to hold this space.

**Straight talking**

Straight talking is about neither adopting a position of unhelpful pessimism nor one of unrealistic optimism, but should honestly prepare the person for the journey ahead. Not promising it will be easy but suggesting it will be worth it. A biomedical approach might give the impression that all the person has to do is take their medication and that everything will be fine. This can lead the person to adopt a passive role and to underestimate the part they can play in their own Recovery. In a Recovery orientation there is a focus on the person’s inner resources and self-righting ability (Glover 2010) along with other resources already available to them, including friends, family, complementary therapies, for example, which complement the support that might be available from mental health services. This straight talking might be more challenging than being given a pharmacological solution alone but it is more realistic and has the potential for an increased sense of control and self-efficacy and a more sustainable Recovery.

**Panning for agency**

By agency, I mean capacity of a person to make choices and decisions in order to act in the world. This notion of agency is central to the concept of Recovery and I believe that all people have agency and it is not possible to have no agency even if it is difficult, sometimes, to see it. Practitioners need to confront any hidden belief they might harbour about whether or not a person has agency. Recovery orientated practice is not about trying to get someone to have more agency, rather it is about mining or ‘panning’ for existing agency and helping the person to recognise and utilise their own agency. Practitioners need to refocus their efforts away from doing things to people and towards being a witness to the person’s agency and igniting their ability to bear witness to their own agency. This is especially important when there might appear to be little movement or progress or when the person might feel a complete lack of agency. Practitioners must develop sensitivity to notice and amplify even those smallest, gossamer threads of existing agency, which might be easily missed. Noticing and responding to the smallest glimpse of effort becomes a therapeutic intervention in itself. Practitioners must be willing and able to be curious about and recognise the self-righting efforts (Glover 2010) and self-mastery that the person already has and to support them to build upon it. This must be balanced with practitioners being mindful not to take responsibility for the person’s Recovery. An invitation to face the challenge leaves the choice and control with the other person – the agency belongs to them.

**Tough love**

Tough love, or practicing with backbone, along with mining for agency sits right at the heart of creative tension. Although it might be easier for practitioners and indeed service users not to face the challenge, it is essential for growth in the same way as it is necessary to remove the plaster cast from a healing limb and to exercise it to strengthen it. Of course the challenge can come from within the person or their close family and friends, but if it doesn’t practitioners need to introduce opportunities for people to flex their self-righting ‘muscles’ while still valuing them as they are; inviting them into the creative tension and taking care not to take responsibility for their Recovery.


**Letting go**

Letting go primarily refers to letting go of a personal attachment to the other person’s Recovery and the responsibility for the other person’s Recovery outcomes. It can also mean stepping away from a need to impose certain professionally determined goals and agendas but it is not about abandonment. Letting go re-orientates the professional to offer an invitation into a creative space rather than towards a direction of travel in which the practitioner holds a heavy personal investment. We should beware of assumptions we might hold about peoples’ relationships with services which we might expect to be very long or even lifelong. In addition, practice needs to be focused on mastery of things that get in the way of the person’s life. That might include intrinsic aspects of the person’s life like relationships and core beliefs or fears, or it may be how services impact negatively on the person’s life by asset stripping them or inviting them into a position of despair. It may also include the person’s own distress getting in the way of their lives. This invites practitioners to move away from the traditional focus on symptom control and eradication. Practitioners need to let go of the need to take responsibility for the other person, to let go of needing to know best and to let go of the relationship once the person no longer needs it. This enables the person to remain more in the driving seat of their life as far as possible and avoids the more traditional centrality of professional expertise, making the lived experience secondary.

**Final word**

Conceptually simple but not always easy to apply in practice, ‘Holding the Space of Creative Tension’ or practicing with heart and backbone, however you prefer to think of it, has the potential to assist practitioners to orientate themselves towards Recovery or self-mastery. Like all frameworks it works best when applied flexibly not rigidly and mainly it offers a lens through which to view professional practice. It also provides a flexible framework for reflection in the moment and post hoc for retrospective learning. When all aspects are judiciously applied, against a backdrop of reflection

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**Diagram 1 - Holding the space of creative tension.**
in action and dynamic striving to maintain a sense of self, despite the tensions, this becomes a powerful combination. Indeed I try to apply the same principles in my own practice. I can’t say I am totally proficient; I have a way to go yet. One thing I am clear about, though, is that when I feel stuck or am struggling to offer something helpful, it is most often my own assumptions, pre-judgements or automatic responses that are getting in the way, rarely the framework. Only by facing these assumptions or automatic responses can I be sure that I am doing all I can to make sure I am getting off people’s backs and not weighing them down with my need to feel helpful.

My thanks to Helen Glover for her help and support in this article.

References


Collaborations

Community Mental Health Service: 
An experience from Lille, France

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Abstract

This article describes the care structures set up progressively, over the past 30 years in the Eastern Lille Public Psychiatric sector. This innovative set up conforms to WHO recommendations (“Facing the challenges, building solutions” Mental Health Ministerial Conference Helsinki 2005). The essential priority is to avoid resorting to traditional hospitalisation, and integrating the entire health system into the city, via a network involving all interested partners: users, carers, families and elected representatives. The ambition of this socially inclusive service is to ensure the adaptation and non-exclusion of persons requiring mental health care and to tackle stigma and discrimination. It gives a new perception to psychiatry that is innovative and experimental, and observing human rights, i.e., citizen psychiatry. This experiment also provides lessons to India for effective implementation of its national mental health program.

Introduction

For thirty years, every effort has been made to integrate Psychiatry into the field of medicine, and Mental Health into the health field. Mental health has become everyone’s business: psychiatry and social exclusion specialists and non-specialists are united in fight against mental disorders. Information about diseases and treatments, prevention and psychosocial rehabilitation are part of the patients’ rights and society’s duties. This mix of all sectors is termed as citizen psychiatry based on the 5 following principles, which were developed over time:

1) Human and civic rights are inalienable. 
Psychiatric disorders can never invalidate them.

2) Justice and psychiatry, prison and hospital, imprisonment and care must no longer be confused.

3) Society, and therefore Mental Health services, has to adjust to patients’ needs, not the other way round.

4) Citizen Psychiatry supersedes the strategy of French sectorization, in force since 1945, as it
promotes the closure of medical and social exclusion places like asylums and large institutions.

5) Fighting against stigmatization and discrimination is essential: raising the population’s awareness in order to modify the prejudices of danger, misunderstanding and incurability against people with mental problems and facilitating access to care.

The application of these principles to the functioning of a healthcare service implies changes in fundamental practice that can be summarized as follows:

1) Change of paradigm: Psychiatric services should no longer have partners but be a partner.

2) Liaison of the psychiatry sector with mental health participants: users, families, towns’ health and social leaders.

3) Coordination of responses to the population’s needs in healthcare requires the involvement of local elected officials, in order to give coherence to a global and non-segregated position, between health, social and cultural services.

4) Involvement and integration of users and families in healthcare and its management.

Socio-demographic context of the psychiatry sector in East Lille

The psychiatry sector of East Lille covers an area of 2653 hectares in the south-eastern area of the metropolis of Lille, i.e. 6 towns of the Eastern suburb, which has a population of 86,000 inhabitants living in the urban zone. Eastern Lille Suburbs comprises the following towns: Faches-Thumesnil, Hellemmes-Lille, Lesquin, Lezennes, Mons-en-Barœul and Ronchin.

The E.P.S.M (Former Psychiatric hospital of Armentières renamed Etablissement Public de Santé Mentale, Lille Métropole, i.e., Public Mental Health Institute Lille Métropole) Lille-Métropole, whose administrative headquarters are located in Armentières 25 km West of Lille, is in charge of the service administrative management. This area is close to the Nord-Pas-de-Calais region of France, in which 4.2% of the population is of foreign origin and has more unemployment (15.6% vs. a national average of 11.1%). Health statistics show an abnormally high death rate, the shortest life expectancy in France and an under resourced health system. The Nord-Pas-de-Calais region is, historically, having big asylums and 4 big hospitals located in around Lille, whose psychiatry units started to integrate themselves closer in to the community 10 years ago.

In 1998, the psychiatry service of Eastern Lille suburbs, Mental Health Public Trust Lille Metropole (EPSM Lille Métropole) was promoted as a pilot site for community mental health by the mental health division of World Health Organisation (WHO). Since 2001, it has recognized the French WHO Collaborating Centre for Research and Training in Mental Health (WHOCCRTMH) for its community mental health program. WHOCCRTMH is one of the founding members of the International Mental Health Collaborating Network, created in 2001 in Birmingham, for the promotion of international cooperation in the field of pilot experiences in community mental health.

History

In 1977, there was shift in the management of mentally ill subjects in one of the sectors. The leadership decided to change the treatment modality in adult psychiatry sector. From the 6 units in the Mental Hospital at Armentières hosting over 300 chronic mentally ill people, about 60 “restless” people from the whole region and the Loos Lez Lille prison, were restricted to the regional units for compulsory treatment, and 15 tuberculosis patients.

To help the transformation, a private non-profile Medico-Psycho-Social Association (AMPS: Association Médico-Psycho-Sociale) was created early in 1977, which gathered all good will of that
time to change the asylum system and to develop psychiatric sectorization. In conjunction with the hospital of Armentières, the AMPS gathered the elected officials of the 6 towns in the sector, care professionals, social partners and people interested in the implementation of the sectorization policy in East Lille. To begin with, it brought about the opening of the Maison Antonin Artaud (medico-psychological centre) and favored the free acquisition of the premises by the municipality of Hellemmes. It acted as the lever for all the subsequent development that was carried out.

The first mission of the AMPS was to raise the population’s awareness about mental health issues and the importance of integrating people suffering from mental health problems into the City. Numerous meetings were organized in the neighbourhood. Then, research was carried out to study more precisely the stereotypes of “mental illness” and “madness” and the stigmatization of “mentally ill” or “mad” people. This research work, supported by the Nord-Pas-de-Calais Regional Council early in 1979, enabled the implementation of a policy of integration and public education. The project was able to develop common ground for psychiatry team and local artists, keeping as an objective of rooting out the negative image of madness and mental illnesses by the population in the towns of the sector. Several cultural and artistic programs were organized together by the psychiatry teams and municipal authorities.

In 1982, AGORA (Greek word for an open "place of assembly"), a centre of housing and deinstitutionalization, specializing in the rehabilitation of long term patients, was created. Its employees were paid by the AMPS. This experience initiated first contacts with social landlords, for the setting up of an associative and ‘therapeutic flat’, then for access to dispersed associative housing facilities.

These thirty years of common work within the association and with health and social authorities enabled the changes, and this constitutes the psychiatry sector of the Eastern suburb of Lille today. The change occurred in 2 essential steps:

The first step (1975-1995) was the shift from the psychiatric hospital to the community, by the development of sectorization with the help of the global budget. In 1975, 98% of the budget was devoted to full-time hospitalisation (i.e. 300 beds in Armentières).

The second step (1995-2006) consisted of decentralising and opening the psychiatry service by integrating team professionals in the health, social and cultural services of the towns. This integration increased the partners’ participation (users, families, professionals and elected officials) in the decisions of the psychiatry service. The overall objective is that the psychiatry team goes out of its ghetto and thus professionals become “nice to know” by the population. Structures cannot be set up without the local elected officials’ legal agreement. The overall philosophy is one of care and support. The practice is open and multi-faceted.

In 2009, 80% of professional staff was assigned to the city, while 20% remained assigned to full-time hospitalisation (26 beds, 7 are occupied in average). Today’s care structures of the East Lille sector are, thus, spread within the cities, over a dozen different places, and always in contact with one another, which facilitates the patient’s moves between each unit. These supported places are either rented most of the time or put at the disposal of patients by the towns, and are located closest to the treated population.

In 2010, following the positive development in France of the mental health local council (National Program 2008-2011) where the AMPS has been transformed into a mental health local council (MHLHC) gathering the 6 municipalities of the eastern Lille mental health services territory. The MHLHC provides a discussion platform for 6 towns’ mayors, citizens, users of mental services, families, artists, cultural services, low income housing services, curators, social services, sanitary services, and psychiatric services.

No decision on creating new services and care organizations in the city is possible without getting approval from MHLC. Similarly, prevention and information education communication activities are planned with the involvement of all stakeholders.

Caring Places: Accessibility and Continuity Consultations

The psychiatric consultation centre “Maison Antonin Artaud” is located in a municipal house in Hellemmes. This place also hosts social receptions of the Unité Territoriale de Prévention et d’Aide Sociale d’Hellemmes (Territorial unit of prevention and social help / General Council) and the support service for gypsies.
The Van Belleghem medico-social centre is located in a Communal Centre of Social Action (in Faches-Thumesnil). This centre also hosts consultations for Maternal and Child Welfare, the Alfred Binet child psychiatry centre, sports medicine and social services. Psychiatric consultations are available within the Sports-Medical Centre located in the premises of the swimming pool in Ronchin. They are also available in the premises of the Territorial unit of prevention and social action of Hellemmes and Mons-en-Barœul, which deals with elderly people and children (Maternal and Child Welfare) and is in charge of the follow-up of people in a precarious situation in the towns being served. Finally, they are available in the Medical House (Maison Médicale) of Mons-en-Barœul, where one of the offices is rented to the sector team.

In all these places, consultations are offered. Besides psychiatrists of the sector, psychologists, psychomotility therapists and psychoanalysts offer diverse techniques such as psychoanalytic, cognitive-behavioural or systematic therapies.

Any person wishing to have a mental health care in that service, automatically see his/her general practitioner first, who provides an introductory liaison letter. These people are welcomed within 24 hour by a nurse of the sector, who assesses the situation and the emergency level, according to the attending physician and the result of the nurse assessment. If need be, the user is seen on the very same day by a psychiatrist. For cases that are judged as non-urgent, an interdisciplinary meeting is organized twice a week, in order to provide user with better guidance and care.

Services of inclusion and care activities integrated in the City

Centres of therapeutic activities are called services of inclusion and care activities integrated in the City. A devoted team organizes inclusion and care activities in all artistic, sport and cultural places in the 6 towns of the sector and in the Frontière$ centre.

Altogether, 48 different activities are offered per week, with 60% of them taking place in 21 places outside the service (association, social centre, maison folie, media library, retirement home, sports facilities, etc.).

In this system, activities are made upon medical prescription and reviewed regularly with users. They are all carried out in municipal structures, in conjunction with the local associative network, and are led by professional artists, sports professors (49 hours of weekly time paid by the EPSM Lille-Metropole).
Métropole). These activities include Plastic arts workshop, aesthetics workshop, media library, sports, dance, music, singing and video activities, as well as psycho bodily activities (body awareness “vécu corporel”, stimulation, aquarelax).

Also, a therapeutic workshop has been developed at the FRONTIERES Centre in Hellemmes. This artistic centre in the inner city is co-located with a contemporary art gallery, financially being supported by the Regional Direction of Cultural Action (Direction Régionale de l’Action Culturelle), which organizes monthly exhibitions. The planning is meant to be diverse, as it opens towards inhabitants’ leisure and daily life. No matter where they take place, activities are above all designed as a springboard to support the users’ integration into local life and to give them the tools to break their social isolation. These activities include the possibility to have one’s meal in municipal restaurants or in a municipal room where meals are being delivered by a caterer.

The psychosocial rehabilitation teams (apartment service, activities service, work placement service), lead inclusion activities and are also in charge of home visits, scheduled nurse interviews, and socio-educative guidance in conjunction with the City’s services. Whether at home or in a unit, the multidisciplinary team offers a personalized follow-up with adapted intensity and frequency, in conjunction with a psychiatrist in-charge. Over 500 patients benefit from this type of support every year.

Full-time hospitalisation

The historic part of the local services, the Jérôme Bosh Clinic, a full-time in-patient unit, remains located in EPSM Lille-Métropole at Armentières. This in-patient service will be transferred to the Lille General Hospital in the near future (2012). In these fully renovated premises, 20 patients can be hospitalised and benefitted from the intensive care program. In 2006, the mean occupancy was 10 beds out of 20 for a mean length of stay of 8 days. During hospitalization, besides medical, psychological, nurse and socio-educational interviews, the patient benefits from artistic therapeutic activities (plastic arts, video, and music) and from bodily support (psychomotility, hydrotherapy, relaxation, dietetics, and aesthetics). The unit is completely open (doors are not locked, a person at the entry is in charge of watching entries and exits), and whatever the kind of placement is, it could be compulsory by legal order or by a third person request or free will of user. Patients have access to the information applicable to them, including their medical treatment. They also attend meetings between carers and users, twice a week. There is a close articulation with the teams of the sector, which establishes first contact with the patient during hospitalization, to consider his/her discharge. Some hospitalized people are also taken to the FRONTIERES Centre, in order to benefit from therapeutic activities, and meals in the Concorde room (in a municipal town), with patients in day care.

Alternatives to hospitalization

Therapeutic host family as an alternative to hospitalization: Therapeutic host families as an alternative to hospitalization were established in 2000 and there are currently 12 beds already available. In this case, the patient in an acute situation is sent to the family either directly, after a consultation, or secondarily after a hospitalization, for some days or some weeks. Instructions given to families are to host the person, not to cure him/her. Nurse and the social and medical team take care of support during home visits (management of treatment, link with therapeutic activities and consultations with the sector, in order to develop the individual project). Support is similar to that offered within the full-time hospitalization unit located in the hospital: medication, hydrotherapy and therapeutic activities carried out in the city in consultation centres and the towns’ activity centres.
Families are paid up to 1036 euros per patient per month by the EPSM Lille-Métropole. They are an integral part of the psychiatry sector team. They provide attention and support which are important for patients. In family stays as an alternative to hospitalization, the average length of stay is 21 days. The host family in this way is therapeutic through the family dynamics complemented by the professional team and thus, enables personalised care of good quality.

Intensive care integrated in the City as an alternative to hospitalisation: This unit of 10 beds organizes reinforced follow-up of people who need it, during a repeatable period of 8 days. This follow-up takes into account the close circle of supporters and the patients’ needs for a brief time, and for a reinforced follow-up (nurse interview, psychiatry, psychological consultations, relaxation, activities, etc.). This mode of intervention involves all carers (private nurses, general practitioner, local pharmacist, etc.) and all the person’s de facto caregivers (family, friends, circle, etc.). It is the same team, along with the psychiatrist on call in the sector, which can be mobilized within 24 hour for people in the need of the service. It responds to post emergency situations, in order to guarantee total continuity of care and guidance to the patients.

Reduction in stays and admissions for full time hospitalizations related to host families and development of home care treatment is given in Table 1.

Inclusion and rehabilitation: “DARE TO CARE”

The aim of the social inclusion program of WHO was to include and integrate care of mentally ill person within social groups and the regularization of the administrative, financial and social situation of the user. Mental health service at Lille has adopted WHO theme “Dare to Care: by developing and combining these three components in order to reach the overall objective: housing; employment; leisure, arts and culture.

Housing

Associative apartments: Access to associative apartments spread in the social fabric of the town is one of the major components of inclusion work. An “apartment committee” gathers the members of the Medico-Psycho-Social Association (AMPS: Association Médico-Psycho-Sociale), the representatives of public housing offices (HLM: Habitation à Loyer Modéré), social landlords, caregivers, the representatives of users and family associations and trustees. This committee decides on the allocation of apartments located in the public housing stock. The president is a locally elected official. The AMPS covers the deposit; the patients cover the rent and the general expenses, with the help, if need be, of the trustee or the guardian and the team. The caring and socio-educational team is in charge of medical and socio-educational follow-ups. The therapeutic program comprises regular consultations with the psychiatrist in charge, the treatment taken, nurse interviews and schedules of therapeutic activities. Since the creation of the Committee, 150 apartments have been put at the disposal of patients, mostly as a co-tenancy of two or three people, with the presence of one student per apartment, who is hosted ex gratia to share the tenants’ lives.

Currently, 57 apartments are supported by the “apartment committee” and 95 people, who accepted a contract of social inclusion and care, are being benefitted from this method of housing allocation. They are follow up by a specific mobile team, 7D, 24H.

Résidence André Breton: This associative and therapeutic residence is another form of access to accommodation, again within the framework of the public housing system. It is located in Faches Thumesnil and comprises six sheltered apartments and a large therapeutic apartment which hosts six people with severe handicap. The residence is completed by 5 social accommodation facilities entirely managed by the municipality. This accommodation is made possible by the constant presence of hospital staff (care assistants, health education assistants, education assistants and hospital service agents). Each patient is the tenant of his/her apartment. It is a genuine alternative to the concentration of the severely handicapped in specialised homes, which is a new form of handicap segregation. Assistance is given to the person who enables a good mix of the population, rather than segregation.

Housing to avoid very long term hospitalization

The Résidence Ambroise Paré, located in a block of low-rent accommodation, comprises two studios, one of which is occupied by a student, one 3-room
apartment occupied by two users residents, and a 4-room apartment housing a student and 2 residents. This scheme is part of a social program of low rent accommodation approved by the municipality of Lille and social landlords.

The Résidence Samuel Beckett is a former centre for housing and social rehabilitation, for patients from the sector, settled here as a first step to change the service (discharge of patients who have stayed in hospital for a long time). This centre, which is owned by the municipality of Fâches Thumesnil, hosted the hospital day-activity and the regional centre for the setting up of basketball boards in the cities. Today, the structure, which is put at disposal by the EPSM Lille-Métropole, hosts:

- an apartment accommodating a therapeutic host family, providing an alternative to hospitalization, with a user host for a mean period of six months, that corresponds to the rehabilitation period. The family also insures supervision duties in exchange of free accommodation.

- a second 5-room apartment, next to the first one, which is a therapeutic, associative, social and transitional hosting place, for patients who are medically stabilized and in transit for sheltered accommodation, a private or social apartment, a retirement home or any other accommodation facility. A student is also accommodated with the beneficiaries.

There is a housekeeper in the transitional apartment premises. The educational team is there during evenings and weekends. It observes and assesses the people’s self-sufficiency and ability to live alone or in a shared apartment and to manage their daily life on their own. The sector nursing staff is in-charge of the visits and monitors therapeutic treatments.

**Economic rehabilitation**

Partnership with the Centre d’Adaptation à la Vie Active (CAVA - Centre for adaptation to working life): The CAVA located in Fâches-Thumesnil, is an association through the French law of 1901 (Association de Handicapés de Fâches Thumesnil: Association of disabled people of Fâches Thumesnil), which is part of the field of inclusion through economic activities. Its purpose is to promote access to the job market for people with major difficulties of social and professional exclusion (recipients of minimal social income, long-term unemployed people). It has 20 places via a contrat

Table 1: Paradigm shift from full time hospitalisation to home care treatment in Lille, France.

<table>
<thead>
<tr>
<th>For 86 000 inhabitants</th>
<th>1971</th>
<th>2002</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>People in care</td>
<td>589</td>
<td>1677</td>
<td>2572</td>
</tr>
<tr>
<td>Ambulatory care (number of acts)</td>
<td>0</td>
<td>23478</td>
<td>48315</td>
</tr>
<tr>
<td>Admission to hospital / acute beds</td>
<td>145</td>
<td>444</td>
<td>360</td>
</tr>
<tr>
<td>Compulsory treatments</td>
<td>145 (100%)</td>
<td>99(22%)</td>
<td>87(24%)</td>
</tr>
<tr>
<td>Mean lenght of stay (in days)</td>
<td>± 213</td>
<td>14,5</td>
<td>6,5</td>
</tr>
<tr>
<td>Number of days of hospitalisation</td>
<td>77 640</td>
<td>4248</td>
<td>2490</td>
</tr>
<tr>
<td>Number of people admet in host families (AFTAH)</td>
<td>87</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Number of people admet in home care treatment (SIIC)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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The establishment of vocational rehabilitation integrated in the city: Following a three-year study carried out by a committee of experts, an experimental project was created, led by the municipality of Lezennes in the framework of the AMPS, composed of representatives of users and family associations, and associations of professionals in the field of economic inclusion. It is “integrated in the city” insofar as it is devoid of any production unit; all handicapped workers practise their professional activity within municipalities, local communities and partner associations, via the Work Centre. It enables people who are unable to integrate normally into the ordinary environment and who can however, find their place in conditions adjusted to their handicap.

Therapeutic work: In 2006, we added a new project to this scheme: “therapeutic work”, whose purpose is to renovate and to furnish associative apartments, which needed furnishing or improvements to the living spaces. It is based on the principle of voluntary service and self-help by and for users, and it is led by a workshop supervisor, and an occupational therapist, assisted by an artist. It is a first step towards the return to employment, through the help of active groups.

1. Art, culture and leisure

The Frontiere$ Centre: The Frontiere$ Centre initiates artistic activities, in the framework of a
hospital/culture partnership, which was created 18 years ago. It started with the rehabilitation of the J. Bosch Clinic, a former unit for compulsory treatment, by the patients who had stayed there, with the help of an architect. A scale model of the Centre was presented during a cultural week Pavillon 11 – Procès de la folie in 1984. At that time, the mental health department sector Lille-Métropole wanted the Centre to be located in the city. This was impossible because of local political and medical pressures, which wanted employment linked to “madness” to remain at the site in Armentières. The sector was part of the “Health, Culture and Musical practice in institutions” mission, organised in 1983-84 by the French Ministry of Culture and the French Ministry of Health. Since then, 49 hours of cultural work per week have been implemented by the EPSM Lille-Métropole for artistic activities. Full-time artistic participation was created two years ago. For over a year, an arts professor has been hired by the E.P.S.M. Lille-Métropole. All cultural structures of the sector, or the city of Lille, are entrusted with these activities; groups are led by artists and supervised by nurses. For activities carried out by the school of body practice in Villeneuve d’Ascq and the Dance association in Lille, groups are organized by these institutions and users and resident users are gathered in these artistic schools.

Art has the particular faculty of establishing equality between patients and non-patients for artistic production. It allows evaluation and social acceptance. Contemporary art at least, the spearhead of our work in the sector, like mental disorders, requires interpretation, it cannot be understood immediately. The integration of artists into the psychiatric sector contributes to the production of imaginative works: its creativity reaches beyond the stigmatization that people with mental disorders suffer from. As is suggested in this brief description, it is not Art Therapy: The purpose is not to “cure through art”, but rather to enable non-stigmatisation thanks to art and contact with artists.

REAL NETWORKING: NO LONGER HAVE PARTNERS, BUT BE A PARTNER

In addition to the multiplicity of care facilities and their integration into the urban framework, the originality of the East Lille sector is its diversity of links established with the different partners, within a real network.

The elected officials: The elected officials lead this partnership and are committed to social inclusion by making available housing facilities, consultation places, municipal rooms for catering and therapeutic activities. By making use of their networks of relationships, they open doors and smoothened difficulties in order to provide their fellow citizens, suffering from mental illness, with a real place in the community.

Social institutions: Social institutions are other essential partners: social workers, a communal center of social action and the general Council are often included in the support, and guarantee people’s rights. Using these services, in collaboration with educational associations ensures housing provision and solutions to problems of financial resources and rehabilitation. The cornerstone of this collaboration can be illustrated by the sharing of the General Council’s premises in the Centres for Prevention and Social Action of Mons en Baroeul and Hellemmes, for psychiatric consultation. In addition, special links have been established via formal agreement with the associations in Lille devoted to the homeless, in collaboration with 6 other general psychiatry sectors. This service has been the promoter and partner of a mobile team concerned with Mental Health and homelessness, called DIOGENE, which meets homeless people in the area of Lille, and can refer them to a public psychiatric facility if need be.

Cultural institutions: The National Lille Orchestra, the theatrical association QUANTA, the Nieke Swennen company, independent artists, plastics technicians, photographers and musicians have made it possible to offer therapeutic activities that are fully integrated into the local cultural landscape. Going to a concert, creating a ballet and taking part in an exhibition preview are new experiences for some patients, and a factor facilitating better contact with others and with the real world. The Frontieres gallery was managed for years by the artist Gérard Duchêne, and is now being run by David Ritzinger. Its window onto the street displays this alliance between care and art.

Users and family groups: Users and ex-user groups are favored partners, which are considered as “experience experts” in the field of Mental Health. These associations, members of the FNAPSY (Fédération Nationale des associations d’ex-patients en psychiatrie, i.e., National Federation of associations for psychiatry, ex-patients), develop a program of representation and training for users. They are actively
associated to the research programs. Representatives from UNAFAM (Union Nationale des Amis et Familles des Malades psychiques (National Union of Friends and Families of people with psychiatric disorders i.e., national union of families and friends of mentally ill people) sit on the Commission for allocating accommodation, and are called upon more and more to take part in events organized by the sector and in its projects.

Mutual self-help groups (GEM: Groupes d’Entraide Mutuelle), meeting and self-help centres managed by users, have become essential partners for rehabilitation and for the fight against social isolation. They were created in 2005 through government funding (French Mental Health Plan 2005-2008) and run by users themselves in autonomy most of time. In 2009, 280 groups were in activity, out of which half of these groups were piloted 100% by users NGOs. These groups certainly do fight against isolation, yet they tend, above all, to become bridges allowing users to progressively leave the psychiatric care system.

**Health partners in the towns**

Last but not least, another long-standing partnership has been established with the other local care providers. First of all, general practitioners in the urban districts in the sector, who are essential collaborators in all follow-up, are involved. They enable the referral of a patient to a CMP (medico-psychological centre) consultation and receive regular reports for each consultation or hospitalization. Outside hospitalization, the GPs are the only prescribers for patients, nominated by the consultant psychiatrist. The frequency of exchanges in mail, phone calls and meetings enable constant discussion on the way a patient should be catered for, given that, as family doctors, GPs are closest to the patients’ daily life.

Several pharmacists are also part of this partnership, so that medication can be delivered to chemist’s offices, in accordance with the need for proximity and routine observance of prescribed treatments.

Private Nurses are also often called upon to visit patients’ homes, providing medications and for nursing and hygiene care, on medical prescription.

Very close links have been established with the Meeting and Crisis Centre (CAC: Centre d’Accueil et de Crise) in the regional university hospital in Lille. This unit takes in patients during an acute state of distress up to 72 hours. When a patient from the sector is hospitalized, a contact is made by the sector team, which routinely goes to the CAC to decide with the patients and the referring physician as to how the patient is to be supported in the sector, with a view of continuity between this emergency unit and short to medium term care in the sector. Usually it leads to intensive follow-up in the city and/or to care in a host family.

Role of the international and national network of good practices in psychiatry in the reorganisation of the mental health services in East Lille (EPMS Lille Métropole)

How did the psychiatry sector of East Lille, and by extension of its referral institute EPMS Lille Métropole, benefit from International Network and continued to be included in its future plans? We owe this mainly to experiences drawn from the international network, training visits organized by the hospital for the whole staff of the East-Lille service in different European and national sites, consequently introducing new practices to Lille which seemed interesting and positive for the support of the population in the towns of our sector:

- After studying all good practices in Trieste, 1976 led to their implementation in east Lille suburb in 1977.
- Host families as an alternative to hospitalization (one family= one bed), during a conference with all alternative global experiences in Trieste in 1986 (example taken from Madison USA 1998) led to implementation of same in Lille in 2000.
- Home care 7 days a week with a mobile team: seen in Birmingham in 2000 and same was implemented in Lille in 2005.
- Totally open psychiatric wards were seen in Merzig, 1997 and in Trieste, 1995 and same was implemented in Lille in 1999.
- Nurses in the front line for welcoming patients, using appropriate tools: seen in Mauritania in 2001 and same was implemented in Lille in 2003 in the whole sector.
- Crisis centres for 72 hour Centre Hospitalier Universitaire de Lille (University Health Centre), 2001
- Operational networks with the attending physicians
- Oviedo, 2002 and was implemented in Lille in 2003 with a network of GPs.
- Cooperatives to access work seen in Trieste in 2003 and similarly, were set up in Lille in 2007 in an experimental program with municipalities.
- Clubs and volunteers in Quebec 1987, in Luthon and Monaghan 2005 and same were implemented in Lille in 2005 thanks to the law about Self-help groups (GEM: Groupements d'Entraide Mutuelle).
- Peer support program has been witnessed in Canada 2008, USA 2009, and UK 2009 and are currently developed in Lille since 2011
- The East Lille Mental Health sector is one of the founding members of the International Mental Health Collaborating Network, created in 2001 in Birmingham. In its collaboration a pilot programs in Community Mental Health for the promotion of international cooperation has been started in Lille. The IMHCN “Mental Health and citizenship” International NGO was founded in Lille in 2006.

Evidence based practices for community mental health: our outcomes
- All hospitalisations even compulsories are made in open structures (no seclusion, restraint is used once a year during 2 hours)
- Every person sent by a GP is received in less than 24h (ISO 9001)
- Suicide rate is 30 % less comparing to the Nord Pas de Calais Region (2000-2008)
- For compulsory hospitalisation, people leaving without medical authorisation per year: 1 vs 29 in average for the other mental health services
- No one stays for a long term at the hospital

The Future of Citizen Psychiatry
It is perfectly possible to implement the WHO recommendations in France by centralizing services for emergencies and stabilizing patients for short stay and rest of the mental services can be given through outpatient or community based health centers. Instead mental health services in Lille are truly integrated into the community with the active support of locally elected representatives. For that purpose, it is essential to go beyond hospital-centrism and to clearly shift from “psychiatry hospital services” to “individual health and social services”, in the person’s living environment. Networking is essential for this paradigm shift.

For thirty years, the psychiatry service of East-Lille has evolved from the isolationism of Armentières to the Eastern suburb of Lille, fully integrated in the urban fabric, becoming more complex and more flexible. With the municipalities and the EPSM Lille-Métropole, we have set up all the structures. We only have to transfer the beds of the former psychiatric hospital, which have been almost empty since then, into a caring structure for the city; the ideal would be a general hospital. This is planned for 2012 as a 10 bed unit, close to the CHR (Regional Hospital Centre) of Lille. The integration of Mental Health into general health psychiatry in medicine is almost achieved, and it is logical to change the last psychiatric beds into a general hospital.

The integration of the mental health services into the city at proximity of citizens after a preparative work is also a powerful anti stigma strategy. The re-localisation of in-patient beds closer to the affected population will definitely mark the end of psychiatric imprisonment and isolation in asylums. This is 21st century psychiatry, which started thirty years ago, a psychiatry in favour of users, integrated in the community, that is to say, for the people.

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The years of my illness were hard times for me, of which I have chosen and needed to forget many things. Approximately eight years ago I slowly started to recovery from my painful mental illness, and discovered stages and relationships that linked me to my past, obstacles to my personal growth because of the sad, limited image they reflected of who I was. I would compare the work I then did to formatting a computer. Cleaning it completely, erasing all that might hamper its smooth running such as damaged files, viruses, useless junk foolishly taking up space and erasing, perhaps, photographs that bring back memories of painful moments. And after this, installing only what I really want to use, newer and swifter programs, perhaps free software, and a limited amount of quality information. Everything then can start over. This is what I did with myself. And this is why when people talk to me of old files long removed I look at them with indifference and say:

Excuse me? I don’t know what you are talking about, I am sorry.

Look at me; do you really see the traces of that old, defecti operating system? I don’t, sorry.

You do still see it? Really?

Well perhaps you ought to have your sight examined, or your hearing, or something.

As a result of infinite effort (and I say infinite because it never ends), of intelligence and bravery, of the support of my social network I have succeeded in forgetting that for a few long years, I was “crazy”.

I am healthier now, mentally healthier, than many persons who never see a psychologist, much less a psychiatrist.

The affirmation is self-evident. Nobody who met me at this moment in life would be able to catch even a glimpse of this “dark” past.

All of which gives me enormous satisfaction, as well as motivation for my daily struggles, to find fulfillment and of course fight to change the world.

Some of the people I know have somehow shared that “dark” past and are unaware of these transformations. These people unintentionally make me remember that “I USED TO SUFFER” from a
very severe mental illness. I would have loved to go to these people with open arms, to format our relationship and start over again, or at the very least to fondly remember that we used to be friends. That is sadly a beautiful dream not often come true. I am not one for nostalgia. There is no way I would want to relive those years.

I would have liked things to be different. Losing so many people along the way has made me suffer deeply. It scares me to think what all those persons who disappeared from my life thought and felt for me when they were with me. Because most people are ignorant of what is really a mental illness, and they often exclude frequently reject them who suffer from such illnesses. The consequence is that on top of being very ill and suffering very deeply, they feel guilty for not acting as is expected of them. It is not understood that persons with illness are not master of their self, their actions lack coherence not because they wish to but because they cannot help it. Mental illness basically means mental suffering for the individual without having any physical wound or any physical disability; hence the nature is more psychological.

With luck this story has a happy ending. I have not ended up in a psychiatric hospital or with a permanent disability: Not only that, I consider myself lucky in overcoming limitations, with a variety of goals achieved, and good health recovered through devoted personal work. Eight years of psychoanalysis which translated into a wide experience in introspection and becoming conscious of things has indeed helped me as a useful tool for living as a happy, healthy person.
Contradictions in goals – invitation to debate

Anne Grethe Klunderud
Norway
WAPR Board at large
Service user representative

WHO identifies mental health problems as one of the main threats to public health and welfare. Mental health problems are described as the fastest growing reason for disability in the world. Through the Global Mental Health Action Plan 2013-2020 the WHO has targeted different areas to stop this escalation. At the same time, WHO draws on the medical diagnostic system. This is a system that easily may define distress, despair, problems based in poverty, unemployment or various social issues, as illness identities and symptoms of a psychiatric diagnosis. Human reactions are labeled as mental disorders.

There has been objections and protests from consumers on these subjects before. The solution of the escalating mental health problems is not in labeling more people as mentally ill. This will only increase the focus on deviance and passive treatment rather than active coping, recovery and social inclusion. Is this a development we really want, that nearly all aspects of life itself become a medical matter?

One target is missing in the action plan, the true treasure chest. Meaning the knowledge of ex-consumers. How can we use and continue to gather the knowledge of coping with mental health problems on a daily basis. How can this knowledge form the basis of policy documents and practice strategies nationally and internationally? How do the ex-consumers manage to cope with the pain and problems of mental disability?

The knowledge of managing mental health problems from lived experience must be acknowledged and respected by professionals and policy makers and become available for clinicians as well as service users. There is no truth in saying “once a consumer, always a consumer”. By providing this knowledge we can also provide solutions for the public in general to coping with every day challenges.

I claim that the treasure of knowledge connected with living and coping with mental health problems is a big part of the solution. Provide recovery oriented frameworks where citizens who are ex-consumers are encouraged to self-management rather than medical management. If we really are looking for solutions, it may be a good idea talking to those who have gone the road already.
Anti-stigma Movement and Human Rights of the Mentally Ill people in Korea

Tae-Yeon Hwang
President, Korean Association for Psychosocial Rehabilitation

Modern Psychopharmacology was started by treatment of Chlorpromazine manic or psychotic patients in the early 1950s. Before introducing antipsychotic medication, treatment such as Insulin Coma Therapy, Frontal Lobotomy, and Electroconvulsive Therapy had a dramatic consequence on people’s lives, personally as well as socially. People’s social behaviour could become bizarre and problematic. This among other things resulted in stigma against mental illness and psychiatric treatment. Long-term care in the large institutions with iron bars and poor community care also made people believe and feel that mental illness is an incurable disease. In the inpatient units many patients could be subjected to horrific violence by other patients and staff. As we have seen in many videos or TV reports, psychiatric institutions tended to be more like human warehouses than places of hope, care and treatment. Many people received no form of stimulation or active treatment and spent days, months and even years living in extreme passivity and boredom and slept a lot because of over-medication. These situations were a result of ignorance and stigma related to mental illness. Many people with mental illness were segregated from the society. Benedeto Saraceno (2006) said that protecting the human rights of people with mental illness is one of the urgent priorities for global mental health development.

In the Asian region, we can see severe stigma against mentally ill people because of hierarchical social structure, under-allocation of mental health resources, ineffective advocacy, ineffective primary mental health care, and inadequate anti-discrimination movements. Perceived stigma has been historically defined as erroneous and negative social attitudes toward a distinguishing physical or behavioral characteristic of a person or group. Usually stigma results in reduction of patient access to resources and opportunities such as jobs, housing, and lower self-esteem, make them isolated, and helpless. Most people learn what they know about mental illness from the mass media. We are exposed daily to radio, television and newspaper accounts that present people with mental illness as violent, criminal, dangerous, comical, incompetent and fundamentally different from the rest of us. These inaccurate images perpetuate unfavourable stereotypes, which can lead to the rejection and neglect of people with psychiatric disorders.
To reduce stigma against people living with schizophrenia, Asian countries such as Japan, Hong Kong (China), and Korea recently changed the local name of schizophrenia. In 2002 Japanese Society of Psychiatry and Neurology (JSPN), change the old term of schizophrenia ‘Split-mind disorder’ into new term of ‘Integration disorder’. The change was triggered by the request of a patients’ family group to JSPN in 1993. The renaming was associated with the shift from the Kraepelian concept of the disease (hereditary but unknown etiology, unable to cure, poor outcomes leading to deterioration of personality) to vulnerable –stress model of the disorder (disintegration of neuro transmitter system mainly dopamine, treatable, expectable to recover and cure). The renaming increased the percentage of cases in which patients were informed of the diagnosis from 36.7% to 69.7% in three years. The renaming of the old stigmatized term into new term with current concept of the disorder has provided hope of recovery to the patients with schizophrenia and promote a modern advanced treatment under realistic optimism (M Sato, 2008). In Hong Kong, psychiatrists renamed Psychosis to ‘thought and perception dysregulation (Chiu CPY, 2010)).

In Korea, the committee for renaming schizophrenia was organized with the representatives of Korean Neuropsychiatric Association, Korean Society for Schizophrenia Research and Korean Family Association for Mental Health in 2008. The committee conducted the activities including questionnaire surveys, proposal for candidate new names, symposium and workshop. In 2010, the committee finally chose the new name ‘JoHyeonByung (Attunement Disorder). Comparison study of stigma according to the term used for schizophrenia, the new term resulted in reducing prejudice and discrimination against people with schizophrenia. (Kim et al. 2012)

Korean Association for Psychosocial Rehabilitation (KAPR)) has been working hard for the human rights of mentally ill people and their families and also contributed so much to eradicate stigma and discrimination against them. Also Korean Neuropsychiatric Association(KNPA) designated Mental Health Day of Korea as April 4th because number four has stigma on it. During the Mental Health Day, KAPR and KNPA have been hosted Mental Illness Awareness Campaign, Public Education, Concert, Play, and Exhibitions collaborating with Mental Health Professionals, consumers and families every year.

Besides KNPA, other NGO just like SEBoD (Socio-economic Burden of Depression) has been
major targets were adolescents, elderly people, and military soldiers those are in a very high risk group of suicide and depression in Korea. Also, SEBoD Korea began contest for Depression Recovery Story in 2005 to draw interest from the public and increase understanding about successful recovery from depression. SEBoD Korea posted all of the awarded stories on the web-site after getting applicants’ permission. Readers of these stories gave feedback to the team that the real stories were helpful in order to understand what depression was about and that recovery is possible and real.

Another important point of our activities is to develop scientific evidences on depression in Korea. SEBoD Korea research team performed “The Impact of Depression on Productivity in Workers” in 2007, and others on depression prevalence and updated information. The active promotion of depression-related material to the community has contributed to recognition of depression in the commonality and impacts of this illness.

working for depression awareness. To achieve meaningful reductions in depression-related health burden a range of preventative and treatment strategies are urgently required. SEBoD Korea Project was kicked off in 2004 aimed to increase early detection and treatment rate and decrease prejudice so that decrease socio-economic burden of depression through multiple strategies and social activities. According to most health-related behaviour model, knowledge and beliefs about mental disorders will aid their recognition, management or prevention. SEBoD Korea has been focusing on public education campaign entitled Escape from Depression since 2004. This program consists of depression screening test using Beck Depression Inventory and Korean Depression Scale, lecture by psychiatrists focused on that depression is not only common and disabling but it responds to evidence-based treatments, and individual counseling. 14 hospitals and mental health centers are engaged and they open education program every quarter. Around 3,300 persons, whether they are patients, care-givers, or non-patients, attended this program in 2009, and the
For Bipolar Disorder Awareness, Korean Society of Depressive and Bipolar Disorder (KSDB) have held 'Bipolar Day' for the screening of Bipolar disorders since 2005. In 2012, 72 Institutes including University Hospitals, Mental Hospitals, Private Psychiatric Clinics, Community Mental Health Centres, and Social Welfare Facilities were participated in this project. KSDB support the project through slides, video, poster, and leaflets to the each organization for screening of polar disorders and public education. According to the reports from each organization, totally 4,428 community people, soldiers, students, patients and families, and elderly people participated in the screening and education. MDQ showed 27% of the responders were highly probable, and BSDS showed 19% were moderate and highly probable state. Feedback from the participants said this campaign was very helpful to identify their undetected bipolar symptoms and they would like to seek help from psychiatrists in the future. KSDB will continue this campaign next year to prevent development of bipolar disorders among publics.

References
Paraguay is a small country in the center of South America, bordered by Argentina to the south and southwest, Brazil to the east and northeast, and Bolivia to the northwest. Paraguay lies on both banks of the Paraguay River, which runs through the center of the country from north to south.

Asunción its capital, Paraguay has about 6.5 millions of habitants: 50 % of them are younger than 20 years.

The Paraguay River cuts the country into two different climate zones: The eastern part, with subtropical, humid conditions and lots of green vegetation; and the western part which does not receive rain regularly so that you will find hot and dry conditions, almost like a desert.

The majority of the Paraguayan population is considered mixed (mestizo in Spanish), and about
5% are members of indigenous tribal groups. There are some smaller groups of ethnic Italians, Germans, Japanese, Koreans, Chinese, Arabs, Ukrainian, Brazilians, and Argentines who have settled in Paraguay. Paraguay's population is distributed unevenly through the country: about 56% of Paraguayans live in urban areas. The vast majority of the people live in the eastern region near the capital and largest cities or in more rural settings. Only 2% of the population lives in the western region, mostly indigenous groups or German speaking menonite settlers.

The official languages are Spanish and Guarani.

Some statistics estimate that 35% of the Paraguayan population is poor, 19% of which live in extreme poverty, 71% of them live in rural areas of the country.

The public health system is not well developed. Everyone who can afford it will try to use private services. Most of the mental health services are concentrated around the capital. People who live in the rural areas often have to travel for hours and go to Asuncion to see a psychiatrist or psychologist. When they go back to their homes there is no follow-up care for their mental health problem.

Centro de Rehabilitación Psicosocial “EL PUENTE”

The psycho-sosial day care center give services from Monday to Friday to about 60 persons with psychiatric problems, mostly like psychosis or intellectual handicaps.

About 40 persons are coming every day from their homes in Asuncion or the surrounding towns. The other 20 are persons who are living in the psychiatric hospital for many years because of their complicated and stressful social situation.

Nearly all of our patients belong to low income families, therefore they don’t need to pay. The center is financed by sponsors and in some way in collaboration with the psychiatric hospital.

In collaboration with our patients and their families, we try to establish an individual rehabilitation plan for each person and family.

The most important experiences of our patients probably are being accepted, finding friends, and learning to express their opinions and feelings. A useful media for this is collaborating with our internet radio program (www.radioesperanzapy.blogspot.com). Having a place to go to every morning helps them to get used to more independent community living and to develop routines of activity and participation.
According to 2011 PreCa Report (*), about 85% of Spanish prisons’ population suffers any kind of mental disorder while they serve sentence. Nevertheless, only 10.7% of those are people with severe mental disorders (psychotic disorders). Spain only has two psychiatric hospitals for penitentiary uses in the whole country for over more 85,000 inmate population. These centers only give 398 seats. It seems not to be enough. So a jail is not the best place for treatment of a mental disease.

This is the basic premise that tries to show #FueraDeLugar an awareness campaign designed by Fundación Manantial and now called Fundación Especial Caja Madrid. The main purpose is to reflect on the high number of inmates in prison with mental disease and make aware judges, lawyers, prosecutors, polices for taking into account this disease in trials and promote alternative measures of admission in prison. Other countries like United Kingdom consider people with mental disease a patient not a criminal and they are treated at specialized centers.

**Documentary film**

In order to attract the attention of society, #FueraDeLugar offers three visual projects that use the power of image as a social awareness element. First of all a documentary film directed by Fernando Guillén Cuervo, a well-known Spanish actor and director strong committed with the campaign. Fernando makes three honest interviews to inmates with mental disease participating in the penitentiary area program of Fundación Manantial. Alberto, Elisa and Iván speak openly about their prison experience and don’t avoid referring to their anguish, fear and even suicidal moments. A rude jail stories with no seasoning but at the same time and optimistic look about their future life out of prison.

They don’t feel *sick* persons, they claim their place in society after serving their sentences.

**Portraits in jail**

Other project is the photograph portraits by the Spanish photographer Omar Ayyashi, well know by his journalistic and social reports. Omar puts his lens inside prison and reflects the uncomfortable sensation of being locked up, alone, with no answers. There is tension but hope too in their pictures.

(*)PreCa. The prevalence of mental disorders in Spanish prisons. Research Article
Lastly, the more innovative element: the cinemagraphs a mix of image and video that produces a troubling effect in audiences. Created by the art designer David Salaices, cinemagraphs show a routine, absurd situation where people are out of place. The visual impact is astounding and helps to strengthen the campaign messages.

If this is not enough, the campaign was completed with training and formation programs addressed to judicial professionals, forensic surgeons, judges and lawyers. More over than 500 people straight involved in a trial.

**Campaign highlights**

#FueraDeLugar starts on October 2012 when the documentary film and cinemagraphs was launched as well as a social media strategy. Facebook, Twitter, Youtube and all Spanish media echoed the reports of the campaign. It was a lucky impact in Spanish press, with more than 150 mentions some in the most important Spanish television and radio stations and in the main newspapers as well.

In the other hand, on February 2013 an exhibition with the portraits was inaugurated at Matadero Madrid, one of the most important art spaces in Spain. At the same time a relevant premiere of the documentary film took place. Fernando, Omar and others guest were the principals of a social event where people, associations, politics and friends mingled with. Everybody could watch the film, the exhibition and cinemagraphs. Everybody learned the lesson and were aware of mental disease in prison is always out place.

**Mental disease doesn't imply violence**

Fundación Manantial works for the integral care of people with mental disease improving their quality of life, autonomy, social integration and ultimately provides them a recovering project of life.

The penitentiary area program of Fundación Manantial makes an attempt to avoid people with serious mental disease ending up in jail. They cooperate closely with penitentiary institutions attending inmates through psychosocial care and support in community and promoting alternative measures to admission in prison.

Most of people with serious mental disease never commit crime in their whole life. Only 3% do it...
and when it happens is due to a lack of an appropriate treatment or social causes as drugs abuse. However there is a social rejection that stigmatizes them and makes them feel social misfits.

**When insanity passes unnoticed**

It’s quite common that mental insanity passes unnoticed in legal trials. A lot of ‘not responsible’ people are being sentenced by slight crimes. The fact is that highly vulnerable people crowd penitentiary centers. Nevertheless it’s a health matter, so we need to give priority to medical treatment and psychosocial support instead to punish someone is not responsible of his acts.

There are some proposals we have to consider. It’s necessary a good evaluation in legal trials to know if crime is due to a mental disease. When it happens, it’s better to promote alternative measures for serving sentence in a community environment. If it is prescriptive to impose internment measures we recommend serving sentences in a sanitary resource close to person’s residence.

Another important issue is that penitentiary health services were integrated by the central health services of the different Spanish regions. This way we can guarantee enough finance for a proper management. With the necessary collaboration between legal, sanitary and penitentiary fields adding political will, we can change the current situation. We have to give some responses to these people. They deserve our special attention. It’s in our hands they will never feel anymore ‘out of place’.

Further information: [saludmentalyprision.fundacionmanantial.org](http://saludmentalyprision.fundacionmanantial.org)

Photo: Omar Ayyashi.
WAPR is considered by WHO as a NGO in official consultative status. We as WAPR have made efforts to honor that consideration, and are currently developing an action plan for the period 2014-16. Benedetto Saraceno, our focal point to WHO met in Michelle Funk (representing WHO) Geneva and agreed a work plan.

In board meeting celebrated in Manchester, UK (April 28th, 2013) the WAPR Board enthusiastically agreed to keep a strong collaboration with the WHO in its capacity as NGO in consultative status.

WAPR will contribute to WHO work through a number of actions related to the recently approved WHO Mental Health Action Plan 2013-2020 (World Health Assembly, May 2013). These actions will be implemented during the period 2013-2015.

WAPR has created an ad hoc group of senior officials of the organization with the specific aim of promoting awareness initiatives and advocacy for the WHO Mental Health Action Plan 2013-2020. This group, called "WAPR-WHO Plan of Action Advocates", will function as a WAPR subcommittee integrated by all Regional Vice-presidents, board members representing users and families, the WAPR-WHO focal point and the Secretary General.

This group (WAPR Sub Committee) will contribute to develop and promote in each country where WAPR has a Branch or a National Secretary: initiatives and activities aiming at disseminating, promoting and, when feasible by WAPR implementing the actions envisaged by the WHO Mental Health Action Plan.

In addition, WAPR will work along the lines and values expressed in previous WHO documents as:

- WHO mhGAP Programme
- WHO strategic work lines in Health and Human Rights.
- WHO Mental Health Atlas.
- WHO QualityRights Tool Kit.

**ACTIVITIES**
The WHO Action Plan considers that actions should be implemented in countries by different constituencies including “civil society, including organizations of persons with mental disorders and psychosocial disabilities, service-user and other similar associations and organizations, family member and carer associations, mental health and other related nongovernmental organizations, community-based organizations, human rights-based organizations, faith-based organizations, development and mental health...
networks and associations of health care professionals and service providers”.

The actions that WAPR will implement will focus on a limited number of activities among those recommended by the WHO Action Plan and its Objectives:

**In relation to Objective 1**
Support the strengthening of associations and organizations of people with mental disorders and psychosocial disabilities as well as families and carers, and their integration into existing disability organizations.

**In relation to Objective 2**
Support coordinated efforts to implement mental health programmes during and after humanitarian emergency situations, including the training and capacity building of health and social service workers.

**In relation to Objective 3**
Engage all stakeholders in advocacy to raise awareness of the magnitude of burden of disease associated with mental disorders and the availability of effective intervention strategies for the promotion of mental health, prevention of mental disorders and treatment, care and recovery of persons with mental disorders.

Advocate the rights of persons with mental disorders and psychosocial disabilities to participate in work and community life and civic affairs.

Introduce actions to combat stigmatization, discrimination and other human rights violations towards people with mental disorders and psychosocial disabilities.

**OPERATIONAL ARRANGEMENTS:**

**COORDINATION:**

a) Composition of the WAPR subcommittee: WAPR-WHO Plan of Action advocates:

- Chair: WAPR President
- Co-Chair: WAPR President-Elect
- Secretary: WAPR Secretary General
- Members: Focal Point to WHO; 2 WAPR Vice Presidents; Vice Presidents for Africa, Americas, Europe, Eastern Mediterranean, South East Asia, Western Pacific; Representatives of Consumers; Representatives of Families.

b) A number of WAPR Task Forces will be especially involved in the implementation of the previously mentioned activities:

WAPR has appointed a Special Delegate for coordination with WHO in Geneva (Dr. B. Saraceno).

All Regional WAPR Vice-presidents will be encouraged to contact the regional office of WHO in order to coordinate concrete regional actions.

**DISSEMINATION:**

All WAPR officers will be encouraged to use and disseminate WHO tools, data and documents, in all WAPR conferences and meetings.

WAPR will promote in its sphere of influence the use of WHO tools in new established action programmes.
WAPR BOARD

WAPR will create a special section in its website for the “WAPR/WHO Plan of Action advocates”.
WAPR will include in every issue of the WAPR Bulletin a special section with references to concrete actions taken by the “WAPR/WHO Plan of Action advocates”.
All WAPR members will receive biannual information about this plan through WAPR network.

ADVOCACY:
WAPR will disseminate WHO tools, data and documents, in all WAPR conferences and meetings in order to advocate for scaling up resources in Mental Health and Psychosocial Rehabilitation.

TRAINING AND CONFERENCES:
WAPR will promote special sessions exclusively dedicated to dissemination and discussion of WHO/WAPR common goals.
WAPR will include WHO references in all training activities.
The following WAPR meetings are expected to contribute to the dissemination and advocacy for the WHO Action Plan:
• WAPR Taiwan meeting 6-7 June 2013
• WAPR Thailand meeting (in collaboration with World Congress of Asian Psychiatry) 20-23 August 2013
• Scientific sessions in collaboration with WPA Section on Psychiatric Rehabilitation at WPA International conferences at Istanbul (18-23 June 2013 & Vienna 27-30 October 2013)
• 3rd Asian Pacific Congress on Psychosocial Rehabilitation, Lahore, Pakistan, 1-3 November 2013
• WAPR Bangladesh meting (collaborative activity) 23-25 November, 2013
• WAPR Indonesia chapter also plans to hold a national meeting later this year (they already had a planning meeting in Bali in Feb 2013).
Regional vice presidents from African & American regions are also exploring the possibilities of having WAPR meetings in their respective regions.

REPORTING:
WAPR will encourage its members to report about all actions taken within the framework of WHO – WAPR collaboration.
WAPR will report WHO yearly.

Mental Health Day 2012 in Madrid, Spain.
WAPR Board Meeting in Manchester, UK.
April 28th.
Murali Thyloth; WAPR Secretary General. Marit Borg, Dep. Secretary General.

Under the wonderful hospitality of the WAPR UK Branch, the spring WAPR Board meeting took place in Manchester, UK.

Information about new branches:

There is an increasing interest and activity in WAPR in the various regions.

Looking at Asia, a new branch is established in Iran and a group is working in Qatar aiming at establishing a formal branch. A new branch was established in Indonesia in 2012 and a group is working in Malaysia aiming for a formal branch as well. There is also activity in the UAE for a WAPR branch.

In Israel there is a discussion whether to establish a formal WAPR branch or to link WAPR activities to another association. Dr David Roe is the contact person, and Ricardo Guinea will mail him about the status of the situation.

Ibrahim Murad gave an orientation of the difficult situation in Palestine, where there is no mental health services. The board decided to renew the Palestine Board.

In Europe a branch is soon established in Bosnia and in Romania, and in Slovenia there is renewed activity. Fundación Manantial (Spain) was accepted as a new WAPR Institutional International member.

In Latin America several countries, like Mexico and Paraguay, have contact persons and small groups working. Regional Vice president Alberto Fergusson together with President Elect Ricardo Guinea is giving a special attention to supporting this activity and establishing new branches in the region. To encourage these activities, website and Bulletin will from now on also be available in Spanish. A list over contact persons in the Americas will be developed and a regional meeting is planned in 2014.

In Africa there is WAPR activity in Kenya, Botswana, Uganda and South Africa, and interest in Ghana and Ethiopia. Regional vice president Solomon Rataemane has developed strategies for establishing contact persons in many countries. The new WAPR introduction paper will be translated in several languages.

Efforts to attract more membership from Australia & New Zealand & the region and establishment of new branch will be explored.

There was a discussion about approving more than one branch in one country due to cultural, geographical or historical reasons. The Board concluded that the standard system of having one branch in a country should be encouraged, and if there is a need for more than one branch, the Board will encourage formation of a national WAPR forum to avoid fragmentation. However, if needed, more branches can be formed in a country after reviewing the situation in the Board.

The Board was reminded of the procedures for establishing branches as described in the Constitution. The Constitutional committee will explore the need for reviewing/amending these clauses in view of the discussions regarding opening of new branches in a country and also regarding the functions / duties of National Secretaries.
committee will also review procedures for situations when a branch has no activity and having no contact with the Board, neither pay their dues.

The Board concluded a proposal that if a branch has not paid dues for two term periods (six years consecutively) it will not be considered as a valid and accredited branch.

**Website and Bulletin**

The website and Bulletin is running well. Thanks were recorded for Marit, Ricardo & their team. Regional Vice-presidents and representatives for service users and family members are actively involved.

At the website a section for past presidents was suggested.

Regular information about WHO priorities and activities will also be emphasized.

**WHO**

WAPR has a consultive status in WHO and the report on past activities and plan for future ones is due. The following was concluded about future activities and information about this has been send to Benedetto Saraceno: WAPR will create a network of "WAPR/WHO Plan of Action advocates"; in each country where WAPR has a National Secretary this person is encouraged to formulate a simple action plan to disseminate, promote and implement the Action Plan of WHO.

WHO will be informed about these activities and WAPR has to report every year.

These activities will be taken:

- WAPR is creating a WAPR committee chaired by President Elect. Members are the two Vice-presidents, the 6 Regional Vice-presidents, General Secretary and service user and family member representatives.

- The committee will focus on WHO / WAPR shares targets. The list of WHO strategic targets will be sent to all Board members.

- Our regional VPs will be encouraged to contact the regional WHO representatives in each region.

- The committee members are requested to send within ten days a local or regional small plan.

- Dr Saraceno will receive all suggestions and can then draft the document we need

All will be requested to report yearly.

**Links with other organisations**

A great progress has been made in establishing links with many other organisational and associations working in the field of mental health (WHO, WPA Section on Rehabilitation, World Association for Social Psychiatry, World Federation for Mental Health, Pacific Rim College of Psychiatrists, Royal College of Psychiatrists UK & Australia & New Zealand, European Federation of Associations of Families of People with Mental Illness(EUFAMI), ISPS, International Club House, International association of Occupational Therapists,
European Mental Health, International Association for Women’s Mental Health).

President requested all Board members that they should develop and strengthen links with other associations / groups in their regions and join in their efforts to promote better mental services for our patients, their carers and families.

Committees & Task Forces

As a follow up of the Action Plan discussed and decided upon at the last Board meeting President Afzal Javed presented a plan for Committees & Task Forces for the 2012-2015 periods.

President will chair these committees with other co-chairs who will take the lead in the working of these committees. The committees and taskforces will report to the President and will make recommendations for developing WAPR statements to the Board for approval from General assembly. The work will emphasize interdisciplinary perspectives and competencies and draw on the board members resources.

WAPR 2012 and 2015 Congresses.

Final reports and budget is received from Milan. The Milan Congress was a great success and the organizers were highly valued for their hard and committed work. The congress faced financial difficulties due to the crisis.

It was discussed that as the congresses generate main financial support to WAPR, all efforts should be made to raise funds from these meetings. It was also suggested that the Board should explore more avenues to generate funding for WAPR.

The 2015 congress plans were presented & Board was satisfied with progress.

Finances & Budget for 2012 -15

As most of the WAPR budget comes from congresses, it was recommended that we all need to look into other sources for income and ways of raising funds especially ensuring regular members subscriptions.

Treasurer proposed 2012 -15 budget that included finances for regional projects (up to 3000 US dollars) for each region along with allocated money for secretariat & president office expenses and costing for Board meetings. The Board approved the budget and agreed with the proposals from the treasurer.

WAPR meeting / sessions at International conferences

President informed the Board about some of the WAPR meetings and WAPR sessions being organised at different meetings during 2013.

WAPR Taiwan meeting 6-7 June 2013
WAPR Thailand meeting (in collaboration with World Congress of Asian Psychiatry) 20-23 August 2013

Scientific sessions in collaboration with WPA Section on Psychiatric Rehabilitation at WPA International conferences at Istanbul (18-23 June 2013 & Vienna 27-30 October 2013)

3rd Asian Pacific Congress on Psychosocial Rehabilitation, Lahore, Pakistan, 1-3 November 2013

WAPR Bangladesh meeting (collaborative activity) 23-25 November, 2013

WAPR Indonesia chapter also plans to hold a national meeting later this year (they already had a planning meeting in Bali in Feb 2013).

Solomon Rataemane & Alberto Fergusan, our Regional vice presidents from African & American regions are also exploring the possibilities of having WAPR meetings in their respective regions. It was mentioned that our Board members and local officers of WAPR branches are very resourceful professionals in their respective countries & regions so they should come up with more activities during the coming years using local resources and support networks. The Board members were requested to let us know if they are involved in any other WAPR sponsored meetings or activities or they are involved representing WAPR at some another meetings / conferences.

Resolution

The Board passed a resolution expressing grave concerns on the issue of impact of violence, terrorism and killings of innocent people in the society in general and mental health of victims in particular. While condemning the recent incidents in Boston and extending full support & solidarity to the US professional colleagues and Boston community, it was urged that professional organisations and NGOs working in the field of mental health should join hands in planning strategies to stay united against all such acts and also organise some programmes to help the victims, their families and all other affected persons in providing different therapeutic interventions. WAPR Board also recommended formation of a Task force to prepare guidelines and directions for future collaboration and work of WAPR in this area.

Next Board meeting

The next Board meetings will be held at Lahore, Pakistan (during WAPR’ 3rd Asia Pacific Conference). A mini board / officers meeting will also take place in August in Bangkok, Thailand during Asian Congress of Psychiatry.

The meeting ended with a vote of thanks to UK branch for their excellent arrangements and hospitality.
## EXECUTIVE COMMITTEE

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<td><a href="mailto:shahidquraishi@hotmail.com">shahidquraishi@hotmail.com</a></td>
<td>Marit Borg, Buskerud University College, Faculty of Health Sciences, Institute for Research in Mental Health and Substance Abuse, Postbox 7053, 3007 Drammen, Norway</td>
</tr>
</tbody>
</table>

More info in [www.wapr.info](http://www.wapr.info)
### WAPR COMMITTEES

#### Congress committee
Co-Chair: Ricardo Guinea (President Elect)

Members:
- T Murali (Secretary General)
- Shahid Quraishi (Finance Secretary)
- Angelo Barbato (Chair of organizing committee of previous Congress)
- Tae-Yeon Hwang (Chair of organizing committee of next conference)
- Harry Minas (Regional Vice President from the region where next Congress is taking place)

#### Nomination committee
Co-Chair: Ricardo Guinea (President Elect)

Members:
- T Murali (Secretary General)
- Lourdes Ladrido-Ignacio (Immediate past president)
- Alberto Ferguson
- Ida Kosza
- Anne Grethe Klunderud

#### Membership committee
Co-Chair: Germana Agnetti

Members
- Ricardo Guinea (President Elect)
- T Murali (Secretary General)
- Shahid Quraishi (Finance Secretary)

#### Publication committee
Co-Chair: Marit Borg (Deputy Secretary General)

Members
- Ricardo Guinea
- T Murali
- Tai Yeon Tae-Yeon Hwang

#### Constitution committee
Co-Chair: Solomon Rataemane

Members
- Pichet Udomratn
- Zeb Taintor
- Antonio Maone
- Pedro Gabriel Godinho Delgado

#### Ethics & Review committee
Co-Chair: Lourdes Ladrido-Ignacio

Members
- Ricardo Guinea
- T Murali
- Gabriele Rocca
- Alberto Ferguson
- Oliver Wilson

### WAPR TASK FORCES

**Task Force on Users & Carers involvement in Treatment and Rehabilitation Planning**
Chair: Helen Herman
Anne Grethe Klunderud

**Task Force on Ethics & Human Rights for persons experiencing mental illness**
Chair: Michael Amering

**Task Force on Curriculum & Training—particularly focusing on recovery**
Chair: Mathew Varghese
Henrik Wahlberg
Marianne Farkas

**Task Force on issues relating to Professionals’ Burnt Out**
Chair: Michael Sadre-Chirazi-Stark

**Task Force on Rehabilitation programmes for Adolescents & Young Children**
Chair: Arshad Hussain
Pedro Gabriel Godinho Delgado

**Task force on Preparing guidelines for PSR Services in low Income countries**
Chair: V.K. Radhakrishnan & Alok Sarin

**Task Force on Asia-Pacific Projects Development and Dissemination**
Chair: Harry Minas

**Task Force preparing a statement on Societal Connectedness, Social Capital, Identity and Modern Terrorism.**
Chair: Marianne Farkas

More info in [www.wapr.info](http://www.wapr.info)
WAPR 2013
MEETINGS ORGANISED, CO-SPONSORED OR WHERE WAPR HAS A MEETING.

More info in the sites.

TAIWAN: WAPR Taiwan meeting 6-7 June 2013


SPAIN WAPR Co sponsored meeting, Second European Conference on Assertive Outreach, entitled 'Improving Integration', Avilés, Spain June, 26 -28 of 2013. www.eaof.org

ROMANIA WAPR Romania meeting in collaboration with Romanian association of Social Psychiatry, Câmpulung Moldovenesc, Romania, 12-14 July, 2013

INDIA WAPR 3rd National Conference of Indian Chapter, 20th & 21st of July 2013 at Kozhikode, Kerala, India. www.wapr.info/World_Association_for_Psychosocial_Rehabilitation_WAPR/Home_files/WAPR%20India%20Final.pdf


AUSTRIA Scientific sessions in collaboration with WPA Section on Psychiatric Rehabilitation at WPA International conference Vienna 27-30 October 2013


BANGLADESH WAPR Bangladesh meeting (collaborative activity) 23-25, November, 2013

SPAIN. Fundación Manantal WAPR co sponsored conference “New models, new treatments, new approaches” which will take place on 28th-29th November 2013 in Madrid. www.fundacionmanantal.org/pdf/XI_Jornadas_Anuales_FM.pdf?PHPSESSID=2980ac5cb2a5bdbc63160c72f3232dea