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WAPR MEETINGS & BOARD MEETINGS
BANGKOK & LAHORE.

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**Editorial:**
- P. 3 : Greetings from the Editorial Team. *Marit Borg*.

**Articles:**
- P. 9 : The 300 Ramayanas and the District Mental Health Programme. *Alok Sarin, Sanjeev Jain*.
- P. 18. ACEH Mental Health In Post Conflicts, Post Tsunami. Dr. M P Deva

**Highlight:**
- P. 24: Fighting stigma. Case Reports:
  - Taiwan. McDonald’s Taiwan discriminates against Down’s patron.
  - Spain. Down Syndrome Association fights a case of discrimination in a hotel.
  - Spain. Angela Bachiller has become in the first council with Down syndrome.

**Reports:**
- P. 30: 3º WAPR Asia Pacific Conference "Recent Advances in Rehabilitation, Biological & Social Psychiatry". Lahore, Pakistan 1-4 November, 2103. Afzal Javed, President WAPR.
- P. 32: TAPR Report for 2013 Symposium: Health and well-being Mental Health and Community-Based Model Supporting Mental Disorders Living. Eva Teng (Secretary General of TAPR).
- P.35: Armenia: Yerevan Declaration: "Cooperation for mental health improvement".
- P. 37: Launch meeting of WAPR Armenia. Yerevan, Armenia; 29 August, 2013
- P 42: “Mental Illness, Dual Pathology and Employment”; Murcia, Spain. Luis Pelegrin

**WAPR ORGANISATIONAL:**
- P. 44;WHO-WAPR Human Rights Committee. April 28th. Amering M, Guinea R., Schulze M.
- P. 51: WAPR, Board meetings.
  - August 22th. Bangkok Thayland.
  - November, 2th. Lahore Pakistán.

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**WAPR Bulletin.**

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**WAPR HEAD OFFICE.**
Afzal Javed, WAPR President. The Medical Centre. Manor Court Av. Nuneaton, CV11 5HX United Kingdom.

**Editorial Board (Equipo Editor)**
Editor: Marit Borg, Drammen, Norway; Co-Editors: Ricardo Guinea. Madrid, Spain; Tae-Yeon Wang, Korea.

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Digital Edition by Ricardo Guinea, Hospital de Dia Madrid. c/ Manuel Marañón, 4. 28043 Madrid (Spain).
Tel. ++34 91 7596692 Fax: ++34 91 3003355;
[guinea@hdmadrid.org](mailto:guinea@hdmadrid.org)
I am pleased that WAPR has remained very active during this year and has 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 has received a lot of appreciation from our membership. Thanks to the editorial team for their hard work. It is indeed a matter of great proud & privilege that Spanish version of our Bulletin will be added to the list of achievements in this area.

Wapr Standing committees are updating their work and reviewing their remit within the functioning of WAPR.

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.

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 are reviving & strengthening our links with the following organizations:
• World Psychiatric Association (WPA)
• World Association for Social Psychiatry (WASP)
• World Federation for Mental Health (WFMH)
• World Federation of Occupational Therapists (WFOT)
• International Centre for Clubhouse Development ICCD
• European Federation of Associations of Families of People with Mental Illness (EUFAMI)
• International Society for Psychological treatments for Schizophrenias & other psychoses (ISPS)
• Pacific Rim College of Psychiatrists (PRCP)
• International Association for Women’s Mental Health
• European Psychiatric Association (EPA)
• Faculty of Rehabilitation & Social psychiatry Royal College of Psychiatrists UK
• Asian Federation of Psychiatric Association (AFPA)
• SAARC Psychiatric Federation (SPF)
• World Health Organisation (WHO)

We have signed joint declarations with some of these organisations and are pleased with the future plans for collaborative work in areas of mutual interest.

Opening of new WAPR Branches

Congratulations & welcome to our new branches and the membership from these countries.
• Iran Jan 2013
• Taiwan June 2013
• Romania July 2013
• Armenia August 2013
Our regional vice presidents (Solly & Alberto) are also exploring the possibility of having new branches in African & American region as well.

## WAPR Meetings & Training sessions on PSR
- WAPR UK meeting, Preston, UK April 2013
- International conference “Crises and Disasters: Psychosocial consequences Athens, Greece, March 2013
- WPA Regional Conference Bucharest, Romania, April 2013
- WAPR Taiwan launch meeting, Taipei, Taiwan June 2013
- WASP meeting Romania July 2013
- World Asian Congress Bangkok, Thailand August 2013
- WAPR meeting Yerevan, Armenia August 2013
- Ongoing Local training (psycho education) in Fountain House, Lahore, Pakistan

## Participation & representation of WAPR in scientific conferences
- Paraguayan Society of Psychiatry Meeting, Asunción, Paraguay, January 2013
- Planning meeting WAPR Indonesia, Bali, Indonesia, February 2013
- Congress on Schizophrenia Research, Bali, Indonesia, February 2013
- WAPR UK meeting, Preston, UK April 2013
- International conference “Crises and Disasters: Psychosocial consequences” Athens, Greece, March 2013
- WPA Regional Conference Bucharest, Romania, April 2013
- WAPR Taiwan launch meeting, June 2013
- WASP meeting Romania, July 2013
- World Congress of Asian Psychiatry, Bangkok, Thailand August 2013.
- WAPR meeting Yerevan, Armenia, August 2013

## Participation in Special Meetings / Task forces / meetings with other international organisations
- WPA Section on Education meeting on Developing recommendations for undergraduate teaching in Psychiatry, Coventry, UK, March, 2013
- WFMH International conference “Crises and Disasters: Psychosocial consequences Athens, Greece & signing of joint declaration, March 2013
- Meeting with AFPA, PRCP, WPA, WFMH Asian psychiatric Associations at World Congress of Asian Psychiatry held at Bangkok, Thailand 2013
- Joint meeting & signing of Joint Declaration with president of WPA, WASP, WONCA, Ministry of Health Armenia at Yerevan, Armenia August 2013
- mhGAP Forum - World Health Organization, Geneva, Switzerland, October 2013

## Future meetings 2013
- WAPR Training Programme Ethiopia, Oct 2013
- Asia Pacific Conference on psychosocial Rehabilitation, Lahore, Pakistan

I once again thank all the Board members, national secretaries & membership of WAPR for their continuous support and hard work for WAPR.

Afzal Javed

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**From the Editorial Committee.**

**Marit Borg.**

WAPR Bulletin Editor.

This Editorial of the WAPR Bulletin 3-2013 is attending an issue we find crucial to focus more on in the coming years in WAPR; namely human rights. Ricardo Guinea, MD and WAPR President Elect, gives an outline of historical and present challenges in relation to human rights in the context of mental health and psychosocial rehabilitation.

Several articles and reports in this Bulletin discuss themes relevant for human rights.

We wish you all a happy reading and a very happy new year.

Let 2014 be a year when human rights and mental health are at the top of our agenda.

**Marit Borg**

Editor
For the first time in history, in a formal and explicit way, the United Nations (UN) proclaimed in 1948, after the horrors of World War II, the idea that the human being is an inalienable personal rights holder. UN proclaimed that it is "without distinction of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

The Universal Declaration of Human Rights (1) initially had no binding legal effect, but gained it in subsequent years by the voluntary will of sovereign countries expressed in international treaties promoted since 1966 within the General Assembly UN.

In 2006 a step further was taken with the adoption of the International Convention on the Rights of Persons with Disabilities (2). This new development was based on the finding that, despite previous proclamations, the idea that people with disabilities were also human right holders seemed to need an explicit reminder. The UN special rapporteurs responsible for reporting on the topic globally described huge gaps, and particularly an unacceptable and regular association between disability, poverty and social exclusion.

The Convention stressed the need to approve as rights dignity, autonomy, non-discrimination, participation and social inclusion, respect for differences, the right to equal opportunities, accessibility to community services, and equality in gender. The respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities, was also emphasized.

It is worth noticing that this new Convention specifically includes people with disabilities following mental illness and mental health problems. It has been welcomed with enthusiasm by organizations of people suffering from mental health problems like the “World Network of Users and Survivors of Psychiatry» ( WNUSP ) who also participated in its drafting.

The Convention is particularly relevant for our field. The realizations of potential conflicts with the rights recognized in the Convention are particularly common in some interventions in mental health services. In fact, ironically, as WHO points out, some of the worst conflicts and transgressions occur precisely in mental health services.

Some human rights (which are sometimes described as "negative") address avoiding invasion of the personal space of rights of the person. This refers to the right to liberty, freedom of movement, dignity, freedom of thought or capacity to act. The most obvious area of conflicts comes from the widely accepted interpretation that in a situation of mental illness that challenges judgement or behavior, society and its stakeholders may and must act in the protection of the person or third parties affected, temporarily suspending some rights. In this delicate, sensitive and challenging area, it is certainly necessary to find a way balanced way to protect the need for security and public order. But
it is also necessary that required precautionary measures are proportionate, taken with due guarantees, and not operate as insurmountable obstacles to the possibility of future restoration and recovery of the person.

Since stigma is still influencing the public view of mental health and mental illness, part of the media, non informed public, and sometimes policy makers influenced by the former, tend to bias their concepts to control measures. This comes at the expense of other efforts of preventive care, like to provide targeted support, value independence and improvement of people's life conditions. Suspension of human rights certified by law and detention or involuntary treatment, raise many dilemmas for the professionals in ways of ethical standards and procedures and in developing supportive relationships and recovery oriented practices.

All parts involved, but specially the professional community need to be informed and reminded about this: it is essential that measures taken keep in mind the principles of the human rights.

An more in-depth analysis of the situation will help us to become more aware of the fact that that temporal restriction of some personal rights does not imply that the person cannot be heard or included in decision making wherever possible. Protocols to identify good practices in challenging situations are needed and should be disseminated. Professionals should be familiar with such protocols, as well as with open and reflective communication techniques and conflict resolution approaches. There are references in the literature that such approaches and procedures significantly reduce the frequency and duration of the compulsory interventions. Professionals involved in the recommendation of compulsory treatment should be aware of the effect this will have on the person. Even in the best conditions and with every justification, any reduction of human and personal rights is a traumatic situation for the person concerned, who will also have to recover from this experience.

It's easy to find comprehensive evidence that these approaches are not merely rhetorical. To mention only some, revising the fact of the death of a person submitted to physical restraint in a hospital in a developed country, a later survey revealed dozens of similar incidents in recent years (3). Similar reports have been found in other countries.

Another dimension of human rights (which is often described as "positive" rights) is characterized by the need of specific activities and resources provided by states and social organizations for its implementation. This includes the right to receive treatment and protection, of evidence based, quality and effective treatments, or the right to social inclusion, participation and equal opportunities. Here, we see the ratification of a major change in global perspective.

As far as the view of the states supporting the Convention is concerned, the needed resources for the implementation of the rights are not anymore to be seen as a charity, or a gracious option, but as recognition of a civil right and correspondingly as an obligation of countries.

From this perspective, the problem remains on the material conditions necessary for its implementation. It is a dual problem. On the one hand, which derives from the limitation of the available resources and conflicting needs in the communities. On the other hand, we need to consider the management of priorities and political will.

To be realistic, it is necessary to be aware of how limited resources affect the activities in the various countries. We can consider, for example, the situation in developing countries with endemic health problems to address, as malaria or AIDS. This shifts the emphasis to aspects related to equity and justice. WHO reports that despite the evaluations conducted since 2001 (4), underlining that the problems related to mental health
contribute the most to the suffering of populations (in terms of accounting “disability adjusted life years”), the resources allocated to these citizens’ care are disproportionately low, compared with those of people suffering from other diseases. This represents still a clear global inequality and unfairness towards people with mental illness.

WHO proposes five strategic areas in the promotion of Human Rights in Mental Health (5). Five ways we can use to test whether people affected by mental illness have equal access as other citizens to common opportunities.

The right to an adequate standard of living should imply decent housing conditions. It also includes adequate standard in institutional settings, like prevention of overcrowding, of poor hygiene, and of inhuman and humiliating situations.

The right of access to the best possible condition of physical and mental health, should implies at least the access to basic medicines and treatment, hopefully counseling and some support for caregivers, and attention to possible physical concurrent conditions.

Addressing the right to legal capacity should require, first, adequate information and consent to measures affecting the person, to make informed decisions possible. And second, in situations where it is considered the need to suspend some human rights, the right to effective legal protection, procedural safeguards and monitoring measures.

The right to be free from exploitation, torture, inhuman or degrading punishment or violence is apparently self-explanatory, but it should be noted here how international users’ organizations (as the above mentioned WNUSP) claim that some health services break this principle.

The right to life and to independent living in the community include the opportunity to access and enjoy community resources, participate in leisure and social or religious activities, and measures that support social inclusion. It also requires analyzing the existence of current forms of asylums, or the new phenomena known as transinstitutionalisation.

Considering Psychosocial Rehabilitation from a Human Rights perspective may have several implications. One of them, perhaps the most immediate, is that the evaluation of services from the Human Rights accomplishment point of view can function as a way of quality control. It can also be seen and used as a way of assessing the recovery orientation of services, both from the service users’, carers’, professionals’ and managers’ experiences and points of view. Indeed, there is an evaluation protocol of WHO that could be used or adapted for this purpose (5).

Such evaluation can provide a good opportunity for professionals and managers to regularly assess and review services, facilities and practices. The available reports and assessments indicate that, very often, the material conditions of facilities and the professional attitudes and concrete practices remain in a state of remarkable lack of self-criticism. Service evaluations from users and carers are also of great help here, where the state of the art can be revealed on a concrete level from the reports of the receiving end.

Assessments may indicate that material conditions of some services need changes and new investments. For example, service users in need of residential support deserve safe and homely places, not hospitals or prison-like facilities. The should be offered decent places, clean and inviting, not overcrowded, with easy access to running water and opportunities to personal hygiene, possibility of privacy, personal clothing and items, opportunities to cook and dine, to mention some issues. Furthermore, supported houses should be served by competent, recovery oriented and encouraging professionals.
The assessment may also indicate the need to consider the implementation of changes in professional attitudes and practices. Authoritarian, paternalistic or non-emphatic attitudes may be the most common. But it is also common to find attitudes of abuse. To tackle this situations may require the use of some resources for training and increasing awareness of the staff, but actually it should be always possible if interest and objectives are clearly targeted. The service users can be key sources for revealing stigmatizing or humiliating staff attitudes and practices. Complete lack of expectations and hope for the person’s future, or gratuitous restricting rights should be considered unacceptable. It is always interesting to review the relevance of control measures; small measures in everyday life (such as routine control of cigarettes or pocket money), as well as more important measures as the control of personal assets. Service users’ associations (as the above mentioned, WNUSP) claim, quite rightly (6), that in everyday life, some basic aspects of their rights are not taken into account. They report experiences of unequal and unsupportive relationships with professionals, that are oriented to "control" rather than to collaboration and supporting the persons hopes and aims for the future. Part of the problem is, according to WHO, that many professionals understand the relationship only as "treatment", rather than as a way of supporting the persons opportunity to community involvement and participation, recovery and inclusion as a human beings. Small pilot experiences within WAPR-WHO (in workshops about Human Rights staff members) revealed that the margin for improvement is real and wide. It also informed that this is a topic where changes may not be easy or comfortable; for example, it is the case in countries where Human Rights collide with rooted cultural or religious traits.

At the “macro” level, the perspective of Human Rights may represent a long reaching perspective with a deep political impact. In these days dominated by market values and weary ideologies, dissemination and creation of broad public consensus on the implications of the Human Rights can be an argument with great potential for social change in the hands of civil society.

Human Rights, in similar line the "social determinants of health" (7), represent a person-centred social strategy that aims to consider resources spent on health and social policies as “investments” for the future (rather than as “expenses”), supported by sound, effective, transparent and corruption-intolerant fiscal policies. This would develop healthier populations, better protected from preventable diseases, with more and better education, better quality of life, more supportive and more productive environments. Such a view demands increased awareness, more equity, and awareness of the importance of social participation and of long-term measures in society. It requires determination and awareness of the outstanding opportunities to use the available information about preventive measures.

As final issue, we must be also aware that statements alone do not change things. Real changes only happen when new practices take the place of the old ones. Any change requiring major transformations needs support and defense persistently, over a long period of time, by broad sectors of society.

REFERENCES:
The 300 Ramayanas and the District Mental Health Programme*. 
Alok Sarin, Sanjeev Jain.

Alok Sarin (aloksarin@gmail.com) is consultant psychiatrist at
Sitaram Bhartia Institute of Science & Research, New Delhi.
Sanjeev Jain (docsanjeev.jain@gmail.com) is at the Department of Psychiatry, Molecular Genetics Laboratory,
National Institute of Mental Health & Neurosciences, Bangalore.
Both authors are members of the policy group set up by the Ministry of Health and Family Welfare, Government 
of India.

*This article was previously published in “Economic & Political Weekly”.

With the completion of the Eleventh Five-Year Plan, an appraisal of the mental health initiative in the space of state-sponsored health delivery seems appropriate and timely. Discourses in health delivery usually tend to implement similar sets of tools. This article argues that to achieve some form of clarity it may be appropriate to look at health delivery through the lenses of the social sciences. In this attempt, the article uses the metaphor of 300 Ramayanas and the tools of A K Ramanujan to review thinking about the District Mental Health Programme.

The authors would like to explicitly state that the views expressed here are personal. They would also like to acknowledge the contribution made to their understanding by all the other members of the policy group, and the Ministry of Health and Family Welfare, for setting up the group. The authors specifically like to thank Sushrut Jadhav of University College, London, and Perminder Sachdev of University of New South Wales, Sydney for their insightful comments and suggestions.

In 2011 there was quite a furore over the withdrawal from the history curriculum of Delhi University of an essay by the noted scholar A K Ramanujan. This essay is titled “Three Hundred Ramayanas: Five Examples and Three Thoughts on Translation” (Ramanujan 1991). The point that the essayist makes is that there is no one “authentic version” of the Ramayana, that there are many different retellings of the same story and that with the same “anchor points” many different narratives can be constructed. The controversy has actually ensured that many beyond the confines of academy have actually read the essay, so, in a sense, it has served a larger purpose. As many commentators have noted, the diversity and variety of narrative is a testimony to the pluralism of tradition. To our
minds, this remarkable essay actually makes three points:

There can be no one monolithic telling of a complex story, and that these stories are indeed open to many different tellings, in the nature of narrative, there are interesting similarities and differences between the written and oral traditions, and the interesting fact that the apparently different narratives actually relate to each other in many ways, and so, while there will be narratives and counter-narratives, all of these, will, in a sense, speak to each other. This is what has been called the “inter-textual” nature of the discourse.

Using the story of the seduction of Ahalya, wife of the sage Gautama by the god Indra, Ramanujan elegantly compares and contrasts the telling of it in Valmiki’s Ramayana and the Kampan’s Irmavataram (The Incarnation of Ram). As Ramanujan puts it “…the Ahalya, episode is essentially the same, but the weave, the texture, the colors are very different.”

The Bare Bones of the DMHP.

What we intend to do here is to use this essay and its tools to understand the complex realities of another story with interwoven threads, that is District Mental Health Programme (DMHP), and the story of community mental health in India. The post-Independence central planning for healthcare has relied heavily on the recommendations of the Bhore Committee suggestions, which were made towards the end of direct British rule.

These recommendations were largely influenced by the international advisers to the Bhore Committee, which the authors have commented on in another publication. These were guided in part by disquiet about the status of healthcare (criticism had mounted in the 1930s) as well as the push in the UK (and the rest of British Empire and the Commonwealth) for the Beveridge inspired healthcare programme (later the National Health Service). Universal healthcare was one of the major social reforms to arise out of the post-second world war political process. However, in India (and in much of the postcolonial world) sufficient resources or expertise was not available to evolve complex medical systems for health care delivery. A patchwork of top down programmes that were targeted at specific diseases were often put into place (tuberculosis, malaria, diarrhea, etc) (Park 2008), but a unified comprehensive healthcare service was conspicuously its absence. Even the inclusion (or exclusion) of particular diseases was often guided by “expert opinions” and interventions, though it was often positioned as “community-oriented”.

Mental healthcare was a relatively late entrant, as effective drug treatments became available only recently, and the “medicalisation” of distress was an even more recent development (though doubts are still raised about its validity). Initial community psychiatry services were theoretically inclusive and pluralistic, but given the ambiguities involved did not transfer themselves into the bulleted action plans that were possible for other biomedical disease models. Focused attempts to simplify and codify interventions, with a large emphasis on drug treatments, were thus put to trial in certain areas, and the DMHP was gradually evolved to provide care to the poor.

The DMHP is the flagship mental health delivery programme of the Government of India. The DMHP is the district based, service delivery component of the larger National Mental Health Programme (the
NMHP). It was launched in 1996 in four districts, one each in Andhra Pradesh, Assam, Rajasthan and Tamil Nadu. The spread of the DMHP was gradually increased to 27 districts in the Ninth Five-Year Plan (1996-97 to 2002) period, with a total budget allocation of Rs 28 crore (Isaac 2011).

The objectives of the centrally-funded DMHP scheme were as follows:

• Provide sustainable mental health services to the community, and to integrate these services with other services;
• Early detection and treatment of patients (of mental illness) within the community itself;
• See that patients and their relatives do not have to travel long distances to seek treatment;
• Take pressure off mental hospitals;
• Reduce the stigma attached to mental illness through change in public attitudes; and
• Treat and rehabilitate mentally ill patients discharged from the mental hospitals within the community.

With a budget of Rs 190 crore, the DMHP coverage was increased to 100 districts in the Tenth Five-Year Plan period (2002-07). This was also supported by other activities in the NMHP including upgradation of the departments of psychiatry in the medical colleges, modernisation of the mental hospitals, funding of information, education and communication (IEC) activities on mental health and support of research and training issues related to implementation of the NMHP.

In the Eleventh Five-Year Plan (2007-12), the total approved budget was Rs 408 crore, and the DMHP is supposed to be active in 123 districts over the country.

Also 10 centres of excellence in the field of mental health have been funded in different parts of the country. Other planned activities have included upgradation of mental hospitals, strengthening of IEC activities, and research activities.

These are, then, the anchor points or the “bare bones” of the DMHP story, as it were. The question before us is whether the DMHP has been successful.

Critiquing the DMHP.

Interestingly, there are as many answers to this as there are many Ramayanas. (Well, maybe not quite as many, but many “tellings” of the answer do emerge.) In fact, depending on whom one asks the question of, very different stories emerge.

There have been a number of appraisals of the current status of the delivery of mental health services in the country, and the effectiveness of the DMHP, and these have yielded interestingly different conclusions and pointers to the ways ahead.

Jacob (2011: 53: 195-98) in a recent guest editorial is quite categorical in the opinion that “Despite it’s good intention, the programme failed to deliver”, going on to say that the situation on the ground in most LMICs (low and middle income countries) has not changed. The national programs remain on paper while some smaller initiatives, after the initial fanfare, are dysfunctional. Other attempts at appraisal offer different perspectives.

The World Health Organisation and World Organisation of Family Doctors (WHO/WONCA) joint report on “Integrating Mental Health into Primary Care – A Global Perspective”5 in 2008 cites the Thiruvananthapuram district in Kerala as an example of success of the DMHP, quoting it for other low resource countries to follow.

An oft-repeated point has been that there has been no independent evaluation of the DMHP. Such an evaluation was conducted in 2009 by the Indian Council of Market Research, at the behest of the Ministry of Health and Family Welfare, Government of India. Twenty districts from different zones and five non-DMHP districts were evaluated. Various parameters of efficacy of the programme were evaluated, including areas of capacity building, awareness of mental illness in the community and the beneficiaries, the process of diagnosis,
medication and personnel availability, and budget allocations and utilisation.

A wide variety of administrative, managerial and implementation problems were flagged by the evaluation, which included shortage of trained personnel, difficulties in retaining committed staff, delays in initiating programmes, low utilisation of funds, and difficulties in accessing the funds.

Intriguingly, however, among many other suggestions and recommendations, the Indian Council of Medical Research suggests the expansion of the programme to the other districts of the country.

In a clinical ethnographic exploration of the community mental health programme in the Kanpur DMHP district, Jain and Jadhav (2009: 60-85) opine:

As the pill journeys from the Ministry of Health to the clinic, its symbolic meaning transforms from an emphasis on accessibility and participation to the administration of a discrete ‘treatment.’ Instead of embodying participation and access, the pill achieves the opposite: silencing community voices, re-enforcing existing barriers to care, and relying on pharmacological solutions for psychosocial problems. The symbolic inscription of NMHP policies on the pill fail because they are undercut by more powerful meanings generated from local cultural contexts. An understanding of

Isaac (2011), one of the architects of the current DMHP format, in a plea for reappraisal of the DMHP, asks a few pertinent questions:

• Is the main approach of the NMHP, namely, integration of mental health with primary care still the right approach?
• How effective is the implementation of the NMHP?
• Is there any evidence for the effectiveness of primary care of mental health?
• Has there been any independent evaluation of the DMHP?

He suggests a number of measures, which include looking at local modifications of the plan, strengthening of the sub-centres, capacity-building, and community participation. He also explores the possibility of integrating it with other governmental programmes like the National Rural Health Mission (NRHM), and strengthening partnerships with the non-governmental and private sectors.

Jacob (2011: 195-98), raising similar concerns, is of the opinion that the new community care initiatives, largely driven by World Health
Organisation (WHO) ideology, are merely, a “slick repackaging” of older models, and so doomed to failure because they do not take into consideration the ground reality in the third world. They do not factor in poor infrastructure, overburdened systems, inappropriate training, professional apathy, problems with finance and delivery and a paucity of technical and advocacy inputs, and are therefore destined to the same dismal fate.

The Ministry of Health and Family Welfare in 2011 set up a policy group, to help frame a national mental health policy, and in the process prepare a Situational Analysis for mental health care in the country and the current provision for mental health care in the country, including issues of human resources, essential drug procurement and distribution, advocacy, prevention of mental illness, rehabilitation and care and promotion of mental health.

Murthy (2011: 26-35), another architect of the DMHP, has, made an exhaustive review of community mental health initiatives in India, attempting to list its limitations, successes and problems.

Describing both the strengths and weaknesses in the delivery of public mental health service, he writes about the developments in general hospital psychiatry, the benefits of family support, the space for traditional systems of healing, and the development of the private sector.

He suggests that future planning should talk about prevention and promotion of mental health, the need for decentralisation, resource development, support of both the non-governmental organisations and the private sector, increasing awareness, research activity and governance.

He says, that while there is actually a limited amount of published data evaluating the functioning of the DMHP, “published papers and (an) independent evaluation of the DMHP, indicate that the DMHP is, to a large extent, ineffective in practice”.

The Impact of the DMHP

If we are to step outside the realm of the world of published data and try to see what actually happens on the ground, and see in what way the DMHP has made any difference to the lives of people living with mental illness, what emerges is not particularly positive.

In this process, the authors, as members of the policy group, have attended a number of the DMHP reviews conducted by the Ministry of Health and attended by the nodal officers of the DMHP. This was followed by a number of visits to various DMHP sites in an attempt to answer the basic question – Does the DMHP work and in what way does it need to be modified to make it more effective?

In a sense the answer to this vexed question lies with Ramanujan. All the “tellings” are true. In most of the districts where the DMHP is funded, not very much is actually happening. In some places human resources are not available, in most places medication is not. The difficulties with access to and availability of funding is an oft-repeated tale. The problems with implementation are many, the issues with governance are clear. Mentoring, monitoring and audits are woefully inadequate. Interestingly, the problem is not actually availability of finance. A rather large part of the allocated budget lies unutilised, because the DMHP sites are either unwilling or unable to access them.

The basic ideology of the focus of integration with primary care and how specialist driven the service should be, are questions that get answered by ideology and rather fixed positions.

This is not necessarily to suggest that the ideology is flawed, but rather that, like all ideology, much more needs to happen on the ground for it to be convincingly accepted.

This, however, should not distract from the fact that in many places sterling work is actually being done. With limited resource, and despite innumerable hurdles, in many districts, innovative and interesting strategies are adopted. In fact, the narrative that the DMHP is a failure, and does nothing, would, to our minds, be as invalid, as the one that whitewashes it with the false patina of unblemished success.

In the course of visits across many DMHP sites, we found, among other things, the records instructive. In Hoshiarpur district in Punjab, the register maintained at the DMHP site was an endless series of undecipherable squiggles. In neighbouring Sangrur, the register quoted diagnoses of schizophrenia, bipolar disorder, delusional disorder, anxiety states, and trichotillomania (a syndrome where the patient plucks hair from the head and swallows it), reading very much like a compendium of psychiatric diagnoses. In a sense, also, the moving away from the published literature to the stories on
the ground, may, by moving from one form of narration to another helps us go beyond the projected fact and understand ground realities better.

What is also interesting is that the fidelity to the original DMHP model is actually quite variable and hence the degree and nature of integration of the service with primary care is very different.

So Karnataka still follows the original Bellary model on which the DMHP is conceptualised, while in neighbouring Kerala the service tends to be more specialistled. It is also instructive that Kerala is most often quoted as success of the DMHP model.

**Ramanujan and the DMHP.**

So, depending on the perspective of the narrator, we could tell the DMHP story as a heroic struggle against overwhelming odds or as a case of abject failure. We could cast alternatively in the role of villain or hero the primary health centre doctor, the specialist, the state government administrator, the grand panjandrum in the central ministry. We could deify or demonise the ideological underpinnings of the model. Therefore, depending on the teller and the construction of the tale, the blame for non-performance can be laid squarely on the lack of implementation as a failure of governance and “hand holding” by the central ministry, a failure of dialogue within the ministry, and a communication wall between the directorates of health and medical education, a wall between state and centre, apathy in states, and the list essentially is endless. And each narrative would both be real and interconnected.

This is, as Ramanujan tells us, the intertextual nature of narrative. *These various texts not only relate to prior texts directly, to borrow or refute, but they relate to each other through this common code or common pool. Every author, if one may hazard a metaphor, dips into it and brings out a unique crystallisation, a new text with a unique texture and a fresh context.*

Where this takes us, inevitably, is to what the new, improved version of the DMHP should look like and what relationship this should have with its earlier avatar. To understand this better, we suggest that we turn again to Ramanujan.

As Ramanujan says, *Now, is there a common core to the Rama stories, except the most skeletal set of relations like that of Rama, his brother, his wife, and the antagonist Ravana who abducts her? Are the stories bound together only by certain family*
resemblances, as Wittgenstein might say? Or is it like Aristotle's jack knife? When the philosopher asked an old carpenter how long he had had his knife, the latter said, “Oh, I’ve had it for thirty years. I’ve changed the blade a few times and the handle a few times, but it’s the same knife.” Some shadow of a relational structure claims the name of Ramayana for all these tellings, but on closer look one is not necessarily all that like another.

So, as we prepare to change either the blade or the handle, it may be wise to remember the different telling of the tale and the nature of the intertextuality, which would be the nature of the conversations that both the narratives, and the narrators would have with each other. To carry the metaphors of the Ramayanas further, it may be a good idea to refer to Paula Richman (1991), who, in her introduction to this powerful essay, talks about tellings as both “re-fashioning” and opposition, and as commentary and programmes for action. Quoting Thapar (1989), Richman is specific in warning us about monolithic state-sponsored versions of narrative. An obvious caveat to this would be that, looking at mental health delivery to the community as state responsibility, as we do, the contextuality of state-sponsored narrative is obviously difficult to not pay heed to.

The next logical step that this takes us to is that while the Ramayana is one telling of the life of Ram, Sita, Lakshman, and Ravan, other powerful and valid narratives exist. Similarly, the DMHP is one telling of the story of mental health delivery in a pluralistic reality. Other narratives, often counter to this narrative, do exist, and ignoring them is something we do at our peril. In another essay, Ramanujan (1989), exploring the nature of Indian thought, quotes a parable about the Buddha. He says:

Once a man was drowning in a sudden flood. Just as he was about to drown, he found a raft. He clung to it, and it carried him safely to dry land. And he was so grateful to the raft that he carried it on his back for the rest of his life.

It could be posited that the DMHP is the raft that we are, as the Buddha ironically tells, carrying with us. If, for the purpose of argument, we were to accept this, then we may want to start thinking beyond the scope of the DMHP, in dimensions of both time and space. Essentially, a programme of the nature of the DMHP is conceptualised as a short-term initiative, which then is meant to seamlessly flow into a continuing care system, and this is something that has not really happened with the DMHP. This may be a good time to start thinking of these issues.

An Indian Way of Thinking
To extend the use of metaphor further, and paraphrase Ramanujan, in his second essay, we could ask –

• Is there a DMHP way of (mental) healthcare?
• Is there a DMHP way of healthcare?
• Is there a DMHP way of healthcare?
• Is there a DMHP way of healthcare?

To attempt an answer, psychiatric care in India has not developed a clear ideological position, and has largely relied on empiricism. Thus, the first query is not likely to be true, as the practice is not underwritten by any one ideological or scientific position.

There are, however attempts to codify or simplify procedures, so that a simulation of uniformity is produced and the answer to the second is a qualified yes. The answers to the third and fourth are probably the more revealing. So, whether there is a DMHP way of thinking and healthcare, begs the question as to whether the programme becomes autonomous, or whether it is seen as a short-term enabler of healthcare delivery. This is particularly worrying, as there is no apparent planning for subsequent upgrading and evolution of services. The DMHP premise of a chronic shortage of well-trained professionals for the poorer sections of society sits uncomfortably with the burgeoning medical education, and private healthcare provision sector, which are seen as a successful business model. The relations between this de-professionalised service and the growing number of professionals, and the health industry have obviously been a source of tension, leading to questions being asked about the intent and nature of the DMHP. Visions of the DMHP thus tend to be viewed through preconceived notions about the nature of healthcare, and the role of the state and civil society in providing this. In the meantime, the number of mentally ill has continued to grow, the initial euphoria about the “success” of new psychiatric medications has been tempered, and planning for the future now has to be even more
pragmatic. This two stream system will accentuate disparities, and authenticate, even validate, them.

Healthcare that is low cost, locally sensitive, respectful of diversity, and deliverable through minimal investments in skills has been attempted in many postcolonial countries. Austerity is criticised as a false remedy for the economic crisis of European Union and North America (with much dismay expressed about its impact on health and welfare services), while permanent austerity is portrayed as a virtue for the rest of the world.

In many ways, the answers will be myriad, and pluralistic, but, all, we think, are worthy of debate. We also need to realise that even if no concrete answers emerge at this stage, this debate and the recognition that the impact of a single monochromatic rendition would be limited is important. For effective intervention in both policy and planning, we will need to view healthcare in the wider social and political matrix of healthcare.

Notes:
4. The Beveridge report available at: http://www.sochealth.co.uk/history/beveridge.htm


References:
2015 World Congress of WAPR in Seoul

Date: Nov, 1st~4th, 2015
Venue: Grand Hilton, Seoul, Korea
www.grandhiltonseoul.com
Tsunami is a Japanese word describing the angry sea that follows undersea earthquakes. But Tsunamis are not unknown in South and South east Asia. Folklore warns people on the coast that if you see the sea retreat watch out there is a tsunami on its way – run to higher ground. In South India the Tamil word Kadalkol describes the killer sea that the tsunami describes and is said to have swallowed two previous cities of Madurai in living memory leaving the recent Then Madurai the successor. The ancient people of Nicobar fled to hills at the first warning of a tsunami on 26th of December 2004.

But thousands in nearby Andamans in India Aceh province in Indonesia, the east coast of Sri Lanka around Mullathivu, and Galle, the beach resorts of Phuket and the coastal folk did not recognize the dire warnings and were drowned as the racing 500 mile an hour tsunami overwhelmed them in a flash. Indeed neither it seems did sophisticate tsunami warning centres around the world see the warnings of the tragedy that was unfolding .

All things considered it appears most relief and emergency bodies were caught unawares. When they found their feet aid for physical relief rushed in by air and sea. Search and rescue teams medical and health teams Field hospitals and water purification units flooded in – but the weeping masses the hysterical women who lost all were largely left to recover on their own. The Health it appears once again forgot the mental in health. Indeed one of the immediate calls for help from leading psychiatrists in S E Asia was met by responses such as ‘there is no need to rush in , let them get blankets and tents and water first’ from those further away. However neighbouring
countries’ mental health teams did rush in with psychiatrists and mental health workers who spoke Bahasa Indonesia/Malay/Tamil to help those in Aceh and eastern Sri Lanka. They stayed on supported by ad hoc support for a few months until things stabilized.

But what was badly needed was on site mental health services that most affected areas lacked. Training of counseling workers and basic mental health trained doctors and nurses was of the essence the crucial aid needed. A lot of theories in managing disasters in the mental health field needed revisions and experts the world over with experience were asked to help – with varying degrees of success. Aceh had but 3 psychiatrists for its 4 million people, East and south of Sri Lanka less than 5 and the Phuket area similar numbers. Colleagues from the rest of the country and some from overseas had 2
to rush in. The response from the rest of the world was slower and uncertain. The humanitarian tragedy of monumental proportions that took over 170,000 lives in Aceh alone with over 40,000 in one district of Meulaboh in Aceh - found the psychiatric community and medical community wanting

The problem that most local professionals realized after the fact was a woeful lack of adequate numbers of trained human resources in mental health to cope with a tragedy on this
scale. Aceh was by no means alone in lack of mental health services - the badly affected areas of Sri Lanka, Thailand, and India all had less mental health staff than needed even in normal times. In Aceh, with a then population of about 4 million, there were not more than 3 psychiatrists – and all based in Bandar Aceh, the capital and one old mental hospital with about 150 beds had the mental health service for the conflict torn province now battered by a sudden tsunami. The tsunami killed some of the patients and injured staff and patients and left the province without mental health services. Many hospitals and clinics were damaged and Indonesian and many aid agencies from overseas rushed to rebuild them while Indonesians psychiatrists from other provinces and colleagues from Malaysia who speak the same language provided professional psychiatric help for several months after the 26th December 2004. International NGOs in health like MSF, IMC, and CBM provided medical assistance. After appeals from the WPA Zone representative for Zone XVI the WPA called for a meeting in Cairo in early February to appoint a Task force for Tsunami to assist Indonesia and Sri Lanka Psychiatric associations with emergency training for volunteers in emergency and disaster counseling. A sum of 20,000 USD was spent on this.

What followed after the tsunami were efforts to strengthen the mental health infrastructure and build new systems to cater for the casualties of the disaster assisted by WHO, Indonesian Government and NGOs. These took the form of training assistance consultancies and curriculum development for GP- PLUS Primary care Nurses PLUS that upgraded their mental health knowledge and skills to cope with basic mental health care and consequences of disasters. The next step was the start of mental health units in the 6 or more district level general hospitals that had no psychiatric services prior to the tsunami. Principal among the needs was the town of Meulaboh which was one of the worst hit outside of Bandar Aceh. Meulaboh suffered 40,000 deaths and its hospital was very badly damaged. The Singapore Government rebuilt a more modern Cut Nyak Dhien Hospital (named after an Acinese Heroine in the war against the Dutch) in Meulaboh and the kindness of the Hospital administration and doctors allowed a 10 bed Mental Health ICU – the first in Aceh to be set up. Gradually 6 of the district hospitals have built small 5 to 20 bed mental health ICUs. But more than that every ICU in mental health in 6 districts is staffed by a psychiatrist trained in the 4 year national postgraduate psychiatry residency programmes all over Indonesia and sponsored by funds from the Districts themselves except for the first psychiatrist whose training was funded by CBM.

The Mental Hospital in Bandar Aceh (RSJ Bandar Aceh) severely damaged by the tsunami was rebuilt by the Indonesian government with assistance from Norway into a 320 bed modern psychiatric hospital and staffed by no less than 9 psychiatrists.
In 2012 a team led by Dr Yani Director of Health Services Aceh embarked on adding psychosocial rehabilitation services to the already strengthening curative mental health services in Aceh.

Dr Yani led a team from Aceh supported by CBM and facilitated by its Regional Mental Health Adviser, Dr. Andrew Moh.

Anraj visited 3 Psychosocial Rehabilitation Day Centres in Malaysia in 2012 at Sungai Buloh, Petaling Jaya and University of Malaya medical centre. The briefings and experience stimulated staff in Aceh to start PSR centres of their own. Using a Saudi built Primary Health Care Centre that had recently become vacant in Lam Rabo, Kuta Baro in Aceh Besar, the hard working team obtained strong support from the community in the district to organize the activities for clients who were treated but needed rehabilitation to be functional. The building is situated on the grounds of a mosque which generously allowed the centre to be set up. A launch of the centre was held on 16th May 2013 and attended by Provincial Mukim and district officials representatives from CBM Indonesia, Founder of AFPA which awarded the Centre a Plaque for a Centre of excellence in PSR in Post Tsunami, Post conflict.

Aceh. Hopefully the Centre at Lam Rabo, the first of its kind in Indonesia following the multiple traumas of 2004-5 will be the beginning of more in Aceh and Indonesia.
Compagnie de l’Oiseau-Mouche is a permanent professional theatrical troupe made up of 23 actors, all of them individuals with an intellectual disability. Unequaled and unusual, its theatre is aimed at our human essence. Created in 1978, the project remains unique in France. Each creation is the result of an artistic encounter between an invited artist and the actors he chooses to involve in this collaborative adventure. As of today, 38 theater performances have been created and performed over 1,400 times in France, Italy, Germany, Switzerland, Spain, Canada and Peru, among others. Since June 2001, Compagnie de l’Oiseau-Mouche is based at Théâtre de l’Oiseau-Mouche/Le Garage in Roubaix, Northern France. This theatrical creation and research center was designed by and for Compagnie de l’Oiseau-Mouche. Each and every season, the theatre opens its doors to other artistic teams on the basis of an active partnership with the troupe.

In 33 years, the company has surpassed the initial goals set at its inception. What seemed impossible for the pioneers of the 70s became the newspaper of the current generation of actors.

Until 1987, the company explores the aesthetics of theater gestures. The text is very present and artists that depict the company are not convinced that the actors can embody speech on stage. This block is exceeded in 1987, the text appeared with Rapt, Philippe Vaernewick and dramaticules Beckett, directed by Stéphane Wart. In 1995, began working with Antonio Vigano which gives rise to three characters whose creations, from Six Characters in Search of an Author by Luigi Pirandello. This is the second show the most played of the company with 146 performances in 10 years. He got the Stregagatto Price in Italy in 1999 (best show for youth).

In the early 2000s, the text becomes a strong component of the theatrical work of the company.
with Phaedra and Hippolytus by Jean Racine and Shakespeare's King Lear, directed by Sylvie Reteuna. Then come Mother of Bertolt Brecht, directed by Françoise Delrue, The Child of the Jungle by Rudyard Kipling An Odyssey by Homer, both directed by Christophe Bihel. Show the most played in the history of the company, The Child of the Jungle celebrated its 150th performance in 2011. The latest creation of the company, "Bird- Fly" was directed by Christophe Piret. In October 2011, the company partners with Cedric Orain for a new creation out of the body, in which the actors explore the language Novarina.

Compagnie de l’Oiseau-Mouche. Director Stéphane Frimat.

Development Manager Cécile Teurlay | cteurlay@oiseau-mouche.org

138 Grande Rue, 59100 Roubaix | France, Tel. : +33 (0)3 20 65 96 52 | Fax : +33 (0)3 20 73 61 72 |

www.oiseau-mouche.org
Collaborations

Fighting stigma. Case Reports:
Taiwan. McDonald’s Taiwan discriminates against Down’s patron.
Spain. Down Syndrome Association fights a case of discrimination in a hotel.
Spain. Angela Bachiller has become in the first council with Down syndrome.

McDonald’s Taiwan discriminates against Down’s patron.
Eva Teng (General Secretary, TAPR)
Shuo-ya, Nancy Liu (Volunteer, TAPR)

McDonald’s fast food restaurant is known internationally for providing a friendly, welcoming and joyous dining atmosphere for the family. All children are fascinated with Ronald McDonald, the primary mascot of the food chain, and his friends. It is not uncommon to see children’s faces lit up when they pass by the big yellow “M.” Nonetheless, an incident that recently took place in southern Taiwan showed that we could all be wrong about the McDonald’s franchise and the values that it held so ardently.

On June 21, 2013, a woman with Down’s syndrome went to McDonald’s Yochang outlet in the southern port city of Kaohsiung to buy ice cream. The woman, surnamed Wang, was in her forties. She walked in and tried to make an order, using the discount coupon she received earlier. Since Wang was not able to express herself clearly due to her health condition, she retreated quietly to a corner, trying to figure out what to do next.

At approximately the same time, the manager of McDonald’s Yochang outlet called the police and falsely reported that “a homeless person was shouting loudly at the restaurant, causing trouble to other customers.” The police was asked to “come to the restaurant and drive her away.”

The police arrived at the scene about ten minutes later but did not see any homeless person making a scene. The manager pointed to Wang as being the one causing inconvenience to other customers. However, after interviewing the customers, the police was sure that Wang did not affect their dining experience.

“Just get her (Wang) out of here, we have a business to run,” the McDonald’s manager told the police, adding that “the police are supposed to help people solve problems. You could either bring her away or put her in a hospital.”

In the end, Wang’s neighbor accompanied Wang home. The police told the media covering this story that they thought the McDonald’s manager lacked sympathy.

A local newspaper Apple Daily ran an exclusive story on this discrimination incident the next day on June 22. After the publication, several media outlets flocked to Wang’s family and neighbors for comments. Wang’s neighbors described Wang as a quiet, kind person who...
never gets into a fight with anyone. Wang’s mother who is just diagnosed Alzheimer’s disease said her daughter was so shocked that day that she took shower five or six times after returning home. Wang also has a brother with mental disorder.

On June 23 and 24, local media continue to cover McDonald’s ill treatment toward Wang. Supporters and disability groups also voiced their condemnation toward McDonald’s response. An assistant manager Ms. Tsai from McDonald’s public relations department explained that “there was a misunderstanding in communication” and that they had “called the police for the sake of Wang’s safety.” The fast food franchise refused to apologize to Wang, promising only to enhance their staff education. In a statement, International Down’s Association noted that McDonald’s response was “shameful.”

On June 25, numerous disability rights groups and human rights organizations, including Taiwan Down’s Foundation and Association, The League of Welfare and Disabled Organization R.O.C., Parents Association for Persons with Intellectual Disability R.O.C., Taiwan Association of Psychosocial Rehabilitation (TAPR)…etc. gathered at McDonald’s Taiwan headquarters in Taipei to lodge a protest. They demanded the disclosure of truth, a public apology and a promise from McDonald’s that such a discriminatory act will never happen again. More than a hundred people with Down’s syndrome also showed up at the protest, voicing their concerns.

Regrettably, McDonald’s executives did not come out to meet with the crowd. An official lady Ms. Chou who is a manager of public relations department told the media that McDonald’s “apologize for Ms. Wang’s uncomfortable dining experience,” but refused to admit that their conduct was discriminatory.

On the same day, Taipei City Government’s Department of Labor noted that McDonald’s is a frequent offender in terms of failing to hire disabled staff. McDonald’s is currently at the top of the list of rule-breakers for failing to recruit 19 physically or mentally challenged staff members. In comparison, other fast food chains like Kentucky Fried Chicken, MOS Burger and Burger King have all fulfilled the hiring requirement. It is obvious that McDonald’s is a business that lacks corporate social responsibility.

Two separate protests were staged on June 26. People with Down’s syndrome and their supporters gathered in McDonald’s Taiwan headquarters in Taipei and McDonald’s Yochang outlet in Kaohsiung. Up to this stage, the incident had caught the attention of not only local but that of the international media. The head of Taipei City Government’s Department of Labor said he would write a letter to Don Thompson, president and CEO of McDonald’s Corporation, and ask him to support the rights of the disabled.

Seven days after the incident, on June 27, the operation vice president Ms. Lu finally extended an apology to Wang. On behalf of the franchise, the vice president said she “apologizes for Ms. Wang’s uncomfortable dining experience” and presented a NT
The case went on for more than four years. In December 2010, the jury agreed that McDonald’s had violated human rights law and was discriminatory toward physically disabled customers. The court ruled in favor of Larson and ordered McDonald’s to compensate Larson US$65,000 (NT$ 1.96 million). (source: http://www.ettoday.net/news/20130623/229064.htm#ixzz2YXVKm2Cv)

McDonald’s Corporation is one of the world’s largest fast food conglomerates today. Don Thompson, president and CEO of McDonald’s Corporation, should take the matter of corporate social responsibility seriously. Consumers should also take the opportunity to re-examine McDonald’s franchise and the value it promoted. If, in the future, McDonald’s continues to fail the public expectation in protecting the rights of the disabled, consumers should resort to boycott.

A letter to McDonads’ General Masnager Taiwan from Dr. Harry Minas, Regional WAPR Vp.

9 August 2013

Dear Mr. Tan,

I have received a report from the Secretary-General of the Taiwan Association of Psychosocial Rehabilitation of what appears to have been a disturbing incident of discrimination by the manager of McDonald’s Yochang directed at Ms. Wang, a woman with Down’s Syndrome. I need not go into the details of the incident as you are now very familiar with them and they have been the subject of newspaper and other reports, and comments by many organisations, including the Down Syndrome International (Dsi).

It would appear that representatives of McDonald’s have not acknowledged that the conduct was discriminatory, have not adequately apologised to the person concerned or offered to make adequate restitution for the conduct. Apologising to Ms. Wang for her “uncomfortable dining experience” and presenting her with a NT$1000 McDonald’s gift card falls far short of what is required. It would also seem that McDonald’s Taiwan has not set out in a clear and convincing manner the steps that it proposes to take to prevent any further similar occurrence.

Beyond this specific instance of what appears to have been discriminatory behaviour it is also a matter of concern that the Taipei City Government Department of Labor has said publicly that McDonald’s is failing in its obligation to employ persons with disability as required by law.

I hardly need to remind you that discrimination directed against persons with disability contravenes both domestic and international law, and that the reputation of McDonald’s in Taiwan has taken a battering because of
In addition, I’m also pleased to say that starting in 2014, we will be organizing 100 McDonald’s Taiwan “Charity day” events annually, hosting parties for disadvantaged children at selected restaurants around the country to bring small joys to these children, while allowing our staff to partake in the rewarding experience of being able to serve and host these children personally at our restaurants.

It was helpful to bounce these ideas off Eva and I am glad that we were able to engage the TAPR on a collaborative basis, and that you found our plans to give back to the community in a small way constructive.

I look forward to working with the TAPR, and other social welfare organizations in Taiwan as we strengthen McDonald’s commitment to Taiwan.

Final Remarks

After the incident, our alliance of advocacy groups hoped McDonald’s Taiwan could admit the fact that the incident was discriminatory against disabled people, and wished that they could try to take appropriate actions to improve their social accountabilities.

Fortunately, when the new General Manager of McDonald’s Taiwan, Mr. Tan who was on board and received the letter from Harry Minas on behalf of WAPR in August, he addressed to us sincerely and tried to make things go to the right way and initiated some action plans good back to disadvantaged people and society, such as enhancing their staffs awareness and understanding of Disabled after our meeting. I really hope it is not just a one-year plan in McDonald’s Taiwan. Through Mr. Tan’s leadership and his team, we wish TAPR and the other NGOs could continue to help and support people in need with McDonald’s Taiwan together for our better society.

In Taiwan we build a very strong network and trust with many NGOs and experts like lawyers, professionals of social welfare and health field, care-givers and users, etc.. to be an alliance. We have a mechanism to gather key persons and have action plans soon when some human rights violation or discrimination incident happened. We are not alone. That is why the informal alliance could work very effectively. Human rights are not only a concept but also an action. For any society, corporations or persons to advocate or support human rights, actions always speak louder.

Next year we will review and look at how do ICCPR, ICESCR and CRPD, especially more focus on CRPD, implement in Taiwan. We do absolutely need support from WAPR members.

Answer from Mr. Wern-Yuen Tan, General Manager McDonald’s Taiwan

Thanks for the perspectives from TAPR, WAPR and Dr. Harry Minas. In my capacity as General Manager of McDonald’s Taiwan, I would first and foremost like to reiterate our absolute commitment to providing quality service to all customers without discrimination.

Having been part of the fabric of Taiwan society for 30 years, McDonald’s takes our social responsibilities very seriously, and welcomes opportunities for collaborative engagement with other key stakeholders and NGOs such as the TAPR. It was helpful to benefit from your thoughts on how McDonald’s Taiwan and other enterprises in Taiwan can strengthen our commitment to the disadvantaged among us, particularly in raising public and employee awareness of the needs of individuals with mental and physical disabilities. Improving the lives of disadvantaged children is an area we are uniquely able to help with, and in addition to our ongoing support of children and their families in need via the Ronald McDonald House Charities, is an important corporate social responsibility that we take very earnestly and seriously.

As we discussed with TAPR, McDonald’s Taiwan looks forward to being able to help contribute back to society to improve the lives of disadvantaged children in Taiwan in two main areas:

- Improving public awareness of the needs of disadvantaged and disabled children; and

- Enhancing our employees’ internal awareness of how to help support these individuals, and create real-life opportunities for our employees to experience the joy of giving back to society in a small way

Since we spoke back in July, we have strengthened our staff training procedures and systems to identify and assist disadvantaged / disabled customers at our restaurants. We are committed to an ongoing review of our practices and performance in this area to ensure compliance with our high standards of conduct.
Spain: Down Syndrome Association fights a case of discrimination in a hotel.


The Spanish association “Down España” (www.sindromedown.net) has claimed that a hotel belonging to a large hotel company prevented a group of young people with Down syndrome in their Prom Trip because “these people could disturb the rest of the customers.” The hotel management apologized to the association and said it was “a misunderstanding”. The case is in the hands of the prosecutors’ office of Almería (Spain).

According to the organisation’s denounce, Down Almeria requested a travel agency a budget for hosting a Prom trip for a group of young people with Down syndrome. However, one of the hotels, said the agency, could not provide a budget due to "we do not accept groups of people with mental disabilities".

The association decided to make it public "not for victimhood, but to make public pedagogy," says Agustin Matia, manager of Down Spain.

The organization notes that when Down España contacted the hotel management to seek explanations, "they reaffirmed their position," adding that "these people could disturb other hotel guests, "as it has happened in the past".

The association took the matter to the attention of the Office of the City on the grounds that "constitute a clear case of discrimination against persons with disabilities and which violate the International Convention on the Rights of Persons with Disabilities ratified by Spain", which prohibits "any discrimination based on disability."

Down Spain recalls two other cases in which the access of young people with Down syndrome to a disco was prevented in Sabadell, last March, in a pub in Alicante in 2010. The owner of the pub was banned a year later. In 2009, a parish priest refused to give first communion to a girl Teia (Barcelona) because she was "an angel of God."

Meanwhile, sources in the direction of Almeria hotel claim that "had already apologized to the association, because it was all a misunderstanding", as in the booking centre they thought it was another group with other intellectual disabilities that had already been in the hotel, and had been "very controversial."

They also state that the staff is "very concerned" about what happened, which is having a strong impact on social networks, and influence that the accusation that the establishment refuses entry to these people directly affects the "dignity" of their employees.

The hotel says has also released a statement saying that "never in 35 years of life" of the hotel has refused entry to a group of people with Down syndrome, "have been, are and will be always welcome". "In fact, we count among our regular customers families of people effected by this syndrome, and are received as anyone else, since the service they require are exactly the same as any other person, and as such they are treated," says the company.

When faced with these situations of discrimination, the association encourages families and organizations to ask for a complaint form, to record what happened, and make contact with the prosecutor’s office, as it tends to act ex officio.
Valladolid, Spain; Angela Bachiller has become in the first council with Down syndrome.


Angela Bachiller has become, at age 30, in the first council of Spain with Down syndrome. She has been two and a half years working in the administration of the City of Valladolid and yesterday took the office after the resignation of another council.

Excited and smiling, Angela swore their allegiance to the King and the Constitution surrounded by cameras, family, friends and members of associations for the disabled. "Thanks everybody for giving me confidence," was all she could say, nervous and overwhelmed by the impact of the act.

Bachiller was submitted to the municipal elections of 2011 at number 18 on the list of her party, which had 17 councillors. She had been serving the city as administrative assistant in the area of Social Welfare. During the election campaign the gained the trust of his party colleagues and now, as a councillor, will have to attend plenary sessions, meetings and informative committees. She will also be the representative of the PP in the Municipal Council of Disabled People of City Hall.

This appointment is not her first milestone. Angela was the first person with Down syndrome to obtain the title of Professional Training of Castilla-León. He had studied in the same public school and high school that her older sister aged 33. “She is a referent for all us”, reflects Isabel Guerra, his mother. “The most important thing is that her family has not adopted a over protector role”, said Rosa Hernandez, Councilman and Head of the Family and Welfare Department in which Bachiller took three years of administrative assistant. After six months in an integration program for disabled workers, Bachiller was awarded a contract to continue at the City Hall.

She is widely considered as a "tenacious" person and able to carry out their work "at all times". In the same vein, Angel Bachiller, father of the new council, defined her as a "breeding fathead", "very responsible" and “able to get what he wants”. “If she had to get up at six instead of seven to study because she need more time, she did,”recalls over the years in high school. Angela plays piano "very well" and helps his father when he is in trouble with his computer. "If she can do something for their peers, will do”.

“This is very positive for Down fellows”, she says. His mother also says that his appointment is an "important milestone" for their collective. Angela has always voted, but it is not the case for all people with mental disabilities. Many people with psychic disability in guardianship loose their right to vote.

The opposition party of the city of Valladolid welcomes her entry into the City Council. “ It is only an issue of normalcy,” said Oscar Puente, president of the Socialist Group of the Consistory: " This can be a stimulus for people in this situation to integrate into society".
The meeting was attended by 350 delegates from Pakistan and by 35 overseas participants with a special participation from the Asian countries.

The conference was co sponsored & supported by:
• World Psychiatric Association (WPA)
• World Association for Social Psychiatry (WASP)
• World Federating for Mental health (WFMH)
• Pacific Rim College of Psychiatrists (PRCP)
• South Asian Forum on Mental Health & Psychiatry chapters
• Asian Federation of psychiatric associations (AFPA)
• Asian Network of Bipolar Disorder (ANBD)
• British Pakistani Psychiatrists Association (BPPA)

Speakers from Austria, Australia, Bangladesh, Iran, Italy, Malaysia, Palestine, Spain, Switzerland, Thailand, Turkey, UAE, UK and USA.

Inaugural lecture by Prof Norman Sartorius (Switzerland) former Head of WHO Division on Mental Elath.

Inaugural function at Fountain House (a state of the art facility for psychosocial Rehabilitation for mentally ill) presided by Governor of Punjab and Conference dinner attended by Federal Health minister as special guest.

Scientific programme with presentations from more than 40 speakers from Pakistan & abroad & including 22 sessions comprising of Plenary & Special sessions, Training courses, Workshops and Teaching programmes.

Special Forum on “Promoting collaboration in the Asian Region” attended by key psychiatrists, leaders & representatives of National associations from Asian countries.

Meeting of overseas experts with College of Physicians & Surgeons officials and Pakistani academics for future collaborative links in the fields of teaching & training

Meeting with Federal State Health Minister and Health Department Government of Punjab for exploring future service development opportunities in the country

6 Academic / educational Workshops on:
• Child & Adolescent psychiatry
• Rehabilitation outcomes measures
• Setting up Rehabilitation services in low income countries
• Personal Recovery in Psychiatric illnesses
• Forensic psychiatry
• Treatment & management of Drug dependence
• Educational workshop on Treatment issues with antipsychotics.

3 Special sessions on:
• Terrorism and political violence: psychiatric and psycho social understanding
• Ethics & mental health
• Human rights & mental health (in collaboration with WHO)

2 Special Plenary sessions on:
• Developing Psychiatric Services in Pakistan (including general & specialised services)
• Young Psychiatrists session on Career in Psychiatry & future perspectives: A Conversation with Prof Norman Sartorius former head of WHO Division on Mental health

Special educational session organised by Asian Network of Bipolar Disorder (ANBD)
Special Teaching & Training Course for General Practitioners & Family Physicians
Poster presentation competition for Pakistani junior Psychiatrists & trainees in Psychiatry
Introduction of TAPR (Taiwan Association of Psychosocial Rehabilitation)

A. TAPR History
TAPR is a young organization which was established by a group of senior, dedicated health and communication professionals in July, 2010. For the first General Assembly Mr. Jung Chang Wang was elected as the first President. The TAPR board of directors and members are professionals with different expertise, such as psychiatrists, social workers, occupational therapists, communication experts and advocates working with women, disabled citizens and people in need, and therefore provide quality services with enthusiasm. The missions of TAPR are to promote health and well-being, increase health literacy from psychosocial perspectives, and support people in their recovery processes. The objectives of TAPR are to raise awareness and understanding for the public, promote the perspective of “prevention is better than treatment”, to emphasize the importance of mental health, and participate in different events and activities to build a comprehensive and well organised health system in Taiwan.

B. Major Activities in 2013
Independent Living support program for people with mental disorders

“Independent living” for people with mental disorders is a new concept in Taiwan. Due to the influences of traditional social values and stigma, people experiencing mental illnesses are not allowed to be independent and their whole lives become family responsibilities. The goals of this program are to help service users to become aware of and understand the needs of independent living through a series of focus groups. 8 training classes are organised to develop the concepts and skills of independent living via a peer group. Furthermore awareness of their needs and ways of effective help-seeking for mental health care and other services is emphasized. This program is the foundation of TAPR’s major program “Action Research : Individual Independent Living Plan for People with Mental Illness” initiated 2012. In 2013 we also edit a pocket handbook about independent living resources the service users might need.

C. Work with WAPR
Fortunately, TAPR joined WAPR as a national branch in 2012 and attended 11th World Congress in Milan 2012 to start learning and working together with this big family. The first cooperation is “2013 Symposium: Health and well-being” in Taiwan.

2013 Symposium: Health and well-being

Dr. Ming Been Lee, Former President Taiwaen Medical Association, Dr Afzal Javed, President WAPR.
The Mental Health Act in Taiwan was amended in 2007. It emphasizes the importance of mental health prevention, community-based model services and human rights. This symposium was a response and follow-up from the MHA in 2007. The symposium was opened by Taiwan Ministry of Interior and Department of Health. It had over 150 participants consisting of professionals, students, family members and service users. We also had over ten professionals’ associations and other psychiatric units including Taiwanese Society of Psychiatry, Mental Hospitals etc. who co-sponsored this important event. The conference discussed more than 12 topics, such as the mental health promotion, human right, media and stigma, independent living support for mental disorders. Additionally, we have special thanks to our WAPR outstanding experts, the President Dr. Afzal Javed, the Vice President Dr. Tae-Yeon Hwang and the Vice President of Western Pacific Region Dr. Harry Minas. Their attendance and presentations were much appreciated and inspired the participants. The lecturers who are the key professionals and researchers of the mental health and psychiatric field in Taiwan made important and innovative contributions to the participants as well.

Taiwan is going to Executive division re-organization in this year. In the new division, the Ministry of Health and Welfare, the commission in charge of mental health level will be raised to Department Head Level, and combine the relevant fields, such as prevention, treatment, and rehabilitation with the Social Welfare Department. These
Symposium National Health Insurance in Taiwan. Prof. Chih Liang Young, former Minister of Health, and David Huang who is Director of Bureau of NHI.

Symposium Social housing, home care and independent living support in Taiwan. Standing right, Prof. Wan I Lin, National Taiwan University; left Mr. Jung Chang Wang, President of TAPR; CEO of Tsuei Ma Ma Foundation for housing and community service.

Topics are reflected the extent and complexity of mental health issues, including the promotion, prevention and recovery in mental health, the multiple treatment and rehabilitation approaches of mental disorders, the anti-stigma of mental illness and have a meaningful and dignified life with comprehensive community support. The main purpose of the symposium was in collaboration with other key mental health associations and people to develop a comprehensive mental health scenario for Taiwan in the coming future.

Due to lack of the overall picture of the mental health care development, Taiwan Government still remain focusing much more on treatments and hospital-based rehabilitation for people experiencing mental health problems rather than other issues from the Mental Health Act of 2007. However, with the raising awareness of human rights and social economic transitions changing, the policies are not able to meet the people’s needs. Thus, this symposium discussed these above important issues with the public and the mental health professionals to understand the meaning of “no health without mental health” (WHO). The TAPR will continue to carry on working with these goals as main tasks including promotion mental health without borders, raising the public awareness towards the human right issues, and the emphasis on cultural and community inclusion in order to be part of the global mental health family.
YEREVAN DECLARATION:
"COOPERATION FOR MENTAL HEALTH IMPROVEMENT"

'We,

The President of the World Association for Dynamic Psychiatry (WADP), the President of the World Association for Psychosocial Rehabilitation (WAPR), the immediate Past President of the World Association of Social Psychiatry (WASP), the President of World Organization of Family Doctors (WONCA) and the President of the World Psychiatric Association (WPA), meeting during the World Psychiatric Association Thematic Conference "Mental Health and Mental Illness: Focusing on Eurasia" held in Yerevan, Armenia from August 29 to August 31, 2013,

Considering:

• That mental health and mental well-being are fundamental to the quality of life of individuals, families, communities and nations;

• That promotion of mental health, the prevention and treatment, and the care and rehabilitation of mental health problems should be a priority for all Governments;

• The continuous increase in the trend of mental health problems worldwide;

• The important role of primary care in prevention, early detection and appropriate management of people with mental health problems;

• Co-morbid mental and physical disorders are common and make a significant contribution to the global burden of diseases;

Recognizing:

• The increasing responsibility of world organizations in confronting the challenges of globalization, including support to low-income countries;

• The lack of access to mental health services for people with mental health problems worldwide;

• The increasing burden of non-communicable diseases including mental health problems, on the economies of all countries;

• The impact of economic and political crisis on mental health;

• The lack of parity between mental and physical health funding and esteem;

• The stigma and discrimination affecting people with mental health problems;

• The importance of the involvement of patients and their families/carers in management programmes;

• Collaboration and integration among providers of health care is effective and leads to better outcomes;

• The special contribution of non-governmental organizations and other members of civil societies, including health professional bodies and academic and health care institutions, in addressing mental health issues;

Committing to:

Supporting the implementation of the following measures, and in accordance with each country's needs:

• Awareness of the importance of mental health problems;
• Affordable mental health services provided to all people regardless of age, gender, race, religion, ethnicity, sexual orientation, social and political preferences;

• The promotion of mental health in families, communities, civil societies, educational and work environments, and Governments and national agencies;

• The involvement of mental health stakeholders in all policies with particular attention to vulnerable groups;

• The implementation of advanced mental health services and increase in the quality of care provided;

• The need to address stigma and discrimination, as well as ensuring the protection of human rights and dignity;

• The need to address the risk factors for mental health problems including alcohol, drugs, violence, and other related factors;

• The capacity of medical practitioners to deliver the best possible management, including prevention, to all people with mental health problems;

• The capacity of working environment at all levels of health care systems to support the effective management of mental health problems;

• The need to strengthen the focus on mental health in medical student training, and in the professional capacity development, continuous education and experience sharing of medical practitioners;

• Promotion of mental health services, particularly in primary care;

• Enhance the involvement of civil societies in mental health activities:

• Enhance the partnership between member organizations and relationships with policy makers;

• Strengthen intersectorial actions at local, regional, and international levels;

• Determine to promote measures to treat and support people with mental health problems, based on current and relevant scientific, technical and economic considerations;

• Promote the coordination of mental health efforts at a national level;

• Promote sound research in the fields of psychiatry, family medicine and mental health taking into account the cultural specificities.

Declare

Nicolai Neznanov (Russia)
President,
World Association
for Dynamic
Psychiatry (WADP)

Afzal Javed (Great Britain)
President
World Association
for Psychosocial
Rehabilitation (WAPR)

Dris Moussaoui (Morocco)
Immediate Past
President,
World Association
of Social Psychiatry (WASP)

Michael Kidd (Australia)
President,
World Organization of
Family Doctors (WONCA)

Pedro Ruiz (USA)
President,
World Psychiatric
Association (WPA)

Secretary of Signing Ceremony
Armen Soghoyan
President, Armenian Psychiatric Association

Yerevan, August 30, 2013
The launch meeting of WAPR Armenia held at Yerevan on 29 August, 2013.

The WAPR Armenia branch has been established by our active members Prof Armen Soghoyan, Dr Khachatur Gasparyan & Meline Tovmasyan. A number of participants of WPA Thematic congress also joined the launch meeting that took place at INTRA, a rehabilitation centre in Yerevan. The Intra Mental Health Centre (MHC) has been established since 2009 by Seda Ghazarian Memorial Foundation (SGMF), which is committed to reducing the suffering caused by mental ill health and disability in Armenia.

INTRA is a well-established Centre with a strong commitment to providing psychological and psychiatric consultation services of a high standard to the widest possible range of clients, including children, adolescents, adults (couples, families and groups), regardless of their financial and social standing. Intra’s specialists work with a wide range of mental health conditions, both long-standing and recently onset. Intra MHC also runs a Day Centre for people with mental disorders and their carers.

The purpose of the Intra’s Day Centre is to assist in the social and psychological rehabilitation of mentally impaired people as well as those with mental health problems. At the Day Centre, visitors are supported to develop their potential skills and learn to live more or less independently. It works across all age groups and all aspects of mental health and is committed to promoting mental well-being through provision of psychological and social services, research and educational programmes.
"Psychosocial Rehabilitation" (RP) is the official publication of the Spanish Federation of Associations of Psychosocial Rehabilitation (FEARP). FEARP was created in 2001; targeted to "spreading the best global research and knowledge in psychosocial rehabilitation. The Federation realised soon on the need of a publication in Spanish, to share and disseminate quality research in psychosocial rehabilitation, and contribute to the transformation of care towards a model focused on recovery. The first issue of "Psychosocial Rehabilitation" appeared in 2004, was semi-annual, and its first editors were Dr. Martin Vargas and Dr. Ramón Blasi.

RP is a multidisciplinary journal aimed to all professionals who practice psychosocial rehabilitation, researchers from different services and programs, and users thereof. It is disseminated "openly" on the Internet, in the link (www.fearp.org/revista/index.php) and the use and dissemination of its content is authorized by any mean.

RP aims to spread in the Spanish language the knowledge related to psychosocial rehabilitation, with full respect to the plurality of methods that is typical of our discipline. This knowledge comes from original papers and reviews in the usual method of social sciences, psychology, and also the most common in the social sciences narrative approaches. The contents of the journal reflect the multidisciplinary nature and diversity of interventions, programs and devices that make up the field of psychosocial rehabilitation.

Psychosocial Rehabilitation draws on evidence, experience and ethics. The journal rests in these three pillars that guide our practice.

In recent decades, psychosocial rehabilitation has been cumulating a series of proofs on the effectiveness of its interventions, and developed a theoretical basis that supports it from the biological to the social point of view. Quality research has allowed that many of the psychosocial interventions are recommended as effective in clinical guidelines of care for people with severe mental disorder. Despite the accumulated evidence, more quantitative and qualitative research, evaluation and implementation of psychosocial interventions are still needed.

Other common practices in rehabilitation are

www.fearp.org/revista/index.php
backed in clinical practice that is why one of the sections of the journal reflects the professionals’ experience in everyday practice.

**Ethical principles must accompany all rehabilitation activities and are present in the pages of the journal:** promoting social, educational and occupational integration, promotion of independent living with the necessary support, respect to privacy, rights or preferences of people with disabilities. The journal is a tool to help bring hope and improve the lives of people with severe mental disorders.

The role of users and family carers, both as individuals or as civil organisations is essential from a recovery perspective. The severe mental disorder cannot be understood without taking into account the subjective experience and the lived experience of those who suffer. The users’ voice is the main tool against stigma. We want them to have a place in the magazine; their contributions “in their own voice”, is an outstanding contribution to empowerment.

We are interested in a special way in contributions that allow better understanding of the recovery process, factors that influence it, and the organization of recovery-oriented services.

As expressed in the Declaration of Valladolid (2010) the journal aims to: "Developing and disseminating the best research and possible knowledge on best practices, taking into account that recovery from mental illness is a complex non-linear process, subjective, biological and social factors are involved. To achieve these goals we invite all those involved in psychosocial rehabilitation to contribute in the magazine, from the plurality of methods, interventions and professional uses.

Our goal is that the magazine "Psychosocial Rehabilitation" will be a future reference in Spanish, for all those involved in the recovery of people with severe mental disorder.

David Gil and Rafael Touriño. Editors.
The XI Annual Conference of Fundación Manantial has taken place in Caixa Forum, Madrid, the 28th and 29th of November, under the heading of “New Models, New treatments, New approach”.

Important International mental health experts came to this conference to expose a new way of understanding and dealing with Psychosis disease beyond biological approach, which reduces the problem to a mental disease and to a pharmacological treatment.

In all of the different conferences they emphasized the importance of the vital experiences and the social context of the schizophrenia origin, as well as a positive vision of the possibilities to prevent the disease.

After, Francisco Sardina, board president of the Fundación Manantial conference, Afzal Javed, president of the World Association for Psychosocial Rehabilitation (WAPR), mentioned that only a 25% of the world population has some kind of mental disease and two thirds of that population does not receive an appropriate treatment.

It’s necessary to give the same importance to prevention, treatment and rehabilitation, professionals also need to change their attitude towards the patients so that they can feel at the same level and believe that you can help them.

The ceremony was lead by Miguel Castejón, head of Social Attention Resources for Fundación Manantial, and counted on very well-known speakers as John Read, head of Clinic Psychology at Liverpool University, who identified poverty as a predictor of a variety of adverse factors which could lead to mental disorders.

He also emphasized the direct relationship between traumatic situations during childhood (abuses, lack of attention, parents lose) and the psychological development of Psychosis during adulthood increasing in a 2,8% the probabilities in this cases.

Read mentioned that the family support is a key factor to understanding the suffering of the patients, and the quality of the relation between the patients.
and their therapist as the main decisive factors to obtain a positive result in their treatment. “We psychiatrists have to learn how to ask people with mental disorders which are the causes of their disease”.

Richard Bentall, experimental teacher at the University of Manchester, remarked a change in the Kraepelian model that considered that people who had schizofrenia would never recover from their disease, to the actual evidence that nearly the 30% of the patients recover and end having a very acceptable quality of life. This percentage, especially in developed countries, increases up to 40%. Bentall made an approximation to delirium and hallucination psychology which are both symptoms of psychosis disease.

Alessandro Svetinni, Psychotherapist at the psychiatric department in Bolzano University, exposed the importance that people with mental diseases could live in the context that they chose and not in a psychiatric Institution. His rehabilitation process is orientated to people’s recovery, so this rehabilitation process has to be based on evidence, but also has to consider the personal dimension of the patients.

Rufus May, professional at The British National Health service, being on one hand a psychologist and on the other a patient, shared with the audience the methodology that he uses so that psychotic symptoms make sense giving therapy to patients.

Once the conferences had finished, there was a round table with all the speakers, which were moderated by Ricardo Guinea, Psychotherapist and elected President for the WAPR, to which Alberto Fergusson, Vice-president for the Americas of the WAPR, was incorporated. And Finally Olga Runciman, psychologist by the Copenhagen University, graduated in psychiatric nursery and a person who hears voices.

At the conference they gave the PREMIO MIRADAS, award that Fundación Manantial gives every year to professionals and organizations that work for the benefit of people with mental disorders. María Luisa Ciriza, Vice-president of the Press Association in Madrid, and jury member awarded Ángel Luis Ortiz, Judge of the Penitentiary Court nº1 in Madrid for this work in the legal scope.

Francisca Foz, member of the Foundation Board awarded the internal prize for innovation “Manantial Innova” to Silvia Parrabera for her project “Early Attention Center”. This is aimed at juths with first psychotic episodes with the objective to prevent chronicity and to give an effective answer to the population who are beginning their psychosis.

The conference was sponsored by the Laboratorios Otsuka and Lundbeck, CaixaForum, Fundacion Mahou San Miguel, Aire Hoteles, and with the collaboration of Imagen en Acción and the team of volunteers of Fundación Manantial.

Fotografía: María Gallego y José Fernando García (Imagen en Acción).

Full recording of the XI Annual Conference of Fundación Manantial
The First International Congress on Mental Illness Dual Pathology and Employment took place in Murcia, Spain, the past 24 and 25 October.

The conference was organized by representatives from 7 different Spanish regions, all members of an “employment and mental illness” task force, which emerged as a result of the regular meeting of the Federation of Associations of Psychosocial Rehabilitation, held in February 2013 in Madrid. It was decided then to create a group of professionals nationwide focused in elaborating on different rehabilitative experiences, incorporating new ways of training and new ways of helping in the process of incorporation into a job, weather protected or standard.

The meeting was made possible in collaboration with the Murcia Association of Psychosocial Rehabilitation, who managed the conference and provided the venues; and also in collaboration of Murcia Health Service, Ministry of Health.

The congress included speakers from 9 different Spanish regions; included stakeholders form all areas of intervention: professionals, service users, families, colleges from different offices on the administration, and businessmen. Many topics of interest about the contribution of a job to the personal recovery were dealt, as well as national and international strategies of intervention, including those credited and already proved practices, but also those still experimental and innovative.

The congress was attended by 284 people from all the regions of Spain, from all sectors closely related to mental illness, including more than 80 psychiatric nurses from all kind of services (inpatient units, rehabilitation centres), over 50 psychologists and 40 social workers, nearly 30 professionals responsible for integration projects and about two dozen psychiatrists.

The opening ceremony of the conference was hosted by Mrs. Ángeles Palacios Sánchez, Health Counsellor in the Region of Murcia; by Ana Vallespí Cantabrana, Vice President of the Federation of Associations of Psychosocial Rehabilitation and by Luis Pelegrin Calero, President of the Murcia Association for Psychosocial Rehabilitation.

All the lectures, and oral communications presented at the conference, selected posters as well as a selection of photos from different moments of the conference can be viewed on the conference’s site in www.isolmurcia.org and www.fearp.org.

Michelle Funk, Coordinator, Mental Health Policy and Service Development (MHP), Department of Mental Health and Substance Abuse, World Health Organization, announced the official launch of the World Health Organization’s MiNDbank online platform. WHO MiNDbank is a product of the QualityRights Project, WHO’s flagship campaign to improve care and end human rights violations against people with mental and psychosocial disabilities. WHO MiNDbank brings together key policies, strategies, laws and service standards for mental health, substance abuse, general health, disability, human rights and development. The platform aims to facilitate debate, dialogue, advocacy and research in order to promote national reform in these areas, in line with international human rights and best practice standards. Please find attached the WHO MiNDbank flyer in English, French, Spanish and Portuguese.

MiNDbank currently includes nearly 4000 documents and resources for over 160 countries.

To access WHO MiNDbank: www.who.int/mental_health/mindbank

“People with mental disabilities still face discrimination, violence and abuse in all countries,” says Dr Michelle Funk, from WHO’s Department of Mental Health and Substance Abuse. “The easy-to-use platform was established as a tool to facilitate debate, dialogue, advocacy and research on mental health, to improve care and to promote human rights across the globe.”

The care available in mental health facilities may often not only be of poor quality but can also hinder recovery. It can still be common in some countries for people to be locked away in small, prison-like cells with no human contact or to be chained to their beds, unable to move. The MiNDbank will help decision makers to address these issues, support reform efforts and ultimately improve the lives of people with mental health conditions in line with the Comprehensive Mental Health Action Plan 2013-2020, adopted by the World Health Assembly in May 2013.

The database, established with support from a broad range of partners, allows visitors to tap into the health information of WHO Member States and other partners. Users can review policies, laws and strategies and search for best practices and success stories in the field of mental health.

“If a government, for example, wishes to develop a new mental health policy in line with international human rights standards it can - on the new platform - quickly get an overview about the policies of other countries and benefit from their experiences and an array of international guidance tools and resources,” explains Nathalie Drew, WHO Technical Officer working on mental health and human rights. So far, already more than 160 countries are sharing key mental health information through the MiNDbank and updates will be provided on a regular basis.
The workshop explored the current state of the art and the actual status of discussions on Human Rights and Psychiatry.

One starting point was the debate currently forced by the UN Rapporteur on torture and other cruel, inhuman or degrading treatment with regard to psychiatric settings and especially involuntary interventions, and the new “WHO QualityRights Tool Kit”, that has set out to give orientation for compliance with CRPD with a choice of five themes. This instrument provides means of assessment of quality and human rights in mental health and social care facilities in low-, middle- and high-income countries.

Ricardo Guinea and Michaela Amering gave brief inputs on these and related issues in order to facilitate an inclusive international workshop discussion of essential topics such as whether the question of where to start might receive different answers in different countries and contexts. The workshop came up with a list of uncontested needs of action worldwide as well as defined areas that warrant debates and specific developments according to local contexts.

A number of significant leaders in mental health in Pakistan took part in the workshop, and a SWOT analysis on the current situation was used as a tool in the short time available. A number of issues were found as strengths, weaknesses, opportunities, and threats: in Pakistan, family links are strong, the media is strong and independent, the mosque can act as an ally, there are some programmes in schools; the particular momentum in Pakistan is propitious; on the other hand, there is a lack of services, trained professionals, knowledge, and training for GPs, and there was perceived as a threat the violence by perpetrators.
The UN Convention on the Rights of Persons with Disabilities (CRPD) took effect in 2008. For the first time in the history of human rights, persons with mental health problems are explicitly mentioned and thus included. The unprecedented support, which the treaty has received – more than 130 ratifications in five years - gives renewed impetus to the longstanding demands of persons with disabilities and the disability movement, respectively: removal of barriers, acknowledgement, respect and enablement of autonomy, renewed efforts toward effective inclusion in all spheres of life.

The CRPD with its 50 articles covers a wide range of key areas in which effective human rights protection and promotion now necessitate revisions of existing legal, health and social care situations as well as new actions in order to fulfill the principles of the treaty. The resulting outstanding challenges and chances for persons with psychosocial disabilities and for the field of psychosocial rehabilitation will determine the work of the WAPR Task Force on Ethics and Human Rights 2013-2015 founded by WAPR President Afzal Javed and co-chaired by Michaela Amering. While to reach all the legitimate aims of the treaty intense work over many years if not decades will be necessary, we will discuss the question on ‘where to start’ in different settings. This question will also kick-off an international Workshop on the CRPD on the occasion of the Third Asia Pacific Conference on Psychosocial Rehabilitation in early November 2013, chaired by Ricardo Guinea and Michaela Amering.

One obvious starting point is the debate currently prompted by the UN Rapporteur on torture and other cruel, inhuman or degrading treatment’s Report with regard to psychiatric settings and especially involuntary interventions. WAPR is collaborating with the chair of the WPA section on the Psychological Consequences of Torture and Persecution Federico Allodi and June Lopez, member of this WPA section and contact to the World Medical Association WMA, which has responded to the report already. A very worthwhile discussion will concern George Szmukler’s concepts for non-discriminatory laws consistent with the CRPD (Dawson & Szmukler 2006; Szmukler et al, 2014). A Fusion Law as suggested by them would cover all persons with problems with decision-making capability for a specific treatment decision and not discriminate against people with mental health problems. The question of guardianship is a crucial one and the issues around guardianship law and the implementation of Article 12 CRPD have been identified as a particular priority by the UN High Commissioner for Human Rights (Bartlett 2012). The draft comment by the UN Committee on the Rights of Persons with Disabilities of September 2013 can be found on http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx. One central topic is a shift from substitute decision-making to supported decision-making.

While the issue of coercion in psychiatric care is a core topic, it is also important to note that the CRPD ‘opens mental disability law to a wide variety of new fields.…… Developed rights to non-discrimination in key areas, including employment, housing, education, health, standards of living and social, political and cultural participation, along with the right to be free from exploitation, violence and abuse, …., the refocusing of lawyers and legal
academics towards their community rights is long overdue.’ (Bartlett, 2012). This very encouraging statement by Peter Bartlett, Professor of Mental Health Law at the University of Nottingham also clearly points to the need for new collaborations between rehabilitation professionals, users of services and their families and friends and lawyers and other legal experts.

Two key areas of interest currently emerge with the need for reduction and understanding of new challenges for the legal basis for involuntary interventions on the one hand and the effects of rights on the individual as well as on the health care system level (including effects of these rights on implementation of recovery-orientation of services and significance of social determinants of mental health) on the other hand.

Recovery-orientation will continue to be a focus of WAPR’s work. Recovery describes an approach to mental health problems that – cognizant of the potential limits caused by a disability – enables autonomy, empowerment as well as integrity and equality of opportunity. The goals of recovery and its central elements intersect with those of human rights, while practices against human rights are factors that hinder recovery. (Amering & Schmolke, 2009)

WAPR will further a process of understanding and participating in shaping the effects of the CRPD in different countries and internationally with regards to accessibility and assistance needs and rights. Such a process concerns especially also, questions of

- Concept of psychosocial disability
- Concept of reasonable accommodation
- Assessment of assistance needs to replace current deficit assessment

Developing and ensuring continued dialogue and discussion about conflicts as well as common ground between mental health workers and users of services as well as their respective advocates is essential for these tasks as is the dialogue with other stakeholders, such as family carers, lawyers, different perspective of different professions within mental health work. The WAPR Task Force on Ethics and Human Rights will work in close collaboration with the WAPR Task Force on user and carer involvement and its members around chairwomen Helen Herrman and Anne Grethe Klunderund. Members will include psychiatrists from around the world, such as Alberto Fergusson, Solomon Rataemane, George Szmukler, and Eva Teng and other mental health professionals such as Marta Ferraz and Marit Borg as well as lawyers such as Peter Bartlett, Professor of Mental Health Law at the University of Nottingham and Marianne Schulze, human rights consultant and inaugural chair of the Austrian CRPD Monitoring Committee. The CRPD implementation handbook of of World Network of Users and Survivors of Psychiatry (WNUSP) will also be a valuable support for our work (www.wnusp.net) and for understanding the critical user perspective.

WAPR works in cooperation with WHO as laid out in WHO-WAPR action plan including introduction of the WHO QualityRights Tool Kit and the the focus on Human Rights and Recovery orientation as part of the WHO Action Plan 2013-2020.

Through these and other avenues the WAPR Task Force on Ethics and Human Rights aims to come up with a consensus on the main consequences of the rule of law of the CRPD for psychosocial rehabilitation.

REFERENCES:
http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx
http://www.wnusp.net/index.php/crpd.html
In June 2013, through the intervention of Professor Markos Tesfaye (University of Jimma, Ethiopia), WAPR received the request made on behalf Gefersa by Miss Veerle Lebecke (psychiatric nurse), to receive training in psychosocial rehabilitation.

Gefersa (Addis Ababa, Ethiopia) is a residential mental health care service founded in 2007 and managed by Fracarita, an international NGO for cooperation and development, managed by the Brothers of Charity. Fracarita received the task form the Government to transform the former poor services into a new psychosocial rehabilitation centre. They are currently in the process of organizing an inpatient rehabilitation program and community based program.

Gefersa is located 30 km away from Addis Ababa, counts 75 workers, 140 in-patients and 23 out patients in a community based program. The design of the programs tries to follow the WHO rehabilitation matrix, adapted to the local context. The main focuses of the work are psycho education, working with families and communities and to promoting economic empowerment of their clients.

WAPR studied the proposal and accepted the challenge. Two members of the Board, Dr. Solomon Rataemane, University of Limpopo, Pretoria, South Africa; and Dr. Carmen Ferrer, Spanish Health Service, Zaragoza, Spain, to travel to Addis Ababa, accepted to organize the training activities.

The meeting was presented by brother Eric Amin Jeje, General Manager of Gefersa Mental Health Rehabilitation Center, who introduced the participants and explained the main objectives of the meeting. The meeting was also attended by Dr. Tedla W. Giorgis, Advisor of the Ministry of Health of Ethiopia, who started the conference presenting the National Mental Health Strategy (2013/2014-2015/2016), that subscribes the mandate to deliver effective and quality services in Ethiopia by:

- Integrating mental health into the existing primary health care delivery system,
- Conducting an audit and update the essential list of psychotropic drugs,
- Organize, launch and support anti stigma campaigns to educate about the causes and treatment of mental disorders, being one of the priorities the legislation and intervention concerning the protection of human rights of people with mental disorders,
- Defining mental health indicators to be collected...
and analyzed and use the results for informed planning and decision making, and

Creating a monitoring and evaluation system to implement and regulate mental health care.

The Strategy is being developed using as one of the main tools the WHO’s mental health Gap Action Program.

The principles underlying the strategy are that all persons with mental illness must enjoy the full range of human rights on an equal basis with others.

One of the most important topics of the National Strategy is the need for training of health workers in the diagnosis and management of mental disorders as long as the promotion of self-care education programs.

Dr. Salomon Rataemane and Dr. Carmen Ferrer conducted a two days meeting with Gefersa’s staff and also staff from other mental health services (including a specialized centre in the treatment and recovery of women affected by fistula). The main topics were the following:

Evolution in the Approach to Mental Health during the last decades, with especial emphasis on Human Rights protection, Empowerment, and fight against discrimination.

Concept and treatment of psychosis: Therapeutic approaches.

Relevance of Psychosocial rehabilitation.

Burnout syndrome and secondary traumatisation.

Groups of discussion about possible projects of Psycho-social rehabilitation in Gefersa.

The participants were particularly concerned about the possibilities of improving the practices in the centre, and in promoting the transformation of the mental hospital. During the last years, the hospital’s structure has been thoroughly reformed, improving the facilities and the quality of life the users.

The main perceived challenge at this moment is create and introduce new activities, such as nursing therapeutic activities, basic occupational activities, training programs and work insertion centres, from a general approach that promotes empowerment in the clients and fights stigma.

The proposed transformation involves establishing different areas in order to provide a therapeutic approach adapted to different patients’ profiles, their needs and possibilities of recovery: aged persons, patients in mid and long stays, etc.

The perspective of recovery, involves instilling feelings of hope and optimism in workers and clients, and developing the programs in coordination with community resources, in order to avoid the centre’s isolation, and the consequent rejection of the most severely ill persons.

The last day, Professor Rataemane and Dr. Ferrer, and Miss Lebecke had a meeting with Gefersa’s manager, brother Eric Jeje, and with the General brother Gerard Simpamagaye, in order to give advice and counseling about the challenge that they are facing to transform a traditional mental hospital in a recovery oriented service, integrated in a more rich and complex network of complementary services, including other community oriented centres, rehabilitation centres, and occupational and residential services, in cooperation with the Ministry of Health and other organizations involved in this task at national level.

Dr. Rataemane and Dr. Ferrer invited the members of Gefersa to meet other significant professionals in order to join the WAPR, founding an Ethiopian chapter, from the consideration that working in the framework of WAPR can empower them and make them feel supported developing their programs and activities.

Dr. Rataemane introduced Dr. Solomon Teferra, from the Department of Psychiatry of the University of Addis Ababa, and invited all of them to contact Dr. Markos Tesfaye and other professionals and associations in order to constitute a foundation group to establish a section of WAPR in Ethiopia.
SOME DATA CONCERNING THE SITUATION OF MENTAL HEALTH IN ETHIOPIA

Psychiatric and substance abuse beds and facilities

<table>
<thead>
<tr>
<th>Resources</th>
<th>Total numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Psychiatry Centers and Clinics</td>
<td>1 facility in Amanuel hospital</td>
</tr>
<tr>
<td></td>
<td>1 long-stay unit in Gefersa</td>
</tr>
<tr>
<td>In-patient psychiatric units</td>
<td>2 in Addis Ababa</td>
</tr>
<tr>
<td></td>
<td>318 beds</td>
</tr>
<tr>
<td></td>
<td>2 in regional towns</td>
</tr>
<tr>
<td></td>
<td>35 beds</td>
</tr>
<tr>
<td>Out-patient psychiatric clinics</td>
<td>4 in Addis Ababa</td>
</tr>
<tr>
<td></td>
<td>57 (in regional, zonal and district hospitals</td>
</tr>
<tr>
<td></td>
<td>outside Addis Ababa</td>
</tr>
<tr>
<td>Nurse-led psychiatric units</td>
<td>6 in regional towns</td>
</tr>
<tr>
<td>Children and adolescent services</td>
<td>2 out-patient services in Addis Ababa</td>
</tr>
<tr>
<td>Police</td>
<td>In-patient unit in Kality Prison, Addis Ababa</td>
</tr>
<tr>
<td></td>
<td>(35 beds)</td>
</tr>
<tr>
<td>Prison</td>
<td>In-patient</td>
</tr>
<tr>
<td>Centers for substance abuse treatment</td>
<td>2 out-patient facilities in Addis Ababa</td>
</tr>
<tr>
<td></td>
<td>2 in-patient facilities</td>
</tr>
<tr>
<td></td>
<td>21 beds</td>
</tr>
<tr>
<td></td>
<td>Plan underway to open 5 additional centers</td>
</tr>
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</table>
**Human Mental Health Resources**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Total Numbers</th>
<th>Location</th>
<th>Rate per population (per 100.000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>40</td>
<td>10 in regions 30 in Addis Ababa</td>
<td>0.05</td>
</tr>
<tr>
<td>Psychiatric nurses</td>
<td>461</td>
<td>Approximately, 120 in regions, remainder in Addis Ababa and private sector</td>
<td>0.58</td>
</tr>
<tr>
<td>Psychologists engaged in clinical services</td>
<td>14</td>
<td>All in Addis Ababa</td>
<td>0.02</td>
</tr>
<tr>
<td>Social workers engaged in clinical services</td>
<td>3</td>
<td>All in Addis Ababa</td>
<td>0.003</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
</tr>
</tbody>
</table>

**Mental Health Financing – 2012/2016**

In the context of a situation of economical improvement in Ethiopia, the plan describes three scenarios related to the available budget.

<table>
<thead>
<tr>
<th>Level of coverage of disorders</th>
<th>Basic scenario</th>
<th>Good scenario</th>
<th>Best scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression – up to 30%</td>
<td>Depression – up to 30%</td>
<td>Depression – up to 40%</td>
<td></td>
</tr>
<tr>
<td>Care for postnatal depression - up to 20%</td>
<td>Care for postnatal depression - up to 20%</td>
<td>Care for postnatal depression - up to 20%</td>
<td></td>
</tr>
<tr>
<td>Psychosis – up to 75%</td>
<td>Psychosis – up to 75%</td>
<td>Psychosis – up to 80%</td>
<td></td>
</tr>
<tr>
<td>Bipolar disorder – up to 50%</td>
<td>Bipolar disorder – up to 50%</td>
<td>Bipolar disorder – up to 75%</td>
<td></td>
</tr>
<tr>
<td>Epilepsy – up to 75%</td>
<td>Epilepsy – up to 75%</td>
<td>Epilepsy – up to 80%</td>
<td></td>
</tr>
<tr>
<td>Developmental disorders – up to 10%</td>
<td>Developmental disorders – up to 30%</td>
<td>Behavioral disorders – up to 10%</td>
<td></td>
</tr>
<tr>
<td>Behavioral disorders – up to 10%</td>
<td>Alcohol use – up to 25%</td>
<td>Alcohol use – up to 35%</td>
<td>Self-harm suicide – up to 40%</td>
</tr>
<tr>
<td>Alcohol use – up to 25%</td>
<td></td>
<td></td>
<td>Dementia – up to 40%</td>
</tr>
<tr>
<td>Self-harm suicide – up to 30%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>25.240,244 $</td>
<td>28.246,272 $</td>
<td>32.471,919 $</td>
</tr>
</tbody>
</table>
A brief about the action plan was informed by the President and in this regard he praised the work of most of the task forces. However it was felt that some of the task forces have not initiated their work.

There are eight task forces namely: Task force on Partnership with patients, users and carers.

- Task force on Ethics & human rights for persons experiencing mental illness.
- Task force on Project Development and dissemination
- Task force on Curriculum & training
- Task force on Rehabilitation program for Adolescents & Young Children
- Task force on Preparing guidelines for PSR services in low income countries
- Task force on issues relating to Professionals Burnout
- Task force on preparing a statement on Societal Connectedness, Social capital, Identity and modern Terrorism

It was again reemphasized that there is availability of funds to the tune of $3000/ per project as small
WAPR BOARD

grants to pursue any small projects in the regions. All the regional Vice Presidents were encouraged to identify the countries where this can be done. This will be granted after a scientific review of the project by authorized review committee.

Financial report circulated by the Treasure was approved & financial support to the Secretary General’s office was discussed and a grant of $800/ per annum was approved.

As there were no comments about the reports all the reports were accepted

The Board has entrusted Dr Tae-Yeon Hwang to announce the dates of the next World Congress at the earliest so that people can block their dates, which he has agreed.

Dr Solomon Rataemane has informed the board that he is trying to have a regional meeting of interested people from different countries in Africa.

The President thanked all the members present and specially thanked the representatives from WPA,WFMH,WASP, RANZCP, AFPA, Leaders of Asian Psychiatry and office bearers of the National associations who spared their valuable time for this meeting.

The President thanked Dr N.Shinfuku, Dr Pichet Udomratn and their dedicated team for involving WAPR in the scientific programme of the Bangkok meeting and arranging the facility for the Mini Board meeting and reception thereafter for WAPR along with the 4th World Congress of Asian Psychiatry (WCAP).

LAHORE, PAKISTAN, August 22th., 2013.

After the call to order, and the introduction of Board members, the minutes of previous Board Meetings (Bangkok) and Manchester were presented and approved. The notes from the mini board meeting held at Bangkok were also presented and approved.

Business arising from the Minutes of the last Board Meeting:

President briefed the Board about decisions taken at Board meetings and the actions taken as per these decisions.

President presented his repost and described different activities that took place since the last Board meeting. He especially mentioned that many new branches (Armenia, Romania, Taiwan, Indonesia, a Iran and Middle east) have become functional and started new programmes. Similarly branches like Slovenia and Turkey have restarted their activities.

National branches have also organized their local meetings. Collaboration with other international organizations has also been a main feature of the work of WAPR. Similarly WAPR has organized a number of scientific sessions in different professional conferences.
The Regional vice presidents have been involved in initiating different programmes. The efforts for starting new branches especially in African and American regions were greatly acknowledged.

President outlined the activities of different standing committees and Task Forces. However it was mentioned that the work of some of these committees still needs more input and active participation.

Updates WAPR Action Plan (2012-2015)

President and other office bearers reported about different activities.

Regional Vice President programmes

Reports about activities were presented by Regional Vice President

It was acknowledged that WAPR meetings at Bangkok and Lahore have been organised in a very successful way. These two meetings have uplifted the vision of WAPR to a large extent.

Reports from different Board members were already circulated.

Treasurer could not attend the meeting. President updated the Board about current financial statement on behalf of the Treasurer. It was urged that efforts should be made to raise funds.

Similarly Regional Vice Presidents were requested to send their proposals for their projects to the president.

WAPR Congress 2015: Date of 2015 congress was notified to the Board. It was felt that we need to accelerate our efforts to publicize the world congress.

President suggested that WAPR should also encourage having regional meetings in different regions during the term. Giving example of Asia, where three such meetings have been organized, he suggested that other regional vice presidents should consider this as a proposal.

Any other matters

Editorial board of the Bulletin was thanked for their excellent efforts in making Bulletin more informative. All branches were requested to send their activity reports regularly to the Bulletin.

Board thanked WAPR Pakistan branch and especially Dr Nasar Syed Khan (Branch Secretary) for excellent arrangements for Asian Pacific Conference.
## EXECUTIVE COMMITTEE

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Email</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>Afzal Javed</td>
<td><a href="mailto:afzal.javed@ntlworld.com">afzal.javed@ntlworld.com</a></td>
<td>The Medical Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="mailto:afzal@afzaljaved.co.uk">afzal@afzaljaved.co.uk</a></td>
<td>Manor Court Avenue</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nuneaton, CV11 5HX, United Kingdom</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tel: +44 24 76321505, Fax: +44 24 76321502</td>
</tr>
<tr>
<td>Immediate Past-President</td>
<td>Lourdes Ladrido-Ignacio</td>
<td><a href="mailto:lladridoignacio@gmail.com">lladridoignacio@gmail.com</a></td>
<td>Department of Psychiatry, College of Medicine</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>University of the Philippines</td>
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<td></td>
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<td></td>
<td>P. Gil St, Manila, Philippines</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tel: +63 2 525 0803/ 525 1767, Tel/Fax: +63 2 371 3603</td>
</tr>
<tr>
<td>President-Elect</td>
<td>Ricardo Guinea</td>
<td><a href="mailto:guinea@rguinea.info">guinea@rguinea.info</a></td>
<td>Hospital de dia Madrid</td>
</tr>
<tr>
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<td>C/Manuel Marañón 4</td>
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<td></td>
<td></td>
<td></td>
<td>28043 Madrid, Spain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tel: +34 91 759 66 92, Fax: +34 91 759 60 02</td>
<td></td>
</tr>
<tr>
<td>Vice Presidents</td>
<td>Tae-Yeon Hwang</td>
<td><a href="mailto:lilymh@gmail.com">lilymh@gmail.com</a></td>
<td>WHO Collaborating Centre for Psychosocial</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rehabilitation Yongin Mental Hospital</td>
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<td></td>
<td></td>
<td></td>
<td>4 Sangha Ri, Kusung Eub, Yongin City, Kyunggi</td>
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<td>Province Korea 446-769</td>
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<tr>
<td></td>
<td></td>
<td>Tel: +82 31 288 0206, Fax +82 31 288 0363</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mobile +82 10 5335 7219</td>
<td></td>
</tr>
<tr>
<td>Secretary-General</td>
<td>Gabriele Rocca</td>
<td><a href="mailto:garocca@libero.it">garocca@libero.it</a></td>
<td>Istituto Corberi,</td>
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<td></td>
<td>Via Monte Grappa, 19</td>
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<td>LIMBIATE (MB) ITALY</td>
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<td>Tel.: 0039.02.99456024, Fax: 0039 02 73951196</td>
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<td></td>
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<td>Cell.: 0039 3298985311</td>
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</tr>
<tr>
<td>Treasurer</td>
<td>Shahid H. Quraishi</td>
<td><a href="mailto:shahidquraishi@hotmail.com">shahidquraishi@hotmail.com</a></td>
<td>M.S.Ramaiah Medical College and Hospitals,</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Bangalore 233, 2nd cross,12th Main, 4th Block</td>
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<td></td>
<td>Koramangala, Bangalore 560034,India.</td>
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<td></td>
<td></td>
<td>Tel 91-80-25501977 mobile +91-9449523983</td>
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**MORE INFO IN** [WWW.WAPR.INFO](http://WWW.WAPR.INFO)
## WAPR COMMITTEES

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chair/Co-Chair</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Congress committee</strong></td>
<td>Co-Chair: Ricardo Guinea (President Elect)</td>
<td>T Murali (Secretary General) Shahid Quraishi (Finance Secretary) Angelo Barbato (Chair of organizing committee of previous Congress) Tae-Yeon Hwang (Chair of organizing committee of next conference) Harry Minas (Regional Vice President from the region where next Congress is taking place)</td>
</tr>
<tr>
<td><strong>Nomination committee</strong></td>
<td>Co-Chair: Ricardo Guinea (President Elect)</td>
<td>T Murali (Secretary General) Lourdes Ladrido-Ignacio (Immediate past president) Alberto Ferguson Ida Kosza Anne Grethe Klunderud</td>
</tr>
<tr>
<td><strong>Membership committee</strong></td>
<td>Co-Chair: Germana Agnetti</td>
<td>Ricardo Guinea T Murali Tai Yeon Tae-Yeon Hwang</td>
</tr>
<tr>
<td><strong>Publication committee</strong></td>
<td>Co-Chair: Marit Borg (Deputy Secretary General)</td>
<td>Ricardo Guinea T Murali Tai Yeon Tae-Yeon Hwang</td>
</tr>
<tr>
<td><strong>Constitution committee</strong></td>
<td>Co-Chair: Solomon Rataemane</td>
<td>Pichet Udomratn Zeb Taintor Antonio Maone Pedro Gabriel Godinho Delgado</td>
</tr>
<tr>
<td><strong>Ethics &amp; Review committee</strong></td>
<td>Co-Chair: Lourdes Ladrido-Ignacio</td>
<td>Ricardo Guinea T Murali Gabriele Rocca Alberto Ferguson Oliver Wilson</td>
</tr>
</tbody>
</table>

## WAPR TASK FORCES

<table>
<thead>
<tr>
<th>Task Force</th>
<th>Chair</th>
<th>Co-Chairs/Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task Force on Users &amp; Carers involvement in Treatment and Rehabilitation Planning</td>
<td>Chair: Helen Herman Anne Grethe Klunderud</td>
<td>Michaela Amering</td>
</tr>
<tr>
<td>Task Force on Ethics &amp; Human Rights for persons experiencing mental illness</td>
<td>Chair: Mathew Varghese Henrik Wahlberg Marianne Farkas</td>
<td>Michael Sadre-Chirazi-Stark</td>
</tr>
<tr>
<td>Task Force on Curriculum &amp; Training—particularly focusing on recovery</td>
<td>Chair: Arshad Hussain Pedro Gabriel Godinho Delgado</td>
<td>V.K. Radhakrishnan &amp; Alok Sarin</td>
</tr>
<tr>
<td>Task Force on issues relating to Professionals’ Burnt Out</td>
<td>Chair: Michael Sadre-Chirazi-Stark</td>
<td>V.K. Radhakrishnan &amp; Alok Sarin</td>
</tr>
<tr>
<td>Task Force on Rehabilitation programmes for Adolescents &amp; Young Children</td>
<td>Chair: Arshad Hussain Pedro Gabriel Godinho Delgado</td>
<td>V.K. Radhakrishnan &amp; Alok Sarin</td>
</tr>
<tr>
<td>Task force on Preparing guidelines for PSR Services in low income countries</td>
<td>Chair: V.K. Radhakrishnan &amp; Alok Sarin</td>
<td>V.K. Radhakrishnan &amp; Alok Sarin</td>
</tr>
<tr>
<td>Task Force on Asia-Pacific Projects Development and Dissemination</td>
<td>Chair: Harry Minas</td>
<td>V.K. Radhakrishnan &amp; Alok Sarin</td>
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<tr>
<td>Task Force preparing a statement on Societal Connectedness, Social Capital, Identity and Modern Terrorism.</td>
<td>Chair: Marianne Farkas</td>
<td>V.K. Radhakrishnan &amp; Alok Sarin</td>
</tr>
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