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TABLE OF CONTENTS/ Índice

Editorial:

• P. 3: “Legal and Ethical Issues in Psychosocial Rehabilitation”. Michael Madianos. Dept. of Mental Health and Behavioral Sciences University of Athens. WAPR President.

Collaborations:

• P. 7: “General Hospital Psychiatric Units and Rehabilitation Centres in India: Do Law and Public Policy Present Barriers to Community-Based Mental Health Services?” Kevin M. Cremin. American India Foundation Service Corps Fellow 2006-07.
• P. 15: Recovery. WAPR Internatinal Meeting in Milano. Barbara D’Avanzo. Head of the Unit of Epidemiology and Social Psychiatry. Mario Negri Institute for Pharmacological Research, Milan, Italy.
• P. 17: Amnistía Internacional y FEAFES reclaman la abolición de la pena de muerte a personas con enfermedad mental en Estados Unidos.
• P. 18: Douglas Holmes’ e-list: “A number of interesting consumer & carer happenings in Australia.

Events:

• Coming events in Spain, Uganda, Canada., Bamgalore.
• Lopez Ibor Award.
• Europsy 2008 in Slovenia.
• CEFEC Confrence.
• UN Comitte Mental Health Agenda.

WAPR Bulletin.

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Legal and Ethical Issues in Psychosocial Rehabilitation.

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1. Introduction

It is commonly accepted that the field of scientific Psychosocial Rehabilitation is relatively new, although its origins are dating back in the beginning of the 20th century, when mental patients in the large Asylums of Europe and USA, were manufacturing brooms and other artefacts. The development and expansion of the various facets of psychosocial rehabilitation, dealing with heterogeneity of diagnoses, variety of professionals, different sociopolitical problems and challenges in the recent decades, is often facing serious moral dilemmas, influenced by specific ethical and legal codes. These issues are directly or indirectly involved in the rehabilitation outcome.

A professional in the field of psychosocial rehabilitation of chronically mentally ill persons, is likely to be confronted with conflicts linked to clients’ choice of rehabilitation treatment, and the defence of the clients’ autonomy and their human rights. Other important issues are the context and the methods of practice guidelines in psychosocial rehabilitation, avoiding practice deviations and client exploitation, the protection of client’s right to confidentiality, prevention of harmful exposure of clients. On the other hand, anticipation of interagencies conflicts arise in a variety of rehabilitation settings, in which a client is placed (Day Care, Vocational Workshop, Sheltered Job Placement, Half way House, supervised Apartment) is an essential component of good practices of psychosocial rehabilitation.

In sum, the legal and ethical (deontological) issues concern firstly the client of a psychosocial rehabilitation programme, secondly the member of the psychosocial rehabilitation team and thirdly the rehabilitation service.

2. Ethical issues

The four guiding ethical principles of medical practice, also referred to psychosocial rehabilitation practice, are the following: respect for autonomy of the client, nonmaleficence, beneficence, and justice.

Autonomy involves any effort providing the freedom of choice of client’s treatment and course of illness, after hearing the benefits, risks and costs of all reasonable options.

Nonmaleficence (a Hippocratian code of ethic) is an essential rule, preventing the risks of treatment and iatrogenic harm. This principle is often violated with the intention of “good” treatment effect outweighing the “bad” effect.

The concept of justice concerns the issue of equal distribution of rights for help-seeking in the market economy of managed care in a globalized world. In other words, justice is related to the equal distribution of health care resources, especially to those persons are in greater need.

Ethical issues related to the members of a psychosocial rehabilitation programme concern: 1) the case of a client member of a rehabilitation programme, who is not compliant with the programme’s principles and regulations and 2) when aggressive
behavior of a client is directed towards other members and staff, or a sexual misconduct causes problems to others in the programme. It is the staff and the other clients, members of the programme, who will try to “treat” this problematic behavior and prevent harmful consequences within the limits of Therapeutic Community principles.

Regarding the staff, the ethical codes could be broken: 1) when the staff member disrespects the patient’s autonomy with the development of paternalistic behavior. Decision making by the client and freedom of programme’s choice, are fundamentals of the ethical principle of autonomy. 2) if there is a breach of confidentiality e.g. reporting patient’s “diagnosis” of treatment details to a possible employer and when therapeutic work procedures are videotaped or recorded for education or research purposes, without a previous written informed consent, by the rehabilitation service clients. 3) Another important ethical issue is the challenge by the staff the client’s system of cultural values and beliefs, when these are involved in the rehabilitation process.

3. Legal issues

Legal issues related to staff members are the following: 1) Incorrect psychosocial rehabilitation diagnosis of a client, leading to improper service placement 2) improper work supervision, exposing the client to possible work risks 3) failure of staff to monitor psychiatric care or prevent adverse psychotropic drug side effects due to lack of intercommunication between mental health care agencies involved in the treatment and rehabilitation of the client.

All the above document the so called psychosocial rehabilitation malpractice.

4. Ethical and legal issues related to service

Psychosocial rehabilitation services are also subjected to observe the basic ethical and legal codes.

Ethical code violation exists when there is no service internal policy, securing human rights of clients attending the programme e.g. work exploitation, breach of confidentiality or not preventing limitations of the autonomy of clients in rehabilitation.

Additionally, legal issues arise when service organization regulations are not preventing work hazards and risks. A variety of safety regulations are basic component in the rehabilitation procedure.

Building a psychosocial rehabilitation service programme, with inadequate organization procedures, leading to misdiagnosis, activities with no clear boundaries, improper placement and supervision, are liable for malpractice claims.

Finally, employment of service personnel with inadequate specialized training could jeopardize the successful rehabilitation outcome.

However, there is no evidence of malpractice when the client’s poor rehabilitation outcome is unrelated to negligent rehabilitation procedures.

5. Special issues concerning rehabilitation of children.

It is well known that a proportion of children are suffering from mental disorders or mental retardation, requiring admission in specialized psychosocial rehabilitation services. These services must incorporate certain ethical codes concerning the relationships between parents and personnel as well as parents and children. Any known parental deviant behavior, leading to child abuse (physically or sexually) the service personnel must report it. Children have to be “treated” with respect, enhancing
therapeutically their abilities and skills. Therapists must also respect the young client’s value orientations related to family’s culture, the parental roles and their reasonable expectations. Confidentiality is a different task, in child psychosocial rehabilitation. Parents always want to know what their children saying or doing.

6. Conclusions
In summary, the area of ethics and legal issues in the field of psychosocial rehabilitation, incorporates social, political, economic and cultural components. Especially, ethics evolves as societal, political, and cultural values change. Good psychosocial rehabilitation practices must be ethical. The recent developments of many areas of psychosocial rehabilitation of persons suffering from severe and persistent mental disorders with clinical and skills heterogeneity, impose the need for preservation of all the codes of ethics, despite the fact that those were somehow neglected in the past years.

The balance between the ethical principles of autonomy, beneficence, nonmaleficence and justice constitute an integral component of good practices in psychosocial rehabilitation nowadays.

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(Footnotes)
1 Professor of General and Social Psychiatry, University of Athens, Greece. President, World Association for Psychosocial Rehabilitation
General Hospital Psychiatric Units and Rehabilitation Centres in India: Do Law and Public Policy Present Barriers to Community-Based Mental Health Services?

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As an American India Foundation Service Corps Fellow at the Centre for Advocacy in Mental Health (CAMH) in Pune, India, I visited forty-four mental health facilities in Karnataka, Maharashtra, Tamil Nadu, and the Delhi Region. I documented the following aspects of their operations: infrastructure; admission/discharge procedures; relationships with governmental authorities; ward access policies; and inpatient/outpatient services. I then examined this data to determine whether there are any legal or public policy barriers that interfere with the provision of community-based mental health services. Insights were drawn, where appropriate, from the Convention on the Rights of Persons with Disabilities (CRPD) and laws regulating mental health services in other countries. The resulting study, including findings, analysis, conclusions, and recommendations, is available on CAMH’s website at www.camhindia.org/ghpurc.html. The following is a brief summary of that study.

Instead of a national mental health policy, India has a National Mental Health Programme (NMHP). One of the main objectives of the NMHP is “(to) promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.” Several years after the NMHP was formulated, the Mental Health Act (MHA) became law. In its statement of objects and reasons, the MHA emphasizes that “no stigma should be attached to [mental] illness” and that “mentally ill persons are to be treated like other sick persons and the environment around them should be made as normal as possible.” However, most of the MHA’s provisions focus on regulating the admission and detention of mentally ill persons in psychiatric hospitals or psychiatric nursing homes.

Pursuant to Sections 6 and 7 of the MHA, to establish or maintain a facility for the “treatment and care of mentally ill persons,” one has to procure a license. The MHA sets forth two primary requirements for licensure. First, a license shall not be granted unless “the psychiatric hospital or psychiatric nursing home, will be under the charge of a medical officer who is a psychiatrist.” This requirement is particularly burdensome given that there are only approximately 3,500 psychiatrists in India. Second, a license shall not be granted unless “the applicant is in a position to provide the minimum facilities prescribed for the admission, treatment and care of mentally ill persons.” According to Section 94 of the MHA, these “minimum facilities” include: “psychiatrist-patient ratio; other medical or para-medical staff; space requirement; treatment facilities; and equipment.” The minimum facilities are specified in the State Mental Health Rules, which require a “10 bedded hospital or nursing home” to have: “One full time qualified Psychiatrist;” “One Mental Health Professional Assistant (Clinical) Psychologist or Psychiatrist Social Worker;” one staff nurse for every three patients; and one attendant for every five patients.

Because it was considered an improvement over the Indian Lunacy Act of 1912, some commentators have praised the MHA. However, others have criticized the MHA for failing to promote community participation. In particular, some commentators have pointed out that there is an antagonism between the dictates of the MHA and the goals set forth by the
NMHP. My visits to forty-four mental health facilities provide support for these criticisms of the MHA.

Among the rehabilitation centres (RCs) that I visited, there are good models of mental health services that are community-based. A surprising number of RCs, however, have characteristics that are associated with involuntary institutions. For example, five facilities are surrounded by fences that are topped with barbed wire and seven facilities use locking mechanisms to prevent residents from exiting the facility or a portion thereof.

The average RC has approximately sixty-two beds and, at least in size, resembles an institution more than a home. Although the providers’ staffing patterns vary considerably, in the aggregate, their bed to staff ratios are significantly higher than those required by the MHA. For example, the ratio of beds to psychiatrists (whether full-time or part-time) is approximately sixty-four to one. Almost half of the RCs have at least one facility where the average length of stay (ALS) is two or more years. Several of these providers have residents who have stayed for as long as five years. The long-term nature of these facilities indicates that they are providing custodial, as opposed to rehabilitative, care.

For the overwhelming majority of RCs, psychiatrists and the families of applicants play key roles in the admission procedure. This raises the question of whether most RCs are providing voluntary care. The use of force is highlighted by the practices of five providers that find some or all of their residents on the street. For example, one provider stated that prospective residents are “caught” and put in a jeep. Several aspects of the so-called “rescue” procedures described by some providers are disturbing. First, by removing individuals from the street against their will, some RCs appear to be invoking an authority that is generally reserved for the state. Second, the practice of filing a “First Information Report” potentially criminalizes an individual with a mental health problem, and it brings mental illness out of the realm of health law and into the realm of criminal law. Third, the “rescued” individuals are being deprived of their liberty without the benefit of legal counsel.

With regard to general hospital psychiatric units (GHPUs), the majority of inpatient services are in open, but segregated, wards. The findings of this study raise questions about whether the often-repeated, purported advantages of GHPUs are present in their daily functioning. For example, the separateness of many GHPUs seems to be both a result of and a source of stigma.

Inpatient services at government GHPUs are more readily available to low-income individuals than the services provided at RCs, which have an average cost of Rs. 6,135 per month. Outpatient services at government GHPUs are also generally available for free or for a nominal fee. Although the bed to psychiatrist ratio at GHPUs is within the limits imposed by the MHA, it is important to note that GHPUs also provide cross-consultation services and outpatient services for tens of thousands of patients. When understood in this context, the bed to psychiatrist ratio at GHPUs does not provide support for applying the MHA’s ambitious staffing requirements to RCs and other contexts.

With one exception, the ALS for inpatients at GHPUs is much shorter than the ALS for RCs. The exception is one MHA-licensed GHPU where the ALS is ninety days. Apparently, this GHPU admits patients only pursuant to the “special circumstances” provision of the MHA. Pursuant to Section 19, “admission under special circumstances” involves the commitment of a person who is mentally ill by a relative or friend. Interestingly, the “comment” to this section of the MHA categorizes this as a “voluntary” admission. Thus, one of the GHPUs that is licensed pursuant to the MHA is operating in a manner that is quite different from the other GHPUs, resulting in longer hospital stays for its inpatients.

Private GHPUs face a considerable amount of uncertainty about the state of the law. In general, private GHPUs appear hesitant to subject themselves to MHA regulation. Some private GHPUs also appear to think that they are subject to the MHA only if they have a defined psychiatric ward. At least one private GHPU indicated that in order to get a license pursuant to the MHA, a GHPU is required to have a separate ward. Given that there is no provision in the MHA that mandates a separate ward, it would appear that this GHPU is referring to an interpretation of the law that is being promulgated by the relevant State Mental Health Authority (SMHA). The legal situation facing government GHPUs is substantially clearer - none of the five government GHPUs that I visited is licensed pursuant to the MHA.

The vast majority of RCs, GHPUs, and other facilities that I visited are thoroughly dissatisfied with the MHA. One of the most common criticisms is that the law’s staffing requirements are impractical. According to one SMHA, “many organizations are understaffed.” The SMHA is “not taking any punitive actions,” however, because these organizations are providing a service and it is “impossible” to satisfy the MHA’s staffing requirements.

Although one might argue that this SMHA’s use of discretion ameliorates the ill effects of the MHA’s staffing requirements, the result is not the same as if the staffing requirements did not exist. First, this approach gives the SMHA a great deal of discretion that can lead to problems such as bribery. Second, the selective enforcement of MHA provisions undermines the entire act, including its human rights protections. Third, selective enforcement creates uncertainty for both established and prospective mental health service providers.

In general, legislating the minimum bed to staff ratio at the national level can be problematic because the number of qualified practitioners varies greatly by region. If national staffing standards are set, it is important that they are truly minimum standards, and that local governments can, if they feel it is appropriate, set higher standards. Based on this study, the MHA’s staffing requirements are impractical even for mental health facilities
in major metropolitan areas. Instead of focusing on the minutiae of service provision, which can change dramatically over time, mental health legislation should focus on rights, which are fundamental, universal, and relatively constant.

There is substantial evidence that the MHA’s staffing requirements prevent prospective providers from establishing new mental health facilities. Few new facilities have opened since the SMHAs began enforcing the MHA in the wake of the tragic fire at an institution in Ervadi, Tamil Nadu, in which twenty-eight individuals with mental health problems died. One SMHA, for example, has not received any new applications for licenses during the last few years. Given the lack of new facilities, it is unsurprising that there appears to be an overall lack of community-based mental health facilities in India.

Another common criticism that providers have about the MHA is that it does not allow for the licensing of a full range of mental health facilities. The range of facilities that are recognized and regulated in other countries is often quite broad, and having a wide range of services available for people with mental health problems is essential. However, the proper remedy might not be to bring more types of facilities under the purview of the MHA in its current form. Given that India has signed and ratified the CRPD, India will have to re-evaluate the MHA. Change will be dramatic because at least three major aspects of the CRPD conflict with the MHA. First, as opposed to the MHA, the CRPD emphasizes that a person with a disability has legal capacity. Second, the CRPD states that people with disabilities have the right to live in the community.

Instead of emphasizing community-based services, most of the MHA’s provisions focus on regulating the admission and detention of mentally ill persons in institutions. Third, the CRPD prohibits torture and cruel, inhuman or degrading treatment or punishment. These provisions call into question the MHA’s silence regarding the use of ECT, restraint, and seclusion.

Such changes will have to happen relatively quickly. Pursuant to Article 33 of the CRPD, India is required to “maintain, strengthen, designate or establish . . . a framework. . . . to promote, protect and monitor implementation of the [CRPD].” Within two years after the CRPD comes into effect, India will have to submit “a comprehensive report on measures taken to give effect to its obligations under the [CRPD] and on the progress made in that regard . . .” There is cause to celebrate India’s decision to sign and ratify the CRPD, but there is much work that remains to be done.
In writing an article for an international Bulletin about teaching college students to work in the area of serious mental illness (SMI), I am well aware that different cultures and countries vary enormously. What has worked beautifully in the Midwestern U.S.A. is not necessarily going to work as well, or the same way, in other parts of the world. This awareness is uppermost in my mind as I think about teaching students to work with people who have SMI’s, their families, and the cultures of their environment.

Having written the above, I will now try to extract from my thirty years of teaching in this area, some concepts that I think are applicable to all human cultures. In training professionals to work with people who have SMI’s, it is essential that students learn about people first, and diagnosis and treatments afterwards.

Here is a specific example of what I have in mind. These are two descriptions of my fifty-year-old son who has schizophrenia, both written in the year 2006. “His G.A.F. varies from 21-50. He has schizophrenia, paranoid type 295.32. He expresses high levels of interpersonal stimuli, chronic baseline level of anxiety, and has trouble completing daily living skills.” This was written by his main clinician. During the same week I received a letter from a close friend, who wrote of my son: “Give my love to _______. I remember him with such admiration for his courage, dignity, and abundance of talents, even if they sometimes don’t fly out to greet you. I have this vision of a lovely giant... and inside are all these birds which can sing the most beautiful songs, and make lovely pottery, and think beautiful thoughts, but sometimes they can’t find their way from the inner world to the outer... but when they do, their flight is so rare and precious to behold.”

These two descriptions are both true. The first one guides a doctor toward medications that might help. The latter one captures my lovely son. In our way of educating students, it is this latter description that usually gets lost in the shuffle of our training and care systems.

A correct diagnosis is important, but before this, the focus must be on the person. Students quickly develop feelings of compassion and understanding toward people struggling with SMI’s if they first get to spend time with them in their natural settings, whatever they may be. Part of our training of students should have them spending several hours a week with “consumers” in their homes, wherever they spend time, or perhaps going for walks, playing card games, or having a cup of coffee. This key element should be applicable in all cultures: getting to know the person as more than a collection of transmitters gone awry.

In all disciplines that deal with people who have SMI’s, I think our educational systems must introduce students to people who struggle with these illnesses, before they get into content about making diagnoses, treatment planning, and so forth. Does a cancer patient want to be seen predominantly as a bunch of malignant cells gone wild? Or does this person want to be seen as a parent, professional person, an artist, a whatever... who is scared out of his/her wits, trying to cope and wanting the best treatment possible? Because SMI’s affect the mind, and it is our minds that make us so distinctly human, I think we often lose sight of this in our educational process of training professionals in the fields of SMI. One student put it poignantly in a paper she wrote: “The lecture and readings were good, however nothing

Mona Wasow.
explains mental illnesses as well as spending five hours a week with people living with the illnesses. I am so sad for how unlucky these people are to have SMI’s, and the way our society treats them … ”

Another pedagogy that probably crosses all cultural lives is the use of fiction along with research articles, for assigned readings. Creative writers have published a lot of good books and articles dealing with SMI. I always assign a piece of fiction, or writing done by consumers or family members, on a given topic, immediately followed by a research article on the same topic. This works beautifully, for after the fiction first person account, students are sincerely interested in the research. (The reverse order, I find, does not work nearly as well.)

Using lectures, readings, class discussions, and practical clinical experience with consumers in their own environments, the following content should be covered:

1. The main SMI’s as we know them today. It is important to be open about what we do not know, too.
2. Some history about treatments in your own country from at least the mid-1800’s to the present.
3. The deinstitutionalization movement, and the failure to develop adequate community care.
4. What ideal community and/or family care look like in your particular country.
5. Consumer perspectives, family perspectives.
6. Education for all concerned: consumers, families, and professionals. There are now 30-40 years of cross-cultural research showing a direct correlation between education about SMI’s and the well-being of all concerned.
7. Advocacy work on behalf of people with SMI’s. Along these lines, students should know about WAPR, as well as any local advocacy groups in their home communities.
8. Knowledge about treatments of all kind is important: Psychological; bio-medical; spiritual; client-centered; and, of course, the dominant treatment modalities of your particular culture. It is also my bias that humor, playfulness, and creativity should not get lost in the treatment shuffle.

A Surprising Finding

After 30 years of teaching graduate students, varying in age from 22 to mid-50’s, a few years ago I taught the exact same course on SMI to first semester college students, average age of 18. I expected them to do as well in their academic work, but was nervous about placing these young people in the community to do their field work. The agency supervisors were even more nervous!

The first few days in the field were chaotic, but then students quickly developed feelings of compassion and understanding toward the people they met in their field placements, who were struggling with SMI’s. It was not my teaching that brought this about, it was the service-learning component of the course, of this I’m sure.

Here is a typical example of what I saw: Three 18-year-old male freshmen were placed in a boarding house for men who had severe schizophrenia. I had placed graduate students there for several years. Graduate students worked on trying to find jobs for the men, their “daily living skills, social skills, etc.” I decided to observe the three 18-year-old students during their second week of placement. As I walked up the front stairs, I heard laughter coming from within the house! I had never heard that before in this boarding house - what could be going on inside, where no one ever even seemed to say “good-morning” to each other? They were playing poker! All the students and men living in the house: laughing, dealing cards, flipping coins into the center of the table, betting … Oh, what a beautiful sight to behold!

To repeat the obvious, the younger students did not yet know about transmitters that did not work, about cognitive deficits, positive and negative symptoms, and lack of social skills. They saw a great need to try and add a little pleasure to their empty lives.

As I went about from agency to agency to observe the young students, I saw a variation on this theme. Needless-to-say, the people struggling with SMI’s enjoyed playing poker, going for walks in the woods, cooking a meal together, and so forth - more than they enjoyed working on their problems or social skills.

I am not saying that finding jobs, learning social and daily living skills, taking medications, etc. are unimportant. It is a question of seeing people and their strengths before focusing on deficits. That I think is so important.

Summary

The earlier we can expose students to people with SMI’s, the better their chances of seeing the whole person, and not just the illnesses and deficits. People with SMI’s are no different from the rest of us. We like it best when our good sides are seen first!

Teaching young students with a service-learning component provides the opportunity for total involvement in the subject matter, and the student learning process. Students are so open, impressionable, and without cynicism. Many still believe in “miracles,” and as such, even manage to pull a few out of the hat! They talked and wrote about clients’ bravery and abilities to cope with the impossible. As one student wrote in her journal, “I don’t see them as ‘SMI’s’, and I never will again. They are my friends, and the world treats them as outcasts.”

When we are teaching about people, we have to broaden our thinking beyond theories, research and treatment modalities. We must teach in such a way that students learn about loneliness and misery before they learn about DSM diagnosis and medications. The latter is important, it is just a question of which comes first. I want my son to be seen as a “lovely giant” who plays music and makes pottery, not as a “schizophrenic, paranoid type 295.32 . . .”

Mona Wasow.
Dignity, participation and identity: Developing recovery-orientated environments for work and studies in Bergen, Norway.

Ingjerd Sørheim. Psychologist/regional coordinator in mental health, NAV, Bergen.

Introduction

Bergen is the second largest city in Norway with about 245.000 citizens, and is located on the west coast near the North Sea. In Norway, like in most western countries, the services for citizens with mental health problems have gone through major changes over the last decades. The number of inpatients has been reduced and most people with mental problems live in the community. Mental health services are partly organized as primary health care and partly as geographically sector-based specialist services in hospitals and community mental health centers. In June 1998, the Norwegian Parliament introduced The National Action Programme for Mental Health with a major increase in funding, and reorganisation of services. Implementation of the programme has taken place between 1999 and 2008. As in many countries the reorganisation includes a shifting of focus in services from an institutional to community services. This process has strengthened the municipalities in providing preventive and primary care. Furthermore, emphasis on user involvement on all levels, supported housing, vocational rehabilitation, and social programming has been important. Individuals in need of support from several agencies are now entitled to what is referred to as an individual plan. The objective of this plan is to guarantee the service users human and civil rights as well as his or her accessibility to various services and activities. The municipalities are having a key role in the provision and co-ordination of services for individuals with comprehensive needs. Primary mental health care services are integrated with general health care and are provided by local community agencies. Although many of these services are guaranteed to citizens as part of Norwegian welfare policy, there remain several obstacles to improving continuity of care and availability of the “right help and support,” particularly in crisis situations (Borg & Kristiansen, in press; St. meld. nr. 25 (1996-1997).

Since 1997 services for citizens with mental health problems have expanded in comprehensive ways and increasingly become inspired by literature and principles of recovery and empowerment. The service users own stories, experiences and preferences are seriously taken into account, in many new ways. There has been a gradual evolution towards these new values. From 1997 to 2004 we were particularly concerned with providing safe homes and tailored support for individuals in need of this. We developed these services in collaboration with the women and men living in these houses and were given useful feedback from them in an evaluation survey, carried out by a local university college. As more and more of the service users had good and safe places to live, the need for meaningful occupation became evident. In 2000 a new cultural center, the Amalie Skrams House, was established following an initiative from a service user. The center quickly became popular, and it is now visited by between 50 and 80 members every day. The center is inspired by the principles of the Fountain House Organization, with art and culture and not work, as the main occupation.
with the local employment services in 1998 but the outcome was rather scarce the first years. It was as if the perspectives of helpful help, the objectives and intentions, as well as the language of the two services, were completely diverse. In the employment services, the predominant conception of people with psychosis was that they must be protected from the stressful situations of ordinary work. The idea was that the person involved should be “fully rehabilitated” before anyone could start thinking about work. We were familiar with research and literature about employment and recovery (Anthony et al, 1995; Harding & Zahnister, 1994). Here ordinary work arenas for rehabilitation and recovery are emphasized, simply because these environments provide real opportunities for using ones resources and talents, for valuable social roles and for meaning and dignity in life.

In Bergen an enterprise run by the municipality called “Center for preparation to work” was established. After 2 – 3 years this enterprise offered a broad selection of work opportunities, both individually and in groups. The enterprise offered flexible working hours, from few hours per week to full time. The work experience required various skills and challenges. The main goal was to meet individuals’ needs and wishes. Most of the service users had been out of work for many years, and some had never been employed. Tailored jobs were created, like nursing assistants in nursing homes for the elderly, employment in the park and forest department, in libraries, in kindergardens and in various kinds of public services. The work groups offered services like painting, mowing lawns and removing garbage. They also made equipment for playgrounds.

In 2005 the governmental plan for strengthening and improving the mental health services in Norway included extra finances to the four largest cities. The aim was to improve services for citizens who needed assertive outreach approaches. Both the municipalities and the employment services got such resources and a new cooperation was encouraged.

**Work as a part of the recovery process**

The Labour and Welfare services provide opportunities for a wide range of involvement and participation in working life and in society as such. The service also provides financial security for individuals. This requires a mutual and collaborative relationship, not only between helper and user, but also with the labour market and the local municipalities. Extra attention has been paid to those with special needs, and to those in a challenging life situation. In 2006 the Labour and Welfare administrations merged to become NAV (New service for work and welfare), and by 2010 one of the largest public administration reforms on record has been carried out - all to give the citizens a better service. The new organisation will be a local partnership between state and local authority. NAV’s vision is to give people opportunities. This vision incorporates three of society’s fundamental functions:

- Opportunity for work for as many as possible.
- Opportunity for meaningful activity for people with special needs.
- Opportunity for a secure income in accordance with civil rights.

Disability and sickness benefits are increasing, and are the highest in OECD -countries. We also see that far too many are given a temporary rehabilitation pension or an occupational rehabilitation pension for too long period of time. And few join the work force even if they have motivation and see work as a part of their recovery process.

From 2004 the Directorate of Labour strengthened their attention towards people with mental health problems. The directorate had for a long time had funds aiming at supporting people suffering with these problems in finding a way back or into the workforce. On average, there were 20400 occupationally disabled persons with mental health problems as their main diagnosis registered by the Labour and Welfare services (St.meld 9(06-07)). This diagnostic category constituted 26 % of all occupationally disabled persons whose diagnosis was registered. Throughout 2005 approximately 3.3 billion N.kr. or 410 million Euros was spent with the intention of improving the work situation for occupationally disabled persons with mental problems (St.meld 25(1996-97)).

In this context the project Vilje Viser Vei (Where there is a Will there is a way) was started in 2004. The project aimed at developing a systematic approach of providing work for people with mental health problems. Integration into ordinary work environments, and providing educational opportunity or meaningful activity were important objectives of the project. We know that in order to participate in the society, work can contribute to increased self-esteem and coping skills. International literature recognises the importance of being in work or meaningful activity (Anthony el al 1995; Borg & Kristiansen, in press). Work strengthens social skills, reduces symptoms and offers a variety of valued roles. Research also revealed that in our organization we had not focused enough on personal resources. We had not recognised that people have many useful
personal resources in spite of their mental health problems. Instead of offering work or activities based on the personal skills, they were offered jobs and tasks they didn’t find meaningful. Often people were experienced to fail in these situations – or one may say that the services failed in fulfilling their objective (Møller, 2005).

We had to find new ways, and we needed to collaborate more closely with others. We knew through reports and research done in the field, that people with moderate or severe mental health problems need coordinated and tailored services. Traditionally in Norway public services has been fragmented and unavailable for many user groups. Services aimed at the same groups may often have diverging objectives and contrasting skills and resources. Co-operation and exchange of experience was not systematically planned. In addition the experiences and preferences of the service users were not acknowledged or taken seriously.

During the following two years various new projects have developed and put into action. The main objectives of these new projects were rehabilitation and recovery. The projects were developed in partnership with service users and in the following we will give a brief presentation. The new projects are far more flexible, well-organized and accessible for citizens with mental health problems than the previous occupational services. The employees or participants individual needs and preferences can better be taking into account throughout the whole process of returning to work. The main success factor is available professionals with the demanded skills and values, who are eager to be partners in a broad context of services. In Bergen the new projects are now connected to other employment services offering continuity during various programs.

Preparation groups for real jobs – a 17 weeks programs

Many citizens with mental health problems need a gradual “comeback”, because they have been excluded from the labour market for many years. The groups start with social activities two hours per day. The groups are gradually extended to full days, and a period of 8 weeks of work experience in different companies is included. The outcomes can be employment in the company where the work experience was provided, another job, further studies, or even a decision to wait with the next step. In general choices are made based on sufficient information about options.

Vågsbunnen Studio and Vox Art Gallery

This project may be seen as a further development from the Amalie Skrams House, the earlier describes center for art and creative activities. Some of the members here were very successful and talented, and wanted to use their creative skills to create jobs. In Vågsbunnen studio they are offered a warm, inviting and safe environment with supportive colleagues, who also inspire their creative processes. About half of the artists are professionals. In the gallery they sell their pieces of art and by this can improve their income. But most of all they report a better quality of life and less symptoms from their mental health problems.

Supported education

After some years of discussions and contact with a key person in the Netherlands (ref), we finally managed to establish this service in cooperation with Center for Preparation to Work, and the Student Welfare Organization in Bergen. The Student Mental Health Care center offered to integrate this service within the general student welfare program, although they had very little experience with the target group. After one year there are 30 students included in the support program. The students come from all degrees, departments and faculties in Bergen University College and almost all of them have severe mental health problems.

Employees with lived experience

This educational programme aims at qualifying people who have experienced mental health problems for work in different parts of the mental health services.

The traditional mental health services do not sufficiently value the users’ perspectives. Many aspects of recovery-orientated support are not addressed by the traditional psychiatric care system which is derived from this perspective. In addition many users are not satisfied with the services. Individuals with lived experience can offer a vast source of knowledge about supportive attitudes, methods and structures. However, this knowledge base is still not recognized sufficiently in the existing mental health care. Incorporating the user’s perspective into service planning will hopefully lead to fewer users feeling discriminated and degraded, and lead to increased satisfaction with the provision of care. The first training group started in 2006 with inspiration from Denmark. The program
consisted of 10 months practical and theoretical studies. The curriculum included for instance; communication, recovery and discussions around ethical questions. Twelve of the fifteen students completed the program, and almost all of them are now working in different parts of the mental health services. Some of them work in day care centers and some in supported accommodation. Some work in education programmes for professionals, and some in user-organizations. Most of them work part time, and get a salary as well as state pension. In addition to having a job, they are offering professionals new perspectives and practices of helpful help. They also give hope for individuals they meet who struggling with mental health problems about the prospects of recovery.

Job training for citizens with mental distress and cultural ethnic minority background

The objective of this project is to offer refugees who have mental health problems help in understanding the social context and role expectations of the Norwegian labour market. Many immigrants who come to Norway are from war-zones like Iraq, Somalia and Afghanistan. They come from countries where family structures are different. To feel at home and integrated in a modern western society is not easy, even without mental health problems. Many of our new countrymen and women are also traumatized and need special support for this. In addition there is a language barrier and need to learn Norwegian. To offer a fair chance in the labour market is a big challenge.

Summary

One important outcome of all this diversity of employment and cultural opportunities is that we learn more and more about ways of supporting citizens with mental health problems in finding employment. Furthermore we have learned that, in situations where there are no good options, we need to develop new partnerships as well as developing work, cultural and educational programmes. Being recovery-orientated also involves developing the local community and environments. The feedback from service users informs us that they feel more involved in community activities; they have opportunities to improve their situation, and are less troubled by symptoms of their mental health problems. They experience a new dignity and they have developed some personal tools which can be used in their recovery and rehabilitation process. Access to a variety of ordinary community arenas also gives a new identity, not as a patient or a service user, but as a contributor to the community, like people in general.

References


Recovery.
WAPR International Meeting in Milano.
Barbara D’Avanzo. Head of the Unit of Epidemiology and Social Psychiatry.
Mario Negri Institute for Pharmacological Research, Milan, Italy

THE Italian Branch of the WAPR, together with the City of Milan, The Mario Negri Institute for Pharmacological Research, and the Department of Mental Health of the Niguarda Hospital in Milan organised a two-day conference on Recovery and Empowerment with the aim to see what empowerment practices in various mental health services have produced till now and to gather, compare and discuss the various meanings that recovery assumes from different points of view. Since the words recovery and empowerment are widely widespread, thus prompting interests but sometimes also suspicion and discomfort, a main objective of the initiative was making these concepts clearer, even in their complexity.

The attention it was expected to be raised was actually got, and a total of 270 people participated: 33% were psychiatrists, 23% users, 17% psychologists, 10% occupational therapists, 7% family members, 6% nurses and 2% social workers, hence representing the entire spectrum of the actors involved in activities and work in favour of mental health and users wellbeing.

The first day speakers addressed mainly practices oriented to empowerment in the Italian mental health services. Parallel sessions with discussion groups helped free and intense exchange. Users active in the associations expressed empowerment as the never lasting process of self-discovery, discovery of partnership, self-advocacy. The many meanings of recovery according to users themselves were presented in a video on interviews made by users to users. For some persons recovery was connected to good care from professionals, for others it essentially consisted in the overcoming of loneliness, whereas for others recovery was simply impossible. For all, it was synonym of freedom and calmness.

Also difficulties in involving professionals in an empowerment-oriented service, and ways to obtain more substantial collaboration from the staff in this respect were addressed. The point is how to go from individual separate practices to a style of work and relationship which characterizes the whole activity in the service.

The second, more international day, was introduced by Angelo Barbato, WAPR past world president, recalling data on recovery from schizophrenic disorders derived from the Chicago Follow-up study: 20% of people with schizophrenic disorder had recovered after 10 years, and 43% had been on recovery for at least a number of years. Although indications of a possible good outcome in psychoses are witnessed by several studies, and recommendations to use a recovery-oriented approach in the care of severely mental ill persons come from many important and authoritative organisms, societies and agencies in the field of mental health, the worry emerges that the meaning of recovery and empowerment do not yet have sufficient strength and solidity.

His question was: how can we move away from krahelalian pessimism without falling in Pollyanna-like optimism? And, at the same time: how can we avoid to use new bottles for old wine?

From a more theoretical point of view, the relationship between empowerment and recovery was addressed by Cristiano Castelfranchi (National Council of Research, Rome), who underlined the need for further in depth psychological research on such a connection of ideas. The relevance of the dimension of the self either for recovery and empowerment was highlighted also by Kay Sheldon, user representative from Norwich, UK, who,
moving from her own experience, clarified that empowerment is a personal process which can be started only by the subject: *I suggest that you cannot have a meaningful recovery without taking responsibility for your life and becoming empowered. It is not possible to empower other people. You can only do that yourself. The important thing for mental health services, I think, is not to dis-empower in the first place.*

Therefore, the empowering action of the mental health services was posed under question, together with the contradiction of services where it is always possible to be submitted to coercion: …*you cannot empower other people, but you can not dis-empower them. The responsibility for this lies with all of us. In particular there is a challenge for mental health service providers to make sure that they are not actually part of the problem. …Another aspect that I feel impedes full recovery is having a mental health service that is underpinned by increasingly coercive legislation. The fact that you can be locked up, have your civil rights removed and be forcibly treated cannot be conducive to true and full recovery. The threat is always there.*

Natasja Menezes, from the McMaster University, Ontario, Canada, helped clarify the findings of studies providing recovery rates from psychosis, confirming that outcome from psychosis may be more favorable than previously thought. She also underlined the complexity of the concept of recovery, and in particular she suggested to consider outcome domains as independent one from the other (symptoms, social, occupational or educational functioning), a model of recovery which does not exclude the use of medication, and to put emphasis on functioning rather than symptomatology when assessing recovery. From the point of view of psychosis outcome, Alok Sarin, from the Sitaram Bhartia Institute & VIMHANS Hospital, New Delhi, delineated questions about how societies and cultures shape the process of illness: is the outcome of psychosis really better in the ‘low income countries? What are the implications for our understanding of the disease process? What are the implications for policy planning? In particular, he showed that the better outcome of psychosis in the low income countries is not homogeneous within single countries, where areas have bad outcomes; moreover, the better outcome is not only a matter of more favorable natural course of illness, but may also be related to better response to treatment. These observations are the sources of a lively scientific debate currently present in mental health journals.

Andrew Gumley explored the psychological cognitive mechanisms involved in reaction to illness and suffering, suggesting new directions and objectives for cognitive therapy and recovery-oriented interventions.

The conclusive round table saw Stelios Stylianidis (WAPR Board member, Athens), Cristiano Castelfranchi, Kobus Jordaan (from Port Elizabeth, South Africa, and consumer representative in the WAPR Board), René Van der Male (from Amsterdam, Netherlands and consumer representative in the WAPR Board), John Talbott (University of Baltimore) and Marianne Farkas (University of Boston and WAPR vice-president) underlying several problems emerged in the talks.

Much work still need to be done on recovery and empowerment and their relationship: in the services, in order to introduce substantial innovations in their practices and models; in communication and training, in order to make these two words full of meaning and free from ambiguity or gloss appearance; in analysis and study of their meanings and theoretical implications either from a clinical and scientific point of view. Persons with experience of mental illness, care givers and professionals seem all very much interested in going on this way.
Amnistía Internacional y FEAFES reclaman la abolición de la pena de muerte a personas con enfermedad mental en Estados Unidos.

Nota de prensa remitida por Feafes.
Madrid, 12 de Mayo de 2008.

La organización de derechos humanos Amnistía Internacional y la Confederación Española de Agrupaciones de Familiares y Personas con Enfermedad Mental (FEAFES) envían al Fiscal General de Estados Unidos, Michael Mukasey, un total de 61 mil firmas para reclamar el cese inmediato de la ejecución de personas con enfermedad mental en ese país, como paso previo a su abolición definitiva.

Desde 1977 hasta diciembre de 2007 han sido ejecutadas 1.099 personas en EE.UU. Al menos cien de ellas padecían enfermedades mentales graves, tanto en el momento en que cometieron el delito como en el de su ejecución. Esto supone una violación evidente de los derechos humanos, puesto que la pena capital se aplicaría a personas que no siempre son responsables de sus actos, ni participan en procesos judiciales justos.

Como asegura el informe psiquiátrico de una persona con esquizofrenia condenada a muerte: “La enfermedad mental reduce la culpabilidad de una persona por sus actos, no la acrecienta. Si su violencia fue resultado de una enfermedad, entonces castigarle por esa violencia es lo mismo que castigarle por su enfermedad.” En este sentido, la Comisión de Derechos Humanos de la ONU ha pedido reiteradamente a los países que aún mantienen la pena de muerte que no la apliquen en estos casos. Las personas con enfermedad mental cometen menos actos violentos que el resto de la sociedad, y cuando estos hechos se producen, los agresores pueden no ser conscientes de sus actos. Incluso desde la Corte Suprema de Estados Unidos se admitía en Junio de 2007, en la resolución del condenado a muerte Scott Panetti, la dificultad de determinar la responsabilidad judicial de las personas que sufren este tipo de patologías.

Un total de 61.314 ciudadanos se han sumado con sus firmas a las reclamaciones de Amnistía Internacional y de FEAFES al Fiscal General de Estados Unidos para que detenga inmediatamente la ejecución de cualquier persona que sufra una enfermedad mental grave. A esta petición se han unido la Asociación Española de Neuropsiquiatría (AEN), el Sociedad Española de Psiquiatría (SEP) y la Federación Española de Asociaciones de Rehabilitación Psicosocial (FEARP), junto a otras instituciones como el Parlamento Vasco y numerosos Ayuntamientos.

La próxima ejecución

Si las protestas de las organizaciones sociales no lo impiden, Levar Walton será ejecutado el próximo 10 de Junio en Virginia. En 1999 tres expertos en salud mental concluyeron que Walton sufre una grave esquizofrenia que comenzó dos años antes del momento del crimen, cuando el acusado acababa de cumplir los 18 años. Además, seis Jueces de la Corte de Apelación de los Estados Unidos han puesto en duda su capacidad para comprender el proceso judicial y lo que supone su ejecución.

Amnistía Internacional y FEAFES enviarán cartas al Embajador de los Estados Unidos en España expresando su rechazo particular a esta ejecución, e instándole a que haga todo lo posible para detenerla.

De este modo, ambas organizaciones esperan promover el creciente debate en Estados Unidos sobre la aplicación de la pena de muerte de personas con problemas mentales, así como presionar a las instituciones norteamericanas para conseguir la abolición definitiva de esta práctica injusta, cruel e inhumana.

Oficina de prensa de FEAFES.
Douglas Holmes’ e-list:
“A number of interesting consumer & carer happenings in Australia”


Douglas Holmes sends couple of e-mails with information on “a number of interesting consumers & carers happenings in Australia”. This information is spreaded by e-mail to a mailing list with more than 1600 addresses. Holmes’ e-list includes information on:

- St Vincent’s Hospital (Sydney, Australia) two days conference “to explore ways of best addressing the needs of its population and those of other high density inner city environs. This Conference will draw on the perspectives of clinicians, researchers, allied health professionals, consumers and carers, non-government agencies and general practitioners from across inner city centres and provide insights from some of the leading mental health services in the world. Inner city populations are characterised by high levels of drug use, criminality, homelessness and mental illness”.

- The launching of a “Hearing Voices” new network. Some of the aims of the Hearing Voices NSW Network are to:
  - Share experiences and Coping Strategies
  - Educate society about the meaning of voices, and help to reduce stigma in the community. Bring voice hearers who cope with their voices together with those who are distressed by their voices
  - Support a national network of people who hear voices as well as family, friends and mental health workers
  - Help start and provide resources and information for support groups of voice hearers in NSW
  - Develop a range of non-medical ways of assisting people to cope with their voices

- Multicultural mental Health: Multicultural Mental Health Australia (MMHA) has released a number of new mental health resources with a couple of leading agencies. MMHA launched its “What Is...” series of mental health fact sheets in over 20 languages at the recent Diversity In Health Conference in Sydney. The 10 topics cover issues surrounding mental illness, anxiety, bipolar mood disorder, eating disorders, depression, personality disorders, schizophrenia, challenging behaviours and suicide. The fact sheets are available in Amharic, Arabic, Assyrian, Chinese, Croatian, Dari, Dinka, English, Farsi, Greek, Italian, Khmer, Korean, Krio, Macedonian, Polish, Russian, Serbian, Spanish, Swahili, Turkish and Vietnamese. The series has also been adapted for people who are visually challenged. MMHA and Australia’s leading provider of blindness and low vision services, Vision Australia, have produced the series into braille, large print, electronic text for the internet and audio formats such as CD, cassette and DAISY for those with a print disability.

- Mental health in prison. The e-list also reports that according to a ongoing study, “eighty per cent of those in the new ACT prison will have a mental disorder. Ninety per cent of women will. It is a prodigal waste of resources as well as being inhumane if the prison precipitates mental health crises, yet this is what the traditional prison environment does. The study puts forward ways by which people would have a chance of emerging from the ACT prison in better rather than worse mental health”. The e-list also reports on a prison where “prison authorities have ordered the removal of 28 officers from the prison hospital area as part of their ironically named “Way Forward”. This will lock patients into cells at 3.30pm instead of the current 9pm from April 2nd” said Justice Action Coordinator Brett Collins. All sectors affected are in up-roar as a consequence of this projected change before the new hospital opens on May 15. The nurses, prison officers and patients themselves agree that it will be detrimental to their recovery and cause a huge increase in self-harm and suicide. The patients have told the manager that they will be refusing medication from 4pm on in support of the petition they have sent to Premier Iemma and Health Minister Meagher if the proposed lock-in times are adopted. They say “if they really want to drive us mad by this early routine, we will help them to go mad by refusing our anti-psychotic medication”.

- The Cape Town Declaration. A GROUNDBREAKING declaration calling for an end to all forced and coerced psychiatric procedures and for the development of alternatives to psychiatry was signed at Cape Town’s Robben Island Gateway in a ceremony held last week, Monday, March 24. Members of MindFreedom International and local and international psychrights activists gathered to witness the historic occasion in which Mary Maddock, founder of MindFreedom Ireland, handed over the document to Moosa Salie of the World Network of Users and Survivors of Psychiatry.

WAPR editors thanks Mr. Holmes for this information and wishes to acknowledge his effort.
“Vidas Arrasadas:
Segregación de personas en asilos psiquiátricos argentinos”.
MENTAL DISABILITY RIGHTS INTERNATIONAL (MDRI).
CENTRO DE ESTUDIOS LEGALES Y SOCIALES (CELS)

MENTAL DISABILITY RIGHTS INTERNATIONAL (MDRI) y El Centro de Estudios Legales y Sociales (CELS) han elaborado un extenso informe sobre la situación dela atención a las personas con enfermedad mental grave en Argentina.

En sus conclusiones, el informe declara que “el sistema argentino de servicios sociales y de salud mental para las personas con discapacidades psiquiátricas e intelectuales se encuentra desfasado respecto de los cambios ocurridos en el mundo durante los últimos 30 años. Debido, en gran parte, a la inexistencia de servicios de salud mental en la comunidad, las personas con discapacidades mentales han sido segregadas de la sociedad, ubicándolas en instituciones psiquiátricas.

“Al encerrar a miles de individuos en grandes instituciones, en vez de proveer alternativas a la institucionalización —tales como el alojamiento, los servicios y los apoyos ubicados en la comunidad—, Argentina está causando un daño incalculable a personas que, con los servicios y apoyos apropiados, podrían llevar adelante vidas productivas y sanas. La segregación de estas personas de sus vínculos familiares, de oportunidades y de sus comunidades, sin ninguna otra opción que no sea la institucionalización, aumenta su aislamiento, potencia su discapacidad y hace que la posibilidad de que regresen a regirse y valerse por sí mismos sea inmensamente más difícil.

Esta institucionalización masiva es, fundamentalmente, el resultado de decisiones políticas erróneas que se traducen en una mala asignación de los recursos gubernamentales y en la ausencia de planificación en políticas específica cas que se orienten a proveer atención a la salud mental centrada en la comunidad.

“Las normas argentinas que regulan las internaciones involuntarias en los hospitales psiquiátricos no establecen protecciones adecuadas en contra de la detención arbitraria. Las previsiones sustantivas que permiten la detención son demasiado amplias y están mal definidas.

“Los procedimientos vigentes no garantizan el derecho a que la medida de internación de una persona sea decidida por un órgano independiente, no establecen el derecho a la representación y no prevén el derecho a la revisión periódica de las órdenes de internación por una autoridad judicial u otra autoridad independiente.

“Dentro de muchas de las instituciones psi quiátricas argentinas se perpetran violaciones a los derechos humanos de las personas internadas, incluyendo violaciones al derecho a la vida, a la salud, y a un trato digno y humano, cuyos responsables no son investigados ni sancionados. La falta de monitoreo y supervisión en las instituciones asilares contribuye a crear un clima donde no gobierna la ley, tanto por los abusos infligidos contra aquellos que están institucionalizados, como por la corrupción en el funcionamiento administrativo.

“Sin embargo, mientras hay obstáculos importantes a vencer, Argentina tiene los recursos necesarios para comprometerse con un cambio significativo en la manera en la cual se prestan los servicios de salud mental públicos. El país cuenta con una amplia base de profesionales de la salud mental; modelos de reforma de salud mental reconocidos; leyes progresistas que favorecen la promoción de la atención de salud mental en la atención primaria, la formación de servicios ubicados en la comunidad y la desinstitucionalización. En la ciudad y provincia de Buenos Aires, donde se encuentran el 75 por ciento de las instituciones psiquiátricas más grandes, las autoridades, en general, están a favor de la reforma de la política de salud mental y están tomando medidas positivas hacia una transformación en los servicios de salud mental. Numerosas organizaciones profesionales, de derechos humanos, de familiares y de usuarios y “ex-pacientes” están activamente comprometidas con diversas acciones que apoyan este cambio de paradigma.

MENTAL DISABILITY RIGHTS INTERNATIONAL
Mental Disability Rights International (MDRI) es una organización dedicada a promover el reconocimiento y el cumplimiento internacional de los derechos de las personas con discapacidades mentales.

CENTRO DE ESTUDIOS LEGALES Y SOCIALES
El Centro de Estudios Legales y Sociales (CELS) es una organización no gubernamental fundada en 1979 y dedicada a la promoción y protección de los derechos humanos y el fortalecimiento del sistema democrático y el Estado de Derecho en Argentina.


WAPR Editor.
New Canadian Newsletter on Psychosocial Rehabilitation.

WAPR May 2008.

The Canadian Association for Psychosocial Rehabilitation has edited PSR/RPS Connections, a new newsletter aimed to facilitate networking on PSR.

The editor, Steve Bornemann calls for collaboration. The Newsletter can be downloaded from www.psrrpscanada.ca

The index in the spring issue includes topics like “Recovery in everyday life”, a “sharing stories” section, recovery and citizenship, a canadian news section, announcements, events, links and more.

As a main topic, the international committee seeks inputs for a practical PSR definition.

WAPR editorial team congratulates our colleagues in Canada and wishes them good luck.

10th. Festival EURO-PSY Rehabilitation 2008 to be celebrated in Slovenia.

QUOI?
SENT – l'Association Slovène pour la Santé Mentale, en coopération avec EURO-PSY Rehabilitation – Organisera, durant l’Année Européenne du Dialogue Interculturel, un festival de réhabilitation, intitulé LA RONDE DES CULTURES.

OU?
Au « Debeli Rti – Youth Spaand Holiday Resort”, 73, Jadranska cesta, Ankaran, Slovenia

QUAND?

ET POURQUOI?
Si ce que vous souhaitez, ce sont des vacances actives, Dans un environnement à la fois beau et naturel, incluant un programme vous permettant de faire de nouvelles connaissances et d’apprendre de nouvelles choses, ce festival est fait pour vous !

For further information please contact:
Barbara Dolnicar, Festival Co-ordinator [ENT - The Slovene Association for Mental Health, 5, Cigaletova ulica, SI-1000 Ljubljana, Slovenia. Phone number: 386 (0)1 230 78 30 (32), E-mail address: barbara.dolnicar@sent-si.org, Web page: www.euro-psy2008.sent.s]
21st CEFEC Conference.
26&27 June 2008, LISBON, Portugal

SOCIAL FIRMS, EMPLOYMENT AND QUALITY OF LIFE: COMMON STRATEGIES FOR SOCIAL INCLUSION IN EUROPE

ARIA - Associação de Reabilitação e Integração Ajuda, is a non-profit Private Institution of Social Solidarity (IPSS) that works with people with mental health disabilities in psychosocial disadvantage. It was created in 1991, by a group of mental health providers.

This year’s conference is called Employment and Quality of Life in Europe: Common Strategies for Social Inclusion.

The main proposed topics are Employment as a Strategy to Social Inclusion, Highlighting Good Practice in Social Firms in Europe, Relevance of employment in the recovery of people in psychosocial disadvantage, Growing the Social Firm Movement


The UN NGO Committee on Mental Health Agenda.

WAPR May 2008.
The United Nations Committee for Mental Health’s agenda has been dealing since 2006 a number of topics regarding mental health, such as Human Rights in mental health, the International World Mental Health Day, international approaches to alternative healing, gender perspective in mental health, media/information technologies and mental health, transcultural mental health, children, youth and mental health, racism and related intolerances, etc.

The NGO Committee on Mental Health was established in 1996 under the auspices of the Conference of Non-Governmental Organizations (CONGO) in Consultative Status with the United Nations Economic and Social Council. The creation of this Committee has fostered a strong collaboration between NGOs that has strengthened the efforts to bring understanding and appreciation of Mental Health issues to the global agenda at the United Nations.

The primary mission of the Committee is the promotion of psychosocial well-being, the improvement of mental health care services, and advocacy and education in the prevention of mental illness. The Committee works with the United Nations, and its specialized agencies, to ensure the inclusion of mental health issues within a broader context of concerns such as vulnerable populations, human rights, poverty, violence, the environment, peace and well-being.

For more information, visit the CONGO website and search the CONGO Substantive Committees and the Calendar of Events at www.ngocongo.org/ngosubs/mentalhealth.htm.
WAPR WORLD CONGRESS
BANGALORE 2009
12 to 15 November 2009, Bangalore.
“One world: quest for integration”

I WAPR European Regional Congress to be celebrated in Bilbao (Spain) June 5-7th.

FEARP. May 2008.

More than 20 plenary lectures and more than 100 individual presentations will take place at Deusto University in Bilbao. A special WAPR Workshop will also take place with the participation of the WAPR boardmembers M. Gittleman, M. Borg, I. Kosza, G. Rocca, A.. Righi, R. Guinea, chaired by M Madianos. The workshop will deal topics as Recovery in everyday life, recovery and its implications for de health systems, new strategies in housing, and PSR in Bipolar disease.

The congress is also hosting a users meeting, heading to create a users national organization in Spain. This endeavour was prepared from the I FEARP congress, and has been long waited by users organizations. Some users organizations such as ADEMM, Asociacion de Bipolares de Madrid y Asociacion Alonso Quijano are leading this initiative.


R. Guinea. Spain.

21e Congrès Rehabilitation Québec.
25 au 28 août 2008


Pour plus d’information : www.riquebec2008.org
International Juan José López Ibor Award

The Juan José López-Ibor Foundation has created an international award with the name of Juan José López Ibor, one of the pioneers of psychiatry from the second half of the XXth Century.

The award aims to recognise initiatives in favour of human dignity of those who suffer from mental disorders carried out from a scientific perspective. Bridging rational thinking and respect towards those who suffer mental illnesses is the goal of the award. The award, which will be granted every two years, will reward initiatives of research, study, promotion and communication carried out by individuals or institutions.

The candidates can be proposed by any psychiatrist at an individual or institutional level coming from the field of psychiatry, mental health or neuroscience. The proposals must include a reasoned report and a written confirmation of the acceptance of the candidate. Proposals should be sent via e-mail to the Foundation. Deadline to receive proposals for candidates will be April 20th, 2008.

The award will consist of a diploma, a token and 40,000 Euros for the awardee and for an institution that the awardee will freely choose, split into equal parts. The Award will be granted during a ceremony and a special conference during the next World Congress of Psychiatry in Prague, 20-25 September, 2008.

The Juan J. López-Ibor Foundation has received a donation from the Lundbeck Institute from Copenhagen for this Award. More Info in www.fundacionlopezibor.es

GLOBAL FORUM FOR COMMUNITY MENTAL HEALTH

1st Africa Regional Meeting

Community Mental Health in Africa; Sharing Experiences for Better Practic.

Imperial Botanical Hotel.
Uganda. 10th – 12th June, 2008.

Participating Organizations
BasicNeeds, Christian Blind Mission, National Institute for Mental Health England, World Association for Psychosocial Rehabilitation and World Health Organization: Department of Mental Health and Substance abuse

For information contact:
Lorna Kaggwa – Conference Administrator
P.O.Box 29582 Kampala Uganda
Telephone: +256 414 269558
Membership Application/Formulaire d’Adhesion/ Solicitud para hacerse miembro

Please type or print legibly/ Veuillez ecrir lisiblement on dactylographier / Por favor, escribir claramente o dactilografar:

WAPR Head Office
Dr Stelios Stylianidis, Treasurer, WAPR.
EPAPSY, 61 Grammou str, 151 24 Maroussi, Athens, Greece, Grèce, Grecia.
Tel: 0030 210 6141350, 6141351 Fax/Telecopier: 0030 210 6141352.

Name/Nom/Nombre
____________________________________________________________________
Address/Adresse/Dirección
_______________________________________________________________
______________________________________________________________________________________
Telephone/Téléphone/Teléfono __________________________ Fax/Telecopier __________________________
E-mail __________________________________

Check type of membership for which you are applying/Cochez la classe d’adhesion appropriée/Marque que tipo de miembro desea usted ser:
• Regular/Ordinaire/Ordinario: 50 USD__________________ ( )
• Sponsoring/Parrainage/Padrinazgo: 1000 USD___________ ( )
• Organization/Organization/Organización: 150 USD________ ( )
• Students, Consumers, Families/Estudiants, Usagers, Familles/Estudiantes, Consumidores, Familias: 25 USD________________________ ( )
• Reduced fee/ Cotisation reduite/Cuoto reducida (enclose letter with rationale/incluire lettre d’exlication/incluir carta de justificación:
  Amount/Montant/Cantidad ______________________________________________________________________
Donation/Don/Donación:
Amount/Montant/Cantidad ______________________________________________________________________

Interest in Psychosocial Rehabilitation/Centre d’ Interêts en readaptation psychosociale/Area de interés en rehabilitación psicosocial:
__________________________________________________________________________________________
__________________________________________________________________________________________

All money directed to WAPR should be sent by bank transfer to the following bank account/Tous les paiements addresses a l’ AMRP doivent être deposés sur le compte à l’ adresse suivant compte/ Todos los envíos de dinero para la AMRP deberán que ser enviados a esta cuenta:
EUROBANK: WAPR-HELLENIC BRANCH: SWIFT EFGBGRAA
EURO: IBAN: GR1402600020000620201157792
USD: IBAN: GR7102600020000641200035217