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WAPR MEETINGS
DUBAY & LJUBLJANA.

WORLD ASSOCIATION for PSYCHOSOCIAL REHABILITATION
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Welcome and greetings from WAPR!

I am pleased to share more activities and success about WAPR work with our membership through the first edition of our 2014 Bulletin.

WAPR and its all components remained very active and have been involved in a number of activities. Our board members, national branches and especially the Regional Vice Presidents have played an active role in strengthening the mission & philosophy of WAPR in their respective countries.

WAPR Bulletin & WAPR website are continuously gaining more appreciation and acknowledgements from our membership. We are thankful to the editorial team for maintaining standard in their hard work.

WAPR Standing committees are updating their work and reviewing their remit within the functioning of WAPR. I hope that all these committees will formulate their final reports by the end of this term for any further planning and directions.

WAPR Task Forces on Users & Carers involvement in Treatment and Rehabilitation Planning, Ethics & Human Rights for persons experiencing mental illness & Issues relating to Professionals’ Burnt Out has had significant contributions towards WAPR work. I hope other Task forces will also submit their plans of action very soon.

There has been an impressive contribution from Task force on Ethics, Human Rights for persons experiencing mental illness. Thanks to Michaela Amering & Francisco Sardina Ventosa for their hardwork for preparing Replies to Draft General comment on article 12 CRPD and Mendez report.

Our Board members continue with their contacts & links with other professional organizations & NGOs and are establishing their links with partners working in the field of mental health.

We also continue having collaboration and co-sponsorship requests from many organisations for
their meetings and conferences. This is indeed giving us a chance to link with other groups and also promoting WAPR to many other organisations.

**WAPR Branches.**

Congratulations & welcome to our new branches and the membership from many countries.

I am pleased that Slovenian branch has been revived and I have found a lot of interest from our Slovenian members for participating in WAPR activities. Thanks to Vesna Svab for her untiring efforts to keep WAPR on the scene.

Similarly a big support was received from Middle East Mental health leaders to WAPR at a reentry held international conference at Dubai was very visible. WAPR Regional Vice President Eastern Mediterranean Region, Dr. Medhat Elsabbahy needs special thanks for getting the session accepted in this first international conference of Emirates Medical Association through generous support from Dr. Adel Karrani, Dr Riyadh Al-Baldawi. Reports about these two meetings are included in our Bulletin.

There has been an active interest from many of our European friends in highlighting WAPR activities in the Latin & South America. They are in regular contacts with WAPR American Regional officers and also plan a visit to some of the countries in the region through the courtesy of Fundacion Manantial this summer. This will hopefully generate more interest in our association. Participation of WAPR in the recently held congress in Cuba was another landmark development and thanks to Henrik and Alberto for making this possible.

Thanks to our other regional vice presidents for their continuous support and efforts for WAPR activities in their respective regions.

**WAPR Meetings & Training sessions on PSR**

Since the publication of last Bulletin, WAPR has participated in following meetings.

- *Manantial Foundation XI Annual Conference “New models, new treatments, new approaches”*  
  [www.fundacionmanantial.org](http://www.fundacionmanantial.org)  
  Madrid, 28-29 November 2013


- *International Transcultural Psychiatric Conference, Dubai 3-5 April 2014*

- *Regional Congress, Slovenia 9-12 April 2014*

I am very pleased to share the information about having a special full day scientific programme by WAPR at Asian Federation of Psychiatric Association and Malaysian Psychiatric Association’s regional conference in Kuala Lumpur Malaysia in the third week of May 2014. This will be a unique opportunity to have the launch of WAPR Malaysian chapter of WAPR on this occasion.

WAPR branches also continue having their meetings and collaborating with many other professional associations in organizing different academic, educational & professional activities in their countries.

### 2015 WAPR World Congress.

The Congress committee and the local organising committee of our next world congress are busy in making arrangements for this big event. Thanks to Prof Tae-yeon Hwang and his local team for their hard work. Congress Committee had a recent teleconference in March to review the arrangements. We look forward to getting regular feedback and updated reports from Tae-yeon to our membership about the congress details.

And last but not the least, thanks again to all the Board members, national secretaries & general membership of WAPR for their continuous support and hard work for promoting WAPR.

Afzal Javed  
President WAPR
In one of the articles presented in this edition of the WAPR Bulletin, Helen Glover reminds us of a crucial issue: “In our recovery oriented era there remains a strong fixation of changing the person as oppose to rethinking and transforming the service environments that create opportunities for people to realise their potential”.

Although service-user involvement and human rights have been emphasised and given priority for decades, we are still struggling to find ways to meet fellow human beings in need of mental health services as equals and in collaborative ways. Day-to-day routines, financial cut downs and limitations, traditional assessment tools, health bureaucracy, time limits, and standard procedures may easily get in the way for tailored and accessible services and equal partnerships.

In this issue we attend some of these challenges in various ways through experiences and perspectives from many parts of the world. Helen Glover from Australia discusses restoring the relevance of service provision to people’s lives in her article and Barbara D’Avanzo from Italy presents a paper about real consumer participation in quality evaluation and improvement of mental health services. From Greece we have a paper by Stylianidis, Lavdas, Pantelidou & Chondros about creative re-actions in a public mental health system crisis. In the discussion forum we raise issues related to human rights in mental health.

We particularly focus on the Report of the UN Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, on February 1st, 2013, and the Draft General Comment on Article 12 of the Convention - Equal Recognition before the Law by the UN Committee on the Rights of Persons with Disabilities.

And last but not the least we offer information about some of the activities and discussions that are ongoing in our organization.

We wish you all a very happy reading!

Ricardo Guinea and Marit Borg
2015 World Congress of WAPR in Seoul

Date: Nov, 1st~4th, 2015
Venue: Grand Hilton, Seoul, Korea
www.grandhiltonseoul.com

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WAPR 2015
12th World Congress

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2015 World Congress of WAPR in Seoul

Date: Nov, 1st~4th, 2015
Venue: Grand Hilton, Seoul, Korea
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Restoring the relevance of service provision to people’s lives: a personal and professional reflection.

Helen Glover
Director of Enlightened Consultants and social worker

--When mental health services played a central role in my life I was not aware of, let alone involved in, any planning conversations around my mental health needs. This was a foreign concept and one that was left to the domain of professionals who considered they knew best. I couldn’t tell you what the focus of treatment was, it all seemed reactive and disconnected to any purposeful direction. Years later I accessed my file under Australia’s Freedom of Information legislation. I was surprised to find that my file contained a number of plans including treatment plans, relapse preventions plans, and crisis plans. I did not know these existed, let alone have any involvement in their formation. Looking closer

I could see that all the boxes were filled in, but I did not recognise these plans as mine. The goals in these plans seemed driven by other peoples’ agendas. Medication compliance, developing insight and reduction in absconding behaviour seemed to be the central focus. There was a major mismatch between the intent of these plans, and what I wanted to be different in my life. Had I been involved, I doubt that I would have articulated these so called ‘goals’ as the very things that I wanted to achieve and develop competency around.

I often reflect had people taken the time to include me, to enquire as to what I thought I needed to make different in my life, then my experience of mental health services may have been (i) significantly shorter, and (ii) personally relevant, inviting me to be much more active and engaged in the process. I also imagine that the mental health providers may have experienced their efforts as being more relevant, purposeful and useful.

My story, sadly, is not an isolated one. This paper draws on professional and personal reflections on the importance of negotiating service relevancy with people, being clear as to why we are in each other’s spheres, committing to the nature of our work together, and knowing when our work is finished and it is time to exit a person’s life. This inquiry requires us to go beyond a singular focus on goals,
and to rethink the relevance of services in people’s lives.

Refocussing from Goal Attainment to Making a Service Commitment to people

“Begin with the end in mind”. (Covey, 1989) is a useful reminder when walking alongside people who experience serious mental illness. If mental health services hold a vision for people’s lives beyond illness management and maintenance, thereby extending support to people to reclaim and master a full life in spite of any symptomology, then services must engage with people with this end in mind. Realigning practices to a recovery orientation requires a significant ‘paradigm shift’ (Davidson, 2005, Zucconi, 2008, Glover, 2012) from how services have traditionally been provided. This shift resists a provider determined, managed and monitored approach and upholds policies, practices, processes and programs that have a strong focus on self-determination, self-mastery, learning, citizenship and ultimately serving people in reclaiming a full life beyond the impacts of illness. This level of service transformation is a challenging process, inspiring all of us to address those practices that have become comfortable, routine and ultimately irrelevant to the end desire.

Historically mental health services have adopted a powerful ‘whole of life’ responsibility for people, encasing and entrapping them within institutional structures and processes, in both residential and community environments. In a recovery oriented era, services should acknowledge that they are invited guests in a person’s life, and are there for a specific purpose and limited time, after which they should know when and how to exit. Services striving to uphold these principles would acknowledge they are only one of many resources available to people, and would resist adopting a central role in people’s lives. Many of people’s life aspirations do not belong in the domain of mental health services, but sadly have become the major business of many modern mental health programs.

As ‘helping’ services have grown their presence in people’s lives, so have the routine practices that risk a ‘conveyor belt’ experience for people. One of the very early experiences that most people have is to surrender their dreams and aspirations to services. They risk being asked, “what are your goals”, making this the automatic business and focus of any ongoing service intervention, support or treatment. These precious thoughts get written down, sometimes watered down, and then somehow enter the public domain, to be scrutinised, actioned and monitored by others. The achievement, or not, of these very personal aspirations then becomes the domain and satisfaction of the worker and service. Often the credit for the achievement of such goals is taken by the service and utilised as evidence of their ‘good recovery work’. The person is often relegated to being an observer or passenger in their own life, and not an active protagonist. There is a strong risk that the actions, by services, of attaining people’s goals will result in a sense of hopelessness and passivity as opposed to the intended sense of hope and personal agency. One provider’s reflection of this process said that ‘we simply steal people’s initiatives and aspirations and make them our own’. This practice aligns more to being one of managed-care and person-centred practice than that of upholding a self-directed, self-mastery recovery orientation. Practitioners who seek regular
feedback from people will hopefully ensure a strong fit and relevance of the services they provide to the specific areas that people have a desire to master. Without this it is extremely unlikely that people will actively engage meaningfully in any service provision. (Duncan, 2008)

There is a clear distinction therefore between a person’s own life plan and that of a mental health service plan. [Figure 1] Both are relevant but have different purposes. A service plan is a commitment by the service to the support they are able to provide a person to assist them overcome what currently stands in their way. It is not focussed on attaining a good life for people per se, but creating an active learning environment where a person has opportunities to overcome and master what stands in their way of creating the life they wish to live. To confuse a person’s life plan with a service plan only reinforces a sense of service responsibility and ownership of the person’s life.

Figure 1 Differences between a service plan and a personal plan (Glover, 2013)

But how do you ‘motivate someone’?

Having facilitated many workshops on recovery and recovery oriented practice to service providers over the last couple of decades, there are a number of questions that repeatedly arise, most of them leaving the impression that maybe the vital focus in planning supports are being overlooked when negotiating support and treatment with people.

These repeated questions from providers, regardless of their professional backgrounds or experience, centre around: ‘How do you motivate a person who doesn’t want to do anything’; ‘How do you get people to follow their plan’; ‘How do you get people to engage with you’; and ‘What do you do with people who are resisting your support?’ There is a common theme to these questions that requires further enquiry.

All these questions evoke an image of good intentional workers trying to create, stimulate, shift, and even manipulate change in people who may share their agenda. Instead of answering these passionate pleas head on (I have learnt not to do that!), I find myself enquiring in other ways. I
enquire as to the worker’s understanding of the original reason a person has come to them for assistance, for without knowing this I am not sure services can even begin to understand their role and purpose in another’s life.

I usually find myself asking questions like; ‘what has this person asked you for help with’? ‘What is it that they want to get spectacularly good at’? ‘What is it that they hope to be different’? ‘What do they find challenging that they believe you can help them with’? This enquiry usually is met with either blank stares or comments such as ‘I don’t know’, or ‘I will have to go back to the original referral to find out’ or ‘I don’t think we have ever asked that question’. The referral, or any third party input, will not tell us the answers to these vital questions, only the person seeking something to be different can provide this direction.

The focus on enquiry is not about goals, but more about what and why a person wants to invest in creating a difference. No one would be accessing a helping service of any description, if (i) they wanted things to stay the same, (ii) they already had the ability to make the change within their own resources, or (iii) nothing was standing in their way from achieving that.

We do nothing without a reason.

“...And perhaps most importantly of all, when I got out of bed in the morning I always knew the reason why - I had a purpose in life, I had been called, I had a vocation and I kept saying yes to it.”

(Deegan, 2001)

**Be curious about the “Why”**

Exploring the ‘Why’; our reason for desiring something different, creates a natural motivating force. Real motivation is deeply connected to our purpose we organise our life around. It provides hope, meaning, engages and energises us to action. If our reason is not clear, or we are not joined in our reason with others, we become stuck and / or experience conflict with others. The ultimate outcome will be either our passivity, or our resistance. The ‘helping’ industry usually interprets this negatively, seeing it as a red flag, requiring a refocus on the reason for engaging in services, or the reason for providing services.

Many people who access services are not clear about why they are engaging with the service, or what they specifically want support to master. This conversation has not been afforded to them in any depth. When asked, people who access services tell me many differing understandings of the role of services in their life: ‘to monitor and watch me take my medication’, ‘to take me shopping’, ‘to do the things for me’, ‘to be my companion’, ‘to buy me coffee’, ‘to drive me places because I don’t have any transport’ etc. I am yet to hear anyone explain their reason for engaging in services is so that they can master the things that they are struggling with, thus enabling them to live a full life. Our role in a person’s life is often understood by what we do, and not necessarily by what we think we are assisting people to achieve, create, or experience differently.
The story of Jason and Jack

I recall a situation that may be familiar to many of you, either as a provider or someone who has accessed mental health services.

Jason had been coming daily to a service for the last five years. He participated in a workshop I offered and after completing a self-assessment on his self-determination, discovered that he had more things in his life that he had determination over than he thought, and as a result was not the no-hoper that he believed. Taking this opportunity, I asked him if there was something he wished to experience differently about his self-assessment. He wished he could, but said he had resigned himself to not being able to change the things he currently had no self-determination over.

You could be forgiven to want to encourage him to ‘have a go’, to take small steps but I resisted this urge and took a different path. Looking to highlight his existing agency, I reflected that he must have tried lots and lots of things to come to the conclusion that he could not change this situation. This appeared to be news, as he himself recognised the things he had been doing to overcome whatever the challenge was. I enquired further as to whether he had done this himself or with others support? He acknowledged he had only drawn on himself, as it was ‘shame business’. I became curious with him as to his understanding of the role of the mental health service he had visited daily for the last five years, and whether they had anything to offer him. The workshop ended with Jason reflecting on the questions I offered him.

The next day, in a provider workshop, Jack, his mental health worker declared that Jason had come to ask him if he would be willing to work with him on four specific areas. Jack said he was shocked at what seemed to be Jason’s new found motivation and engagement as he had Jason on his ‘maintenance list’ and that really he was a bit of a ‘no-hoper’. Jason had picked up what others believed of him quite accurately. Jack seemed pleased that at last Jason was ready to engage with him. My reply to Jack was challenging, stressing that while he was identified as a person to help Jason, what had he been doing in the name of support for the last five years?

Jack realised that he had not had these types of conversations with Jason, or anyone else that he provided support to, and maybe this was not a sudden change in Jason but something that he had within him all the time. In hindsight he recognised that he had left people ‘blowing in the wind’ because he hadn’t clearly established and identified the very thing that Jason wanted a service to help him develop competency and mastery with.

“...people cannot progress in their recovery while others are in control of their lives, ...(we) may need to think how to ‘let go’ a bit, share authority and power, have a greater openness to what patients(sic) say and wish, and be more trusting and supportive of their personal priorities. Recovery oriented services will see a shift in our role towards becoming coach, mentor, educator and facilitator”. (Roberts, 2007)

Changing the service invitation not the person

In our recovery oriented era there remains a strong fixation of changing the person as oppose to rethinking and transforming the service environments that create opportunities for people to realise their potential. As an example, a clinical mental health team was working hard to review and reform its service relevance in people’s life by asking people, “how do you understand our role in your life”? They were somewhat shocked to hear that most people understood their role as (i) keeping them compliant with medication and (ii) keeping them under the Mental Health Act.

The team were shocked to hear this as they had never told people, nor did they believe that this was their role. They thought their role was so much more than that, to help people to ‘self-right’ (Glover, 2012) and eventually lead a full life where mental health services were not dominant. As a team they reflected on how people could have got this so wrong and realised a number of things; (i) they had never been explicit about their purpose
in people’s lives, (ii) the Mental Health Act was the elephant in the room, never explicitly being discussed, and (iii) their time with people had a strong focus on medication adherence, monitoring mental status, and treatment compliance, with little focus on assisting people to reclaim a life beyond the mental health system. It had become routine.

They reflected that people had not got it ‘wrong’ in how they understood the role of providers, as they themselves had not been clear about their role, relevance and purpose in people’s lives. Consequently, a systemic protocol was developed to remedy this, with the hope that it would transform their work, and people’s experiences of their work.

They brought the focus of the mental health act to the centre of their negotiations with people. Most people did not want to be receiving services, and were very engaged and motivated to get off the order, creating a reason for engaging. Having providers who also wanted to support them in this was encouraging and hope giving.

They fostered conversations that conveyed messages of future, personal agency and expectation, such as, “What do you know about yourself that can master the things you need to be successfully supported off the mental health act?” “What would your life look like if the mental health act did not play a role in it?” “What does the mental health act not stop you from doing achieving?” “What do you think you may need to get good at in order to meet the conditions of the act?” “From your experience of using services, what will help you; what will get in your way?”, “What role could we play in helping you to get good at the things you need to?”, “How will we recognise if our work together is not useful?” etc.

As a result of the redefining and renegotiation of supports, everyone has successfully mastered their way off the mental health act. Whilst this is an exciting outcome, what is more exciting is that both the people providing and receiving support are aligned and focused in their work together, as well as experiencing a greater sense of self mastery and self direction over their lives and their work. One of the greatest appreciations from the team was that
it was not about changing people they support, but changing how they provided support. Suddenly planning and review processes that had once seemed somewhat obsolete and not useful to either the person or the provider became relevant, useful and alive to both.

These stories highlight some important assumptions, principles and practices, that as service providers we need to honour in order to remain relevant to people’s lives.

1. Someone coming to a service wants to invest in change; otherwise they would not be there. Respond to and respect people as adults who know what they need.
2. Begin with the end in mind. Invite a conversation that helps a person connect to their reason and meaning. Establish a reason for the work you are doing together.
3. If nothing was stopping people from leading the life they wanted, they wouldn’t be approaching a service. Establish with people what they want to get spectacularly good at influencing over?
4. The person’s life plan is not the service plan. Not everything is relevant to a service or should be responded to from a service stance.
5. Don’t waste people’s time - know the start and finish of your work together.
6. Follow through with commitments made to people’s live. They are important.
7. Review and monitor the service commitment not the person.
8. Work “as if” people are already active in their initiatives to overcome and master challenges. Be a witness to and curious about people’s personal efforts to make shifts in their own life. Look for them. They are there.
9. Be vigilant of services practices and approaches that have become routine and mundane and are no longer relevant.
10. Be aware of your agenda. Trying to shift, change, modify someone else will usually only invite resistance or disengagement.

11. “Nothing about us without us ” is an essential ethical principle to guide every interaction you undertake with people.

I often comment that practicing from such a life-giving stance is not rocket science. These things may appear common sense and yet for many they are challenging requiring us to bring our whole selves to be fully present with another. On hearing this, one mental health leadership team reflected, ‘No, practicing like this is not rocket science; it is much, much harder than that. It asks us to relinquish our safety net of routines and tick boxes and to reclaim the art form of being with another.’

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How real is consumer participation to quality evaluation and improvement of mental health services?

Barbara D’Avanzo, Secretary WAPR Italy,
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Steps on the way of quality evaluation of mental health services.

Quality of mental health services has long been evaluated by means of indicators mainly identified and used by professionals. Tools to be completed by consumers started to be developed since the 80’s. They were mainly focused on consumers’ satisfaction and less often on evaluation of more objective indicators. The Verona Service Satisfaction Scale (Ruggeri et al, 2003), for instance, investigated satisfaction with interventions received, competence of various types of professionals, quality of the facilities, family involvement and information. However, this and other tools, like the Client Satisfaction Survey (Damkot et al, 1983), were developed by researchers and professionals without involving the consumers, thus potentially missing information about variables more meaningful to consumers. Tools developed by consumers started in the early years 2000 (Howard et al., 2001; Lelliott et al., 2001; Gigantesco et al., 2002; Meehan et al., 2002). The need to come to this type of tools stemmed from the awareness that consumers and professionals have different views of what really matters (Slade et al., 1998; Rose et al, 2003; Karow et al, 2012), together with a growing awareness of the importance of the consumers’ point of view and of their right to have a say in choices related to their health and in service organization and management. Development of outcome measures has more recently become a point in consumer-led research, and the Service User Research Enterprise (SURE) has defined a model for developing outcome indicators from the point of view of mental health service users (Rose et al., 2011). According to the SURE researchers, the absence of user-developed tools in clinical trials, as source of first degree
quality evidence, even challenges the idea of neutrality of science.

Awareness has also grown that strongly community based services do not necessarily involve consumers in several aspects of care, as previously hypothesized (Thornicroft and Tansella, 2005). Involvement of service users in service evaluation is important also to challenge the still common prejudice that consumers are not able to express their opinions, are too changeable, and unreliable. This prejudice is even more dangerous because it is often rooted in the service staff and professionals. From this point of view, mental health services show great need to be evaluated according to sound quality indicators.

A study conducted in the framework of the WHO has clearly shown how central are the issues related to the concept of responsiveness, i.e., how well the health system responds to the population’s expectations of non-health aspects of health care (Bramesfeld et al., 2007). Among several important issues, this concept also focuses on accessibility and capacity of the services to maintain consumers in touch with the service. The concept of responsiveness is particularly interesting for mental health care because illness and health care in psychiatry impact on people’s sense of dignity and autonomy and raise negative feelings such as anxiety and shame. The objective of responsiveness is to counteract these effects and to strengthen patients’ rights in the health care system. According to the concept of responsiveness, mental health services should be viewed as the main setting where consumers’ rights are fully respected. It is therefore compelling having consumers’ opinions collected and discussed as part of the service management.

In service quality evaluation, a critical step has been represented by the shift from the concept of satisfaction to assessment of clearer quality aspects. Although most studies focused on consumers’ satisfaction, a number of researchers suggested that often this is not related to well defined standards and is not reliable for evaluating healthcare performance (Avis et al., 1997; Groenewegen et al., 2005).

The distinction between consumer satisfaction and consumer-led evaluation is not trivial, and it relates to the passive meaning entailed by the term satisfaction - users are required to limit themselves to reacting to the service offer instead of being actively involved. It also relates to the idea that the experience of care in the health system can be accountably reported by a simple rating from fully satisfied to not at all satisfied, thus neglecting any interpretation/rationalization about the complexities of the system and people’s own experience. In this regard, qualitative studies can add something thanks to a process-based approach which can better capture the users’ experience and the dynamic interpretation of that experience (Edwards & Stanizewska, 2000).

Common findings and indications from quality evaluation studies.

Taken on a whole, quality evaluation of services has quite consistently indicated pitfalls in the area attaining to responsiveness. This holds true even considering earlier study, like the study of Barker and colleagues (1996), where consumers were little satisfied with professional qualities and availability of the clinicians, and with the sense of empowerment they received. The Epsilon study conducted in five European countries showed that, whereas the organization of service and the behavior and manners of the professionals were the main service strengths, weaknesses were identified in the physical layout of facilities, in the lack of
involvement of relatives and in the information provided. Relatives’ involvement and information/explanation about illnesses were critical issues in most sites (Ruggeri et al., 2003). A study drawing on experiences from 503 service users from five Health Trust in UK also reported lack of involvement in the care planning process and poor communication with the clinicians. The authors also underlined how long the user campaign groups and how many previous studies had been raising these points, still remaining substantially unheard (Webb et al., 2000).

In a study collecting the experience and the findings of three separate quality evaluations in Italy (one involving only users in a network of services, one only relatives in several services in Italy, and one consumers, relatives and professionals together with a qualitative approach in several services all over Italy), we found that, despite methodological differences, a number of common critical issues were in the areas of information and communication, involvement in the care plan and other core decisions, choice of professionals, length of waiting and accessibility. Helpfulness and effectiveness of interventions were also critical issues. The care plan emerged as a pivotal issue, in terms of involvement of the people concerned and the goals, means, time, and general framework. Users stressed the need for a shared care plan, which instead was often not written, ill-defined and centered exclusively on medications. It also emerged that good relationships with professionals did not correspond to involvement, partnership, efficacy, empowerment, and sufficient information. Similar conclusions had been previously drawn by Barker et al. (1996): the high scores for personal relationships were not paralleled by satisfaction with communication with doctors and other empowering factors. Similarly, a respectful and empowering working alliance was the most important thing for all stakeholders in a qualitative study in several European countries (Van Weeghel et al., 2005). Most of the critical issues emerging from these studies again relate to the concept of responsiveness, as the ability of a
service to overcome the negative side effects associated with mental illness and being treated for it. This means that services must counteract the imbalance of power felt by users and relatives, and should work on empowering, strengthening the rights of the individual in the health care system. (Valentine et al., 2003; Bramesfeld et al., 2007). Information, communication and choice are central issues: they mean exchange, and represent essential rights – if they are not fully respected, the basic conditions for any relationship are not met.

A further crucial step is the acknowledgment of the essential link of quality evaluation and improvement. Although sometimes taken for granted, this is far from being really meant and realized. Moreover, changes have proven difficult to be implemented even when suggested by clinical trials and by compelling evidence of more effectiveness of an intervention compared to another.

What quality improvement entails: power imbalance and necessity of rules.

The different phases of the quality evaluation-and-improvement process often receive different attention, with the practical improvement phase usually left behind. Whereas collaboration and acknowledgment among stakeholders roles is usually strong in tool development and administration, findings discussion, definition of the necessary changes, priorities for changes, ways and schedules to implement changes receive much less attention. At best, the process stops with the phase of discussion of findings.

Evaluation studies should start on the base of a strong commitment to make changes when these are clearly indicated – more than with the intention to have professionals’ expectations confirmed.

Consumer-led and consumer-participated evaluation is a process of democracy inside the mental health services and society. This process does not develop spontaneously and it is usually started by the will of those who are formally in charge of the service management and the interventions delivery – the professionals. From this point of view, empowerment of users is therefore conditioned, and submitted to the professionals’ power. This substantial power imbalance should be acknowledged and faced, thus opening scope to its discussion. The definition of a common room where rules for interaction are negotiated can help realize the best possible power balance in the given conditions. If we think of the entire quality evaluation-and-improvement process as a game to be played by the stakeholders, the players must accept and follow the rules that make the game...
accompanied it concluded that users involvement was deemed useful by managers but was much more disappointing to users themselves. In particular, policies of users’ consultation were never defined or implemented, although strongly required.

It is apparent that there are barriers to take more seriously consumer involvement in service evaluation and quality improvement. The different and divergent interests between professionals and consumers (consumers more interested in quality of relationships inside the service and in their real life, and empowerment, professionals in symptoms, efficacy, and costs) can represent psychological and cultural barriers. Moreover, professionals tend to deem changes indicated by consumers less important, since they feel more pushed to work on objectives defined by themselves or by their managers and policy makers often in view of more efficiency and cost reduction, without testing the relationship between these objectives and consumers’ priorities.

Moreover, services are still very medically orientated. In Italy, where a radical shift from a hospital-centred system to community mental health was accomplished since the 80’s, the system has maintained a marked medical focus. Though the shift from hospital to community mental health services in other countries have followed less straightforward ways, this holds true everywhere. The inclusion of consumers and families as fully entitled partners in the process of evaluation-planning-improvement of services will encompass a reshape of the medical model still informing most services, even when definitely community-oriented.

Let’s make contacts!
Policies and rules of consumers’ role in quality evaluation might at least include delivery of thorough information of how their work and effort will be employed. Rules should therefore preside over the relationship between the service and the consumers invited to contribute to the process of quality evaluation and improvement. Necessary changes should invariably be realized and their implementation and usefulness checked. When this should prove to be unfeasible, reasons should be given and discussed. Rules should therefore define the aims of the process, the actors in charge of each process phase, and the time schedule for each phase, the feedback to the service as a whole (the whole staff and consumers). Rules should be explicit, written, shared and subscribed. This would also encompass more responsibility attached to all stakeholders, consumers included, who would be charged of more tasks to be achieved with their own forces and skills, and would be called to express their opinion explicitly.

At present, this seldom occurs. At the beginning of years 2000 a major experience of user involvement in planning and delivery of two mental health provider trusts in London was implemented. The qualitative study (Rutter et al, 2004) which accompanied it concluded that users involvement was deemed useful by managers but was much more disappointing to users themselves. In particular, policies of users’ consultation were never defined or implemented, although strongly required.

It is apparent that there are barriers to take more seriously consumer involvement in service evaluation and quality improvement. The different and divergent interests between professionals and consumers (consumers more interested in quality of relationships inside the service and in their real life, and empowerment, professionals in symptoms, efficacy, and costs) can represent psychological and cultural barriers. Moreover, professionals tend to deem changes indicated by consumers less important, since they feel more pushed to work on objectives defined by themselves or by their managers and policy makers often in view of more efficiency and cost reduction, without testing the relationship between these objectives and consumers’ priorities.

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References
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Creative re-actions in a public mental health system crisis; the Greek experience.


(1) Prof. of Social Psychiatry, Panteion Univ. of Athens, ex WAPR Vice President, Sc. Director of EPAPSY (2) Psychologists, EPAPSY (3) Psychologist, Head of the MH Mobile Unit of NE Cyclades

Creativity is essentially an integrative force based on love and the sublimation of aggression. Intelligence, which is essentially the ability to establish new linkages, is a necessary requisite of the creative synthesis. Freedom and mobility in the use of symbols is another requirement.

The Integrative Function in Creativity.
Henry Harper, 1951

The Greek socioeconomic crisis has brought upon society many changes which were unexpected, created uncertainty and have been a threat to important goals adjusting. The current crisis has taken its toll on several levels in the Greek society and on mental health as well. Recently collected epidemiological data from research conducted by the University Psychiatric Clinic of Ioannina have shown that in Greece one in six adults suffers from mental health problems, while one in twelve meet the criteria for severe mental illness (Mavreas, 2011). Furthermore, an association between financial insecurity and mental health problems was observed, while the prevalence of depression was found to be substantially higher in those experiencing high levels of financial insecurity (11.45%) in comparison to those experiencing moderate levels of insecurity (4.09%), some insecurity (1.4%) or no insecurity at all (1.05%). Findings from the same study suggest an association between occupation and the presence of severe psychopathology; with retired individuals, unemployed people and housekeepers displaying higher prevalence of severe mental illness (10%-14%), compared to employed people (5%). In addition, evidence from the National School of Public Health (Kyriopoulos, 2011) has supported a substantial increase in the use of psychotropic medication throughout the period 2006-2011: an 18.59% increase in the use of antipsychotic medication and a 34.8% increase in the use of antidepressants. There is also a substantial rise in hospitalization rates (by 24%) while a steady reduction in the use of private health services has been recorded (Kentikelenis et al., 2011). There were 508 suicides in Greece in 2012, according to the Hellenic Statistical Authority (ELSTAT), which represents a rise of 36 percent since 2008, before the country’s economic crisis began. It is not clear from ELSTAT’s data whether this rise is directly related to the crisis. However, the figures indicate there has
been an increase in the number of people taking their own lives over the last few years (ekathimerini.com, 31.03.2014). In 2008, 373 people committed suicide. This rose to 391 in 2009 and then dipped to 377 in 2012. In 2011, however, the figure increased again to 477 before reaching 508 in 2013. While the needs are increasing in complexity and frequency, formal evaluations of the public health system have revealed shortage of adequate and accessible health care units, consecutive budget cuts in public mental health services. The particular contradiction poses a serious threat to the survival of the public mental health system (Stylianidis & Chondros, 2011).

The large extent of uncertainty in the society affects planning at individual and collective level thus making it impossible to follow a concrete mental health plan. The recent goals in the field of mental health planning are included in the Memorandum of Understanding between the European Commissioner of employment, social affairs and inclusion Mr. László Andor and the Minister of Health Mr. Andreas Lykourentzos. The goals that have been set include the “new system” which will be put in place from 01.01.2016, all mental health units adopting common operating standards, setting realistic objectives with measurable results, financing by the Ministry based on the cost per beneficiary and type of mental health unit as well as consultation with all stakeholders. Although this action plan should work as a guarantee for the continuation of the psychiatric reform, the Greek mental health system is still in crisis and will face many adversities in keeping up with the goals of “re-shaping” the whole system. As the ex-post evaluation argued in 2010 (Institute of Psychiatry, 2011) the Greek Mental Health System suffers from fragmentation and lack of coordination. The abovementioned condition combined with financial uncertainty, budget cuts and frequently conflicting agendas among the basic stakeholders lead to increased burden on mental health system and especially on users, families and professionals. The treatment gap is increasing while four separate systems in mental health are working independently and uncoordinated (public, NGOs, social security, private practice).

At this point, it is important to note that there are large mental health workforce shortages in the public mental health system and excess of specific specialties. According to WHO Atlas (2005), in Greece there is a large amount of psychiatrists (15/100.000), psychologists (14/100.000) and social workers (56/100.000) most of whom do not work for public mental health care and are concentrated in large urban cities (Athens, Thessaloniki). Additionally, the training for the above professions is largely biological-oriented with few skills of public health. As for psychiatric nurses the numbers do not exceed 3 per 100.000 most of which are concentrated in large mental health hospitals. Inequity in the distribution of roles among the workers is also a fact in the public mental health system since administrative staff exceeds disproportionately the numbers of mental health care staff. The available budget for mental health is about 4. 43% (WHO, Atlas, 2011) out of which only 15% is funding community-based services. The data presented above, show that the uncertainty of the system can play a major role further increasing the burden of the professionals and the untreated prevalence of mental health disorder. An investment to creativity towards integration would require as Harper points out intelligence in networking, freedom and mobility in the use of symbols.
Mental health reform in Greece has produced a large but still incomplete network of community mental health services, which have been developed rather unequally. In this article we have selected the mobile mental health unit of Cyclades, a community partnership and a plan for self-help interventions as examples of good practice in low resources contexts. These services and actions are being implemented by the Association for Regional Development and Mental Health – EPAPSY. This is a nongovernmental, non-profit organization, which operates in the field of psychosocial rehabilitation and mental health promotion since 1988. EPAPSY currently serves approximately 2,272 mental health users and family members. It employs 210 mental health professionals, psychologists, psychiatrists, social workers, carers, administrative staff, and clinical supervisors. EPAPSY operates under the supervision of the Ministry of Health, but functions under private law as a public body. Since its development, EPAPSY has been primarily funded by the Ministry of Health, the European Union and private donations. With a total of 24 different facilities, EPAPSY now maintains an annual budget of appr. 5 m. €

**Mobile mental health unit of Cyclades: Serving mental health in remote areas.**

EPAPSY holds the responsibility for the function of a Mobile Mental Health Unit in Cyclades (MMHU) (sector population: 87,000). There are two responsibility sectors; one in NE Cyclades which provides services to Syros, Andros, Mykonos, Tinos, Paros and Antiparos (estimated population: 70,000 - 75,000) and one in W Cyclades serving Milos, Kimolos, Sifnos, Serifos, Kythnos and Kea (estimated population: 12,000).

**Modus Operandi.**

Each of the abovementioned islands is visited every 15 days by a multidisciplinary team constituted by a psychiatrist, child psychiatrist, psychologist and social worker. The experts that participate in the team are chosen according to the needs of the local area and the available resources. The sessions take place at each island in a different setting. The MMHU aims at the provision of

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assessment and psychiatric treatment for children, adolescents and adults suffering from psychiatric problems through the integration with Primary Health Care, while needs assessment is an essential part of the work. Another issue that is addressed is mental health promotion which takes place through interventions fighting stigma, sensitization events and training. The therapeutic role of the Unit is combined with the community work that develops and widens local networks between PHC Services, Social Services, local authorities, church and law enforcement services while mobilizing the local resources for mental health prevention and promotion.

Setting up a Community Mental Health Team in an urban setting; Collaborating with Key community partners.

Establishing community partnerships is a basic principle in social psychiatry. Also, when planning for mental health care, accessibility should always be among the prime priorities. In Greece, the Church plays an integral part of the society being in different occasions the frontline in the encounter of mental health disorders. Recent surveys show that one out of three people who face a difficulty in their personal life will first address a priest. This led us to develop a partnership with a parish in an urban area of Attica. The scientific responsibility for developing the collaboration was held by mental health professionals who resided in the same area and already worked in public mental health settings. A network was built between EPAPSY, the local Parish, the Psychiatric Department of “Ag. Olga” General Hospital, the Association for Families and Users in Mental Health for N Attica, the Social Services of the Municipality and other key-agents in public mental health and social services. Through this network individuals or families that resided in the area were mutually referred according to their needs. The local Parish provided the places for mental health care provision as well as financial support for covering mental health care costs for individuals who lived in the area and were in need of mental health services. Among the services that the Community Mental Health Team offered was prevention and promotion of mental health through consultation and constant communication with the priests and other key-persons in the Parish who were dealing with people who might be facing a mental health problem, sensitization events in the Parish etc. Also, the CMHT offered supportive psychotherapy, consultation, interconnection among services, social support for severe psychiatric patients, drug prescription when needed and at-home mental health care if it was called for. People asked for mental health care services directly or were referred by a priest – church key-person, or were referred by an agent of the abovementioned network.

A basic goal of the CMHT was to organize educational workshops for professionals of the network established including the priests of the parish. Four such workshops took place which ranged from issues in anxiety and depression, to the recognition and management of suicidal individuals. Forty individuals were provided mental health services and 430 therapeutic sessions were offered in
behaviors overcoming dysfunctional self-concepts based on the narrow field of diagnosis and disability leading them to interact in an environment of mutual empowerment (Farkas, 2012).

Target of this particular action is to train individuals who will in turn become peer trainers disseminating their knowledge and experience. After this, development of small support and empowerment groups is expected. Some of the issues that self-help and peer education address are the following.

- Empowerment activities.
- Reinforcing communication skills, management of negative feelings and self-concepts.
- Assertiveness behavior training.
- Leadership training.
- Team building activities.
- Role playing to simulate the settings of real life and handling of difficult situations in the family and work environment.

Additionally, a virtual community (in a social networking platform) for self help and support would also support and promote the activities against depression and suicidality, co-ordinated by a mental health professional. The expected results of a self-help intervention would be the empowerment of individuals experiencing depressive symptoms, members of socially vulnerable groups, the

2012. The weekly workload is about 5 mental health users on a daily basis.

The goal of such a partnership is to develop a “model of co-operation” which can be multiplied in several urban areas of Greece which are severely suffering from the consequences of the socioeconomic crisis and the recently developed “urban suffering” (Stylianidis et al., 2012) which increases the risk of developing a serious mental illness as well. In February 2014 EPAPSY signed a collaboration agreement with the Benevolent Trustee of the Archbishopric of Athens. The two parts have collaborated in a programme fighting poverty in the Municipality of Chalandri by providing meals, groceries, medicines and psychological, legal, logistic support in citizens facing poverty and unemployment (Number of beneficiaries during the 1st year: 344, number of meals provided 11922). This agreement aims at enhancing partnership in providing psychosocial support for people facing multiple social, economic, general and mental health problems at a local level.

Self Help Groups – Depression.
Self-help is the basis of the pyramid depicting the priorities of needs related to cost. It’s thus the most frequently met type of care and the lowest regarding the cost. The model of peer support promotes the understanding of the other persons’ condition through the shared experience including emotional and psychological trauma or suffering. This offers the possibility to all peer members to try new
reduction of the perceived isolation which is closely linked with aggression and depressive symptoms (Cacciopo, 2011), the reinforcement of the social network and resilience of the participants which will act as a protective factor against depression and other mental disorders.

Conclusion

In spite of the difficulties and the barriers in developing mental health services in Greece, the fact is that the establishment of a modern mental health care system is still a feasible possibility. The use of cost-effective programmes such as the Mental Health GAP Intervention Guide (mhGAP) to help integrate mental health in Primary Health Care or the use of the WHO QualityRights Toolkit for the Protection of Human Rights in mental health, since advocacy and ethical-based psychiatry is an “ultimate priority”.

Battling against the uncertainty that has been induced at an individual and collective level, empowerment is inseparably linked with community mental health care. According to Laverack (2001) empowerment is about participation, leadership, organizational structures, problem assessment, resource mobilization, assessment of the causes of inequality, link with others, role of the outside agents and programme management. All these constitute integral parts of community work at different dimensions. Self-help interventions aim at the more individual and small group level while the mobile mental health unit and pilot actions with partnerships from the community seem to have a more collective perspective.

Research has also shown that belonging to a dense network of reciprocal social relations can be protective factor against mental illness, while the “pain of loneliness” (Cacciopo et al., 2011) is growing more and more among the people who suffer the impact of the financial and social crisis. As Cacciopo argues it is often treated as “personal weakness” or “depression”, when it has to be dealt as a case of a new “pathology” in times of uncertainty and change. The socioeconomic crisis severely damages social bonds leading the person to a more vulnerable high risk position. It is also shown that a feeling of social connection, rather than the number of friends or the characteristics of social networks, best predicts a rise in wellbeing, whereas a feeling of social isolation predicts a decrease (Cacciopo et al., 2011). Social isolation is associated with lower subjective well-being (Myers & Diener, 1995) and broad-based morbidity and mortality (Hawkley & Cacciopo, 2010) while social resilience is the capacity to foster, engage in, and sustain positive relationships and to endure and recover from life stressors and social isolation. Its unique signature is the transformation of adversity into personal, relational, and collective growth through strengthening existing social engagements, and developing new relationships, with creative collective actions (Cacciopo et al., 2011).

References


Dubai, 3-5 April.

WAPR actively participated in an International Transcultural Psychiatry Conference on “Managing Mental Health in Multicultural Societies” held at Dubai – UAE from 3-5 April, 2014 by having a special session on “Psychosocial Rehabilitation in Gulf countries”.

The meeting was organised by World Association of Cultural Psychiatry & Emirated Medical Association and WAPR Eastern Mediterranean Region had a special session entitled Psychiatric Rehabilitation: Now & Tomorrow. The session was chaired by Dr Adel Karrani and speakers included Dr Afzal Javed, Dr Adel Karrani, Dr Khaled Mufti, Dr Medhat ElSabbahy & Dr Amir Mufaddel.

WAPR UAE, Dr Medhat Elsabbahy, Dr Afzal Javed & Amir Mufaddel.

Some Participants of the meeting.
Dr. Afzal Javed President WAPR introduced the session by giving current directions in the field of Psychosocial Rehabilitation and also about WAPR and its function. Dr. Khalid Mufti spoke about WAPR projects his team is undertaking for war refugees and victims of terrorism and disasters in Pakistan. Dr Medhat Elsabbahy described the Psychiatric Rehabilitation Core Principles and the details of his department’s activities in Abu Dhabi. Dr Amir Mufaddel from Al Ain (UAE) presented Community Mental Health, Expected Outcomes in different areas of psychosocial rehabilitation. Dr. Adel Karrani, chair of the conference emphasised about importance of rehabilitation in clinical practice and spoke about current status of rehabilitation services in Eastern Mediterranean region future needs / proposals about the Arab Federation’s collaboration with WAPR. The sessions attracted a number of participants from different disciplines like doctors, psychologists, social workers, psychiatric nurses working in the psychiatric rehabilitation, community psychiatry and day care units in UAE, Gulf States and Arab countries and worker and other allied psychiatric professions.

Being the first of WAPR activity in UAE, this session attracted a lot of enthusiasm about knowing WAPR and having future collaboration with this association.

Later on a meeting of the regional WAPR officers took place and discussed future plans about different activities in the region. Dr. Adel Karrani, Dr Riyadh Al-Baldawi and Dr Medhat Elsabbahy were thanked and appreciated for their hard work in getting this session in the programme.

Speakers of the conference.
Slovenia 9-12 April 2014.

Psychosocial Rehabilitation received a prominent attention in the WPA Regional Congress held in Ljubljana, Slovenia on 9-12 April 2014. Thanks to Vesna Svab for her efforts to highlight this topic looking at different aspects of psychosocial rehabilitation in the conference and getting two separate sessions in the programme. This occasion was also marked by a re-launch of WAPR Slovenia.

First session on “Rehabilitation & Recovery- Evolving needs and methods” generated a lot of interest among the participants. Dr S. Bajraktarov from Macedonia spoke about Alternative solutions for Psychosocial Rehabilitation for people with mental illnesses in Macedonia. He gave a detailed account of current developments in Macedonia and argued for more international and regional collaboration. Dr Henrik Wahlberg (Sweden) spoke about rehabilitation and empowerment as emerging trends in recovery and rehabilitation. K. Richter (Germany) described a service for immigrants and refugees that she is running in Germany. Dave Mucic from Denmark presented a very innovative project using e mental health in treatment of ethnic minorities and advocated the use of modern technology in supporting the current mental health services.

The second session “Psychosocial Rehabilitation & Recovery: Current trends were chaired by Afzal Javed & Vesna Svab. Prof Armen Soghoyan from WAPR Armenia presented paper describing recent developments in mental health...
plans in Armenia. He especially mentioned about inclusion of rehabilitation in the national mental health policy and launch of WAPR chapter in Armenia in 2013 that motivated a number of professionals to work for PSR. Esko Hanninen (Finland) gave an account of Club House movement and discussed principles of Club House philosophy. Dr Afzal Javed presented results of a study from Fountain House, Lahore about the burden and impact on quality of life on carers and family members of mentally ill. Based on these findings, a programme on psycho-education was developed that has attracted a lot of attention and acknowledgement from the families and carers. Simona from the Department of Social Services presented details of current community based services in Slovenia and mentioned about efforts to gain cooperation from different sectors. It was a good news that Slovenian mental health services will have due share of rehabilitation in their future programme. At the end Henrik Wahlberg summed up the discussions and advocated use of PSR and recovery services in different settings.

After the session a meeting was held with the Slovenian WAPR members and discussions took place about future activities in Slovenia. It was reassuring to note that WAPR Slovenia is in regular contact with the Government and NGOs to promote PSR programmes in the country.
On November 7th -8th 2013 the WAPR National Congress was held in Turin. The congress was titled “Across-Borders, psychiatric rehabilitation through many frontiers” and the idea was to promote a debate and to compare different experiences from an European perspective. In particular, given the geographical proximity, the history and relevance of psychosocial rehabilitation in France and Italy were presented and compared, with a specific attention to the policies that the two countries have had in the last decades.

More than 300 people coming from various Italian Regions and a few from France attended the event. We would like to emphasize that the participants and the speakers were representatives of the large network of mental health which includes psychiatric services, social companies, NGOs, service users and family associations and universities. In addition a symposium was attended by the Vice Mayor of Turin and by the President of the Health Committee of the Italian Parliament, confirming the significant role of the Italian WAPR Branch in our country.

The conference focused on the following main issues:

- The integration of pharmacological treatments and rehabilitative programs;
- Activities and future of users associations;
- Different types of welfare during an economic crisis;
- Traditional Mental Health Services versus recovery oriented ones: the possibility of a third way;
- Social changes and patients’ subjectivity;
- Strategies of supported employment in times of unemployment;
- Public and private interventions in mental health.

During the congress and from the debates some suggestions came out:

The need to increase the service users and families involvement in two specific areas: the organization of mental health services and the treatment programs.

The need to think and realize a new model of welfare turning the economic crisis into an opportunity for change.

The need for an evolution of the Mental Health Services which in Italy were born during the eighties after the psychiatric reform and now require a cultural transformation.

The congress received positive feedback and the participants appreciated the involvement of a branch of another country. Therefore, we confirm our commitment of organizing events to share and exchange experiences, especially in this stage of economic and social crisis.
Announcements

WAPR Participation in Nepal Meeting.

WAPR is co-sponsoring 8th International Conference of SAARAC Psychiatric Federation’s meeting being held at Lumbini, Nepal 27-29 Nov 2014.

Psychiatrists’ Association of Nepal, host organisation, has chosen this venue because of its high significance in Peace which matches with the theme of the conference “Global Peace: To Nurture a Healthy Mind”.

This will be a major landmark meeting bringing together mental health professionals from the SAARC region with presence of esteemed members of World Association for Psychosocial Rehabilitation from the Asian region.

WAPR will organise a workshop on Psycho-social Rehabilitation at this meeting.

For details please contact Dr. Sandip Subedi Organizing Secretary sandipsubedi@hotmail.com

Conference in Athens

2nd Interdisciplinary Congress Psychiatry and Related Sciences. 30.October – 2nd November 2014 in Athens where WAPR is a supporting organisation.

Conference in Canada

Annual Conference: Empowering Change through Psychosocial Rehabilitation

PSR/RPS Canada Conference Committee invites you to join us in Toronto at the Marriott Eaton Centre for the PSR/RPS Canada 2014 Conference in Toronto, Ontario, Sept 22-24th, 2014. Our conference is scheduled for September 22-25; which includes several components. Our website is www.psrrpscanada.ca which will continue to have updates.
In this section we offer links important for our field.
If you have suggestions for websites and links, please mail the editor: marit.borg@hbv.no

Convention on the Rights of Persons with Disabilities:

Mental health publications can be downloaded from the links below or ordered from the
WHO bookshop:

The WHO Mental Health Gap Action Programme (mhGAP):
http://www.who.int/mental_health/mhgap/en/

The WHO Mental health action plan 2013 – 2020:
http://www.who.int/mental_health/publications/action_plan/en/

Implementing Recovery through Organisational Change:
http://www.imroc.org/

Yale Program for Recovery and Community Health:
http://www.yale.edu/PRCH/
Does the Convention (CRPD) oblige to abolish laws which permit non-consensual placement and any substitute decision-making regimes such as guardianship?

Francisco Sardina
WAPR Board Member Representing Families.
Chair Board of Trustees FUNDACION MANANTIAL.

The Committee does not accept any exception to its radical interpretation on its Draft General Comment on article 12 CRPD (point 38):

“As has been established in numerous concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement upon the rights to personal integrity  
(Article 17), freedom from torture (Article 15), and freedom from violence, exploitation and abuse (Article 16).”

Forced treatment has been a particular problem for persons with psycho-social, intellectual, and other cognitive disabilities. Policies and legislative provisions that allow or perpetrate forced treatment must be abolished.”

Beats me how the members of UN Committee went about being promoted to such position. They are showing a lack of legal skills and a lack of knowledge about persons with severe mental disorder reality. There are not absolute fundamental rights. Rights have to be interpreted according the persons’ situation and limited to respect other persons’ rights.

The Council of Europe Steering Committee on Bioethics made the following statement on CRPD compatibility with involuntary placement or treatment (meeting Nov. 2011):

“This is the UN Committee interpretation about 12 article of CRPD:

“These practices need to be abolished to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others” (please, see points 7/20/35/36/37/38/46.1 on Committee on the Rights of Persons with Disabilities Draft General comment on Article 12 of the Convention-Equal Recognition before the Law).

http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx

What a Doctor must do when someone is trying to suicide, for instance? Should the authorities of a country permit that the father of a person with a mental disorder was killed while a crisis without any intervention? I am referring to a real case: http://politica.elpais.com/politica/2013/10/18/actualidad/1382120158_849637.html
“As a result of the discussion, the Committee concluded that the existence of a disability may not justify in itself a deprivation of liberty or an involuntary treatment. Involuntary treatment or placement may only be justified, in connection with a mental disorder of a serious nature, if from the absence of treatment or placement serious harm is likely to result to the person’s health or to a third party”

Even the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment recognizes both justifications for involuntary placement on psychiatric facilities:

“Deprivation of liberty on grounds of mental illness is unjustified if its basis is discrimination or prejudice against persons with disabilities. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention. The Special Rapporteur believes that the severity of the mental illness is not by itself sufficient to justify detention; the State must also show that detention is necessary to protect the safety of the person or of others. Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of “unsound mind” (Point 69/ A/HRC/22/53 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez /1st February 2013).

I have to recognize that the European standards on human rights and dignity of persons with mental disorders make me feel much more comfortable than the UN Committee draft of Comment on article 12 CRPD.

The Committee CRPD in its proclamations about equality before the law and some other fundamental rights of persons with disabilities forgets that there are some other fundamental Rights of the person to protect, as right to life (article 10 CRPD), right to health (article 25 CRPD), and right of dignity, and ignores the existence of other people with the same Fundamental Rights to life and integrity.

Once said this, we would like to highlight that we are not partial of involuntary treatment or involuntary placement as a rule but as a last resort. Neither are we in favor of institutionalization but the opposite. It should aim to enable the use of treatment acceptable to the person. We are strongly committed with a communitarian social model where the wide range of persons with MHP is cared under some positive values. Manantial Foundation is always focusing its psychosocial rehabilitation strategy on the person as a whole. The concerned person takes part significantly on his own Individual Rehabilitation Plan. Hope in future is the paradigm for both, the person concerned and our professional team. And Manantial Foundation bid is the autonomy of the person whose care is undertaken.

The second significant subject is the real and effective need to protect the economic interests of a cluster of persons with mental disorder who are truly unable to manage by themselves. We cannot share the Committee’s radical interpretation about its claim to abolish Substitute-Decision-Making (SDM) Legal Systems to ensure the equality before
the law of people with disabilities. On one hand, it is not a right conclusion about the legal interpretation of the right on equality before the law. On the other hand, not always is possible to manage the support on a Support-Decision-Making basis. Of course we agree on the need to provide support and be as much as possible respectful with the willing and the desires of the person, but there are sometimes limit situations when the supporter (the legal guardian, according the old terminology) realizes that that willing and desires are against the person’s benefit or their economic interests, for instance. Then the ethic and legal duty of the supporter is to provide them the best solution to their life and interests, whether the substitute-decision-making proceedings were made by the supporter, always with the safeguard of the control of the acts and decisions of the representative under a Court, or, by the Court itself, according to the law. I am pointing out the need to protect the economic interests of some persons with severe mental disorder whose vulnerability makes them easy to be swindled. I do not know what happens but when their parents die their fortune flies.

Unfortunately, this article cannot be longer, so, if you are interested, please, see my notes submitted to CRPD OHCHR, “A Caregiver view about Committee Draft General Comment on Article 12 CRPD”, and “The protection of Human Rights and Dignity of persons with mental disorder with reference to Committee Draft General Comment on article 12 CRPD”, where it was showed that the equality principle does not always imply equal legal regulation for everyone regardless any different circumstances with legal weight. Discrimination before the law and arbitrary are forbidden. Nevertheless, special circumstances deserve different legal focusing.

Francisco Sardina Ventosa.
President of the Board, Manantial Foundation.
Madrid, March 3rd 2014
Univ.Prof. Dr. Michaela Amering
Department of Psychiatry and Psychotherapy
Medical University of Vienna

The year 2013 brought forward two documents of historical significance regarding the human rights situation in mental health:

1. Report of the UN Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, on February 1st, 2013. The report has been read as calling for an absolute ban on all forced and non-consensual medical interventions for persons with disabilities, both short-term as well as long-term.

2. Draft General Comment on Article 12 of the Convention - Equal Recognition before the Law by the UN Committee on the Rights of Persons with Disabilities. The comment has been read as a call for only ever respecting the current preference and will of the person and for the immediate abolition of all substitute decision-making regimes and the development of supported decision making alternatives. Furthermore, it is read as to forbid the development of supported decision making systems in overlap with the maintenance of substitute decision-making regimes.

Support and excitement about the possible historical changes have been voiced. However, also confusion, indignation and essential worries have been discussed and formulated in the international health and mental health community in reaction to these two documents and their core assumptions as well as their potential consequences (e.g. WMA, SPPC, WPA, APA).

Among the crucial worries expressed, two goods at stake stand out:
1. The definition of torture.
2. The concept of substitute decision making

Regarding the Report of the Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, an important exchange of letters between the World Psychiatric Association and Juan Mendez can be found on http://www.wpanet.org/detail.php?section_id=7&content_id=1537. In his response to a joint statement of the American Psychiatric Association (APA) and the WPA Juan Mendez confirms the intention of his report to be a ‘vehicle to generate a discussion among States and interested civil society on standards that the mandate believes are necessary to cover issues and practices for which the existing normative framework is ambiguous or unclear’. He acknowledges ‘his regret that some inartful wording has given rise to misunderstanding of some statements included in it’ as well as contradictions. He states that he ‘did not mean to propose an absolute ban on non-consensual interventions (including institutionalization and restraints) under any and all circumstances’, but describes his concerns about discrimination against people with psychosocial disabilities and the domestic legislations and practices in many parts of the world. He also talks about his ‘plan to publish a volume with contributions from many individuals and entities interested in the matter’,
which ‘will include divergent views, including of course disagreements with my report’.

A call for a broad discussion was also the aim of a WAPR statement for its Task Force on Ethics and Human Rights, which we submitted as a comment on the Draft General comment on Article 12 of the Convention - Equal Recognition before the Law by the UN Committee on the Rights of Persons with Disabilities. The Draft General Comment had been open for comments from November 2013 till the end of February 2014. The Draft General Comment clearly aimed at only ever allowing to respect the current preference and will of the person and nothing else. It calls for the immediate abolition of all substitute decision-making regimes. It proposes to develop supported decision making alternatives without taking into account any transition issues, but to explicitly forbid the development of supported decision making systems in overlap with the maintenance of substitute decision-making regimes.

This Draft General Comment provoked a number of reactions, 70 of which one can find as comments on http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx.

It is an impressive assembly of comments by such different senders as the Australian Human Rights Commission (Comment Nr. 7), Autistic Minority International (Comment Nr.9), Clinica Juridica en Discapacidad y derechos Humanos-Pontifica Universidad Catolica de Peru (Comment Nr. 15), Denmark (Comment Nr 19), the Federal Republic of Germany (Comment Nr. 32), France (Nr. 34), the Korean Alliance on Mental Illness (Comment Nr. 43), the Society of Trust and estate Practitioners (Comment Nr. 60), the World Network of Users and Survivors of Psychiatry and CHRUSP-Center for Human Rights of Users and Survivors of Psychiatry (Comment Nr. 67) and the World Federation of the Deaf (Comment Nr. 70).

For the WAPR Task Force on Ethics and Human Rights a statement has been formulated with special assistance of Marianne Schulze. My experience with these debates in different gremia like the WPA sections on Public Policy and Psychiatry, which I chair, as well as the WPA section on the Psychological Consequences of Torture and Persecution under the chairmanship of Federico Allodi had left me with the impression that the debate has covered a lot of ground, but that the admirable ability of so many very knowledgeable and engaged people produced essential arguments, which have been formulated in medico-legal terms and language, thus posing not only great suggestions for solutions but also problems. The main problem I see is that not many people are able to follow these kind of discourses and that this really is a pity, especially as a central aim of CRPD is the inclusion of all.

Thus, our WAPR comment expresses our shared view with a call for a step back and a broadening of the discussion to include more people with a lived experience of mental health problems and care, their families and friends as well society as a whole and to change the language as well as the process to enable such a discussion. It can be found as Comment Nr. 69.
George Szmukler, who is also a member of the Task Force, sent a comment with special relevance (Comment Nr. 23). He focuses on the key issue on how to determine a person’s ‘wills and preferences’ under different circumstances with examples that clearly show situations that require further attention. He also confirms that ‘any law relating to impaired decision-making must be generic’, an essential prerequisite that has been strengthened considerably by his work on the fusion of mental health and incapacity legislation.

Francisco Sardina Ventosa submitted two very important and highly critical comments with instructive and comprehensive examples of the Spanish situation and development during the last years. His statement on ‘The protection of Human Rights and Dignity of persons with mental disorder with reference to Committee Draft General Comment on article 12 CRPD’ (Comment Nr. 45) - sent on behalf of the Manantial Foundation – illustrates many different aspects of the legal, medical and social circumstances that need attention and a focus on support and safeguards leading to the central questions of safeguarding beyond the limits of support. His ‘A Caregiver view about Committee Draft General comment on Article 12 CRPD’ - sent on behalf of FUTUPEMA – was from what I see notably the only comment from the family caregiver perspective. It can be found as Comment Nr. 36.

The 70 comments on the Draft General Comment re Article 12 of the CRPD as well as the discussions with the UN Special Rapporteur on torture illustrate the breadth and depth of the discussions that will concern us for many years to come. It seems of utmost importance that the mental health community participates in this debate with our expertise and knowledge about non-coercive interventions, successes in reduction of coercion, and the role resources play in avoiding low quality care and abuses in psychiatric institutions. The scarcity, inequity, and inefficiency of mental health resources around the world certainly not only limit access to care for people with mental health problems, but also lead to situations that increase the risk for human rights violations.

Clearly, all these essential issues will need to be discussed among mental health professionals, users of services and their families and friends, as well as health and human rights experts from different backgrounds at local, national as well as international levels in partnership, acknowledging areas of dissent and ongoing discussion as well as identifying areas of consent and opportunities for coordinated action.
Context

The mhGAP Forum, which is convened every October in Geneva, is an informal group to promote global collaboration and coordinated action aimed at supporting national efforts to address mental health. The central challenge over the past years has been to scale up mental health services to address disorders in low-resource settings.

Persistent inequalities in social, cultural, economic, political and environmental factors are among key determinants of mental health and mental disorders, which in turn places certain individuals and groups at a significantly higher risk of experiencing mental health problems. People with mental disorders experience higher rates of disability and mortality, which hold back the ultimate objectives of any development agenda: to improve human development and eradicate poverty. Business as usual thus cannot be an option and transformational change is needed. As the challenges of addressing mental disorders are highly interdependent, a new, more holistic approach is needed to promote, for all resource settings, a response that includes public policies in sectors other than health, with a focus on a limited set of objectives and targets to promote well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. Accordingly, the World Health Assembly adopted in May 2013, the “Comprehensive Mental Health Action Plan 2013–2020” (WHA66.8).

mhGAP Forum

The mhGAP Forum is an informal and evolving group of Member States, intergovernmental and non-governmental organizations, including UN Agencies, international development agencies, philanthropic foundations, research institutes, universities and WHO Collaborating Centres.

The Forum gives strategic guidance to the WHO Secretariat on raising the priority accorded to mental health in development work at global and national levels, provides support by raising the priority given to mental health on the agendas of relevant high-level forums and meetings of national and international leaders, and rallies stakeholders and people to address mental health.

The fifth meeting of the mhGAP Forum took place at the World Health Organization, Geneva, on 7 October 2013. The Forum was attended by 48 Member States including 14 Ambassadors, and 58 partner organizations, including United Nations agencies, philanthropic foundations, NGOs, academic and research institutions, and Collaborating Centres. The focus of this year’s Forum was the Mental Health Action Plan
2013-2020. The Action Plan provides guidance to Member States, WHO, and international partners to promote focused, aligned and country-owned responses to address mental health and to guide investments to deliver maximum returns for people most in need. The programme and list of participants are attached as Annex A.

Opening and the Launch.

Dr Oleg Chestnov, Assistant Director-General for Noncommunicable Diseases and Mental Health, welcomed the participants from Member States, intergovernmental and nongovernmental organizations, including UN agencies, international development agencies, philanthropic foundations, research institutes, universities, and WHO Collaborating Centres. He emphasized the importance of building stronger partnerships to facilitate the implementation of the Mental Health Action Plan 2013-2020 and addressed the challenges we need to overcome in order to achieve better mental health in all countries and communities.

A video based on the film, “Hidden Pictures” by Dr Delaney Ruston was screened.

Dr Margaret Chan, Director-General, described the new Comprehensive Mental Health Action Plan as a landmark achievement in many ways, including its foundation in the principles of human rights, its comprehensive menu of policy options, and its call for fundamental changes in the way mental health services are delivered. By underscoring opportunities to reduce inefficiencies, the action plan encourages an expansion of services to meet increased needs at a time when so many are affected by joblessness, homelessness, and hopelessness. Dr Chan committed WHO to provide the much needed technical support to assist countries with their implementation of the action plan.

Statements by Special Invitees:

Ms Robinah Alambuya, special invitee, and Chairperson of the Pan African Network of People with Psychosocial Disabilities (PANUSP), underscored that human rights should be integrated as a cross-cutting principle, incorporating the rights based approach to disability as embodied in the United Nations Convention on the Rights of Persons with Disabilities to broaden full inclusion of the people with psychosocial disabilities in society.

Professor Jeffrey Sachs, special invitee, Director, The Earth Institute thanked WHO for bringing mental health to a central role in primary health care. He stated that the post-2015 development agenda will most likely include a commitment to Universal Health Coverage (UHC). “Universal” should have several meanings. It should include health coverage in all countries, rich and poor. It should include health coverage of all income classes within every country, rich and poor. It should ensure access for all groups within society, by gender, race, ethnicity, religion, indigenous group, and physical geography. It should include the entire life cycle, from safe pregnancy to old age. It should include promotive, preventative, curative, therapeutic, and palliative. And it should include mental health alongside other diseases.

The case for including mental health in the basic package of primary health services has become overwhelming. Mental illness constitutes a heavy burden of disease (e.g. Measured in terms of DALYs). Mental illness imposes enormous economic costs (in absenteeism, lost productivity, and other causes). Mental illness is subject to effective, low-cost interventions, especially for affective disorders such as depression and anxiety disorders. Mental illness is highly vulnerable to societal taboos, missed diagnoses, and lack of systematic coverage. For all of these reasons, the scale-up of mental health services is a very high public health priority. The mental health community, supported by WHO, should continue to formulate detailed scale-up action plans, including:

- Training and recruitment of health professionals in low-income settings;
- Management of mental health interventions within the primary health system;
- Community engagement, e.g. through training of community health workers;
- Demonstration projects plus evaluations, demonstrating efficacy, costs, external
Brazil welcomed and strongly supported the WHO effort to promote mental health and recognized that fighting stigma and discrimination is a moral duty. Brazil’s National Mental Health Policy has, since 2001, put community-based care and an open and consultative model for designing interventions as core principles of its actions. Brazil’s policies for mental health uphold the rights of people living with mental disorders, guaranteeing access to services, promoting integration within their communities and the use of public areas to their benefit.

Canada: Stated that 1 in 5 Canadians experience mental health issues and the country is currently working to strengthen its mental health services. Canada’s Mental Health Commission aims to reduce stigma and foster change. The Commission developed its mental health strategy “Changing Directions, Changing Lives”. The strategy requires all sectors of society to participate in its implementation. The Commission held broad consultations to ensure that all views were included and informed the strategy. The strategy aims to support research for mental health as well as community-based services for First Nations, Inuit and Métis populations, and provides a framework for suicide prevention.

Czech Republic announced the finalization of the Strategy of Psychiatric Care Reform which is in line with the needs and objectives of the European and Global Mental Health Action Plans.

EU: Stated that the financial crisis has exacerbated mental health problems in EU countries, resulting in economic and human cost. In 2010, the total cost for social welfare was Euro 450 million. 45 organizations within the EU are responsible for reviewing knowledge and agreeing on common framework for action as part of the EU health network. Five conferences have been organized to highlight specific themes around mental health.

Finland acknowledged the challenges that all Member States have in the development and improvement of people centered and community-based psychiatric care and expressed its satisfaction that mental health promotion and prevention of
mental disorders are an essential part of the Action Plan.

Guatemala: Stated that it aims to improve attention to human rights issues in mental health services and ensure that epilepsy also receives attention.

Lithuania: Remarked that the Global Action Plan and regional plans is a recognition, by countries, of the importance of mental health to support and strengthen services. Respect for human rights and addressing stigma will need to be a key focus. Lithuania has over recent years passed a Mental Health Care Act, a national mental health programme, and a national mental health strategy. In October, Lithuania will host an EU Conference on mental health.

Monaco described its social outpatient services; underscored its focus on child and adolescent mental health services and systematic research towards school integration; and flagged the attention geared towards older adults (particularly with Alzheimer’s).

New Zealand shared the information that it has recently released the report “Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017”, which is strongly underpinned by the principles identified in the WHO’s draft plan. In parallel they are finalizing the Suicide Prevention Action Plan, and several cross-government initiatives to integrate social services for the improvement of general wellbeing including mental health in vulnerable groups.

Norway recognized that mental disorders are on the rise and that their national policies have benefited greatly from WHO’s normative advice and role. They called for population-based interventions notably in families, child care centers, schools and local communities.
Pakistan highlighted the rising post-traumatic stress disorder (PTSD) amongst young people especially children and expressed its concern about the frequent natural calamities (floods and earthquakes) that have further increased the mental and psychological strain.

Panama highlighted the progressive decentralization of outpatient specialized services and the strengthening of psychiatric care in general hospitals within a coherent and sustainable strategy for the development of community-oriented care.

Peru referred to the 2012-2021 Mental Health National Strategic Plan as the Peruvian response to the needs of the population and the need for improvement of health care services’ provision and showcased the alignment of the national plan to the Comprehensive MHAP.

Switzerland, as one of the three co-sponsors of the resolution reaffirmed its commitment to contribute to the implementation of the Comprehensive mental Health Plan, both at a domestic level – for instance with its new National Strategy on Dementia, as well as abroad in conflict areas, where Switzerland contributes to psychosocial support to victims of gender based violence.

UK: Reaffirmed full support for the Mental Health Action Plan which is in line with the UK mental health strategy. The work of the Department for International Development (DFID) was highlighted including through the PRIME Project which aims to scale up treatment in primary and maternal health care; provide support to Ghana to improve services and implement the mental health law; run a partnership scheme in Zambia to train psychiatrists; and help the aged programme in Mozambique. Also mentioned was the launch of the UK national suicide prevention strategy. The UK will host G8 summit on Dementia in December 2013.

Uruguay recognized the fight against discrimination and stigmatization as one of its main goals, stressing rehabilitation and the promotion of the human rights of people with disabilities, including those with mental disorders. With a rate of suicide of 12.54 per 100,000 persons, their goal is to reduce mortality related to suicide by a 10% for the period 2011-2020.

Planned Actions of WHO Secretariat

Dr Shekhar Saxena presented an overview of WHO planned activities to assist countries in implementing the Action Plan.

WHO African Region:

Dr Sebastiana Da Gama Nkomo spoke of the burden of mental, neurological and substance abuse (MNS) disorders which account for 19% of all disability in Africa. Most of people who suffer from MNS disorders experience exclusion and human rights violation. 80% of the population who suffer from MNS disorders do not receive proper treatment. Dr Da Gama Nkomo remarked that the implementation of the Mental Health Gap Action Programme (mhGAP) in the region was a success. WHO regional office is working on government commitment through advocacy, mental health service improvement, policy development and implementation, strengthening mental health integration to primary health care services. Dr Da Gama Nkomo spoke of the need to work with countries to strengthen resource mobilization for mental health. Also, more inter country and inter-regional networks are needed to share experiences and best practice.

WHO Region of the Americas:

Dr Jorge Rodriguez outlined the progress that had been made in the region. In 1990 countries of the region adopted the Caracas Declaration. In 2012, a resolution on mental health was adopted in PAHO. Another milestone was the adoption of the Regional Mental Health Action Plan in 2011. In addition, a regional plan on epilepsy was adopted in 2013.

Key focus of activities include mental health system assessment through WHO-AIMS for 34 countries; the development, strengthening and updating and implementing of national mental health plans; the integration of mental health into general hospitals. The key focus for the future will be integration of mental health into primary care.
WHO European Region:
The Regional Adviser was unable to attend the Forum. The European Member States recently adopted the European Mental Health Action Plan which is in line with the global Mental Health Action Plan.

WHO South-East Asia Region:
The Regional Adviser was unable to attend the Forum. WHO Headquarters Secretariat stated that they will work closely with the region to implement the Action Plan.

WHO Eastern Mediterranean Region:
Dr Khalid Saeed stated that in 2011, a Regional Strategy for Mental Health was adopted. The provisions of the regional strategy are in line with the global plan. 70% countries in the region do have plans and many countries with existing plans are outdated. Of 22 countries, 16 have mental health laws but only 8 are current, so there is an urgent need to reform mental health legislation. Afghanistan and some other countries are currently updating their laws. There are complex emergencies throughout the region and there is a need to improve the WHO response. Also of note, mhGAP implementation is ongoing in several countries in the region. WHO is working on school life skills programmes and developing mental health literacy materials as well as developing specific models of care tailored to specific countries. The implementation of the WHO QualityRights Project has started in Jordan and work is under way to begin its rollout in other countries. Suicide prevention programmes are underway in countries and efforts are being made to link suicide information system with other information systems.

WHO Western Pacific Region:
Dr Xiangdong Wang pointed out that the Western Pacific Region is the most populous region. He spoke of the problems of people with mental illness living on the streets, the human rights abuses which included those chained at home, in some cases people caged for 30 years. Various high level events have included discussion on mental health, including the Pacific Ministers Meeting, APEC and ASEAN. WHO will look for other opportunities to promote the Action Plan at regional forums. The toughest challenge is a lack of human resources due to difficulties attracting people to the profession. Dr Wang reported that the Pacific Island Mental Health Network (PIMHnet) is running well. There is a need to create networks in order to determine what each stakeholder can contribute to mental health and a meeting will be organized in December to explore this further. The WHO Regional Office will continue to assist countries to access financial and technical resources.

The WHO Secretariat’s actions were discussed by the participants.

Planned Actions of Civil Society
The focus of this session was planned actions of the mhGAP partners working in Civil Society.

The Civil Society partners pledged their support for the Action Plan and spoke of their attempts to ensure its wide dissemination through their membership and networks.

Particular issues of concern included: homelessness of people with mental disorders; establishment of knowledge exchange network on mental health; the need to reduce stigma; mental health promotion in schools; poverty; promotion of human rights; and the need for research and innovation.

The following partners outlined their activities and areas of contribution to the implementation of the Action Plan:

- Alzheimer Disease International
- BasicNeeds
- CBM International
- Grand Challenges Canada
- Gulbenkian Foundation
- European Federation of Associations of Families of People with Mental Illness
- HealthNet TPO
- International Association for Child and Adolescent Psychiatry and Allied Professions
- International Bureau for Epilepsy
- International Organization for Migration
- International Medical Corps
- International Federation of Pharmaceutical Manufacturers & Associations

WHO-WAPR Plan of Action Advocates.
The Forum ended with concluding comments recognizing the unprecedented opportunity presented by the Mental Health Action Plan to improve the mental health situation in the world and the need for all stakeholders to work together in order to maximize the impact especially in low- and middle-income countries.

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Planned Actions of WHO Collaborating Centres/other academic institutions.

The focus of this session was planned actions of the WHO Collaborating Centres and other academic institutions.

The Centres and institutions expressed their strong support for the Action Plan and their commitment to collaborate on the implementation of the Plan. Areas of particular concern identified by the partners included: working through primary health care, involving services users, developing model services, supporting evidence generation for mhGAP, advocating for inclusion of people with intellectual and developmental disabilities, continuing to support the evidence basis, maternal depression, gender and gender identity.

The following partners outlined their activities and areas of contribution to the implementation of the Action Plan:

- American Psychological Association
- Columbia University, USA
- International Union of Psychological Science
- Japanese Association of Psychiatric Hospitals
- Johns Hopkins Bloomberg School of Public Health
- WHO Collaborating Centre, London

- WHO Collaborating Centre, Madrid
- WHO Collaborating Centre, Trieste
- WHO Collaborating Centre, Verona
- World Organisation of Family Doctors
**WAPR 2012-2105**

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  - Anne Grethe Klunderud
  - Michaela Amering

- **Task Force on Ethics & Human Rights for persons experiencing mental illness**
  - Chair: Mathew Varghese
  - Henrik Wahlberg
  - Marianne Farkas

- **Task Force on Curriculum & Training—particularly focusing on recovery**
  - Chair: Michael Sadre-Chirazi-Stark
  - Mathew Varghese
  - Henrik Wahlberg
  - Marianne Farkas

- **Task Force on issues relating to Professionals’ Burnt Out**
  - Chair: V.K. Radhakrishnan & Alok Sarin

- **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: Harry Minas

- **Task Force on Asia-Pacific Projects Development and Dissemination**
  - Chair: V.K. Radhakrishnan & Alok Sarin

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

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