



Improving organizational identity for the benefit of people with mental illness

WPA is in the process of improving its organizational image and identity and the WPA media channels are playing an important role in this process.

WPA media channels (the quarterly WPA News, monthly WPA E-Bulletin and the weekly revised WPA Online) aim to mirror the voice of the WPA Member Societies, WPA Sections and the Affiliated Associations on one hand and that of the WPA Executive Committee, the WPA Board, the WPA Council, and the WPA Standing and Operational Committees on the other, in an harmonized manner.

Lately, WPA media channels had improved in this perspective. WPA Online is being updated weekly to cover the latest activities of our organization. WPA monthly E-Bulletin conveys the highlights of the developments to psychiatrists across the world. Member Societies are asked to provide the e-mail addresses of their members, so that the WPA E-Bulletin could reach individual members, especially working in the underprivileged areas of the world.

This issue of the WPA News you are currently holding reflects these developments. As could be read in the following pages, News from Members Societies, Zonal Representatives, and Affiliated Associations (pp. 5-7), News from WPA Sections (pp. 8-10), News of the WPA educational activities (pp. 29-30), News of the WPA publications (pp. 30-31), News of the upcoming WPA and affiliated scientific events (pp. 24-29) all have their appreciated rights to be heard.

Please particularly mind the advances in the WPA Action Plan (2008-2011) and the news originated from its implementation (pp. 1-3), including calls for proposals for innovative projects (pp. 3-4). Furthermore, two articles reflect the exemplary experiences in mental health and psychiatry across the world (pp. 11-23). It is our shared opinion that such positive illustrations will encourage our colleagues to reach excellence in mental health and psychiatry for the benefit of people with mental illness.

Levent Küey
Editor, WPA News

The WPA Action Plan is in progress



Mario Maj
President
World Psychiatric Association

During the past few months, the WPA has started the implementation of all the items of its Action Plan 2008-2011. Let me list some of the activities which have been initiated:

- **The first WPA International Call for Research Proposals.** We have issued a call for research projects aimed to explore the factors facilitating and those hampering the choice of psychiatry as a career. The deadline for submissions is June 30, 2009.
- **The WPA Guidelines.** We have appointed the Task Forces which will produce WPA Guidelines on: a) protection and promotion of mental health in children of persons with severe mental disorders; b) steps, obstacles and mistakes to avoid in the implementation of community mental health care; c) how to combat stigmatization of psychiatry and psychiatrists; d) mental health and mental health care in migrants.
- **The programme of fellowships in collaboration with centers of excellence.** We have launched a programme of fellowships for psychiatrists from low- and lower-middle income countries, in collaboration with five centers of excellence: the Western Psychiatric Institute, University of Pittsburgh, USA; the Institute of Psychiatry, London, UK; the University of Maryland School of Medicine, Baltimore, USA; the Mood Disorders Program, University of Cleveland, USA; the University of Melbourne, Australia. The first call for applications, for a fellowship at the Pittsburgh University, has been just issued. The deadline for applications is June 30, 2009.
- **The WHO-WPA Work Plan.** We have finalized with the WHO leadership a work plan for the next triennium, including the following items: a) revision of the ICD-10 chapter on mental and behavioural disorders; b) collaboration in the mhGAP; c) partnership on men-

tal health care in emergencies; d) collaboration in the area of substance abuse; e) partnership on involvement of users and carers. The text of the work plan is available on the WPA website. Within the frame of this work plan, the WHO and the WPA will organize in Geneva, from 27 to 31 July 2009, a training workshop on prevention and management of mental health consequences of disasters and conflicts.

- **The WPA/Lancet Initiative on Continuum of Care for Mental Disorders.** The WPA Zone Representatives and Member Societies are participating in a survey on the continuum of care for mental disorders in the various regions of the world, which is intended for publication in the Lancet.
- **The WPA train-the-trainers programme for low-income countries.** The first WPA train-the-trainers workshop took place in Ibadan, Nigeria, on January 26-30. A report is available on the WPA website.
- **The first Call for Research Projects to be conducted by WPA Sections.** We have issued the first call for research projects to be supported by the WPA and conducted by its Scientific Sections. The deadline for submissions is June 30, 2009.
- **The series of reports on exemplary experiences in the mental health field.** A first set of reports on exemplary experiences in the mental health field has been posted on the WPA website and published in World Psychiatry. Further reports are upcoming.
- **The new editions of World Psychiatry.** We have launched the Russian edition of World Psychiatry (electronic version). Selected articles from the journal are being published also in Polish, Romanian and Bosnian.
- **The series of workshops on leadership and professional development of young psychiatrists.** A workshop was held in Singapore on February 24-28. The next one will take place in Abuja, Nigeria, in October 2009.
- **The organization of the Florence Congress.** The WPA International Congress "Treatments in Psychiatry: A New Update" will take place in Florence on April 1-4, 2009. We will have more than 8,000 participants. During the Congress there will be a Special Workshop for WPA Member Societies and a WPA Forum.

■ WHO-WPA WORK PLAN 2008-2011



1. Revision of the ICD-10 chapter on mental and behavioural disorders

- The WPA will be represented by its President in the Advisory Group for ICD-10 revision.
- The WPA will facilitate resource mobilization for ICD-10 revision from sources that are acceptable to the WHO.
- The WPA will provide aggregate inputs from its Member Societies towards the ICD-10 revision. This will be facilitated by one or more surveys conducted with the assistance of the WHO.
- The WPA will collect information regarding national and regional adaptations and cultural aspects of classification for WHO's consideration in the revision process.
- The WPA will facilitate participation of its Member Societies in the ICD-11 field trials.
- The WPA will provide the services of experts to the WHO during the drafting of the ICD-11.

2. Collaboration in the mhGAP

- The WPA will provide assistance to the WHO in the preparation of the mhGAP intervention packages, by making available experts to aggregate and evaluate evidence and its packaging, as needed.
- The WPA will support the WHO in the country implementation of the mhGAP on a case by case basis.

3. Partnership on mental health care in emergencies

- The WPA and the WHO will co-organize in Geneva a train-the-trainers workshop on the prevention and management of the

mental health and psychosocial consequences of disasters and conflicts according to the Inter-Agency Standing Committee (IASC) Guidelines, with the participation of professionals from various regions.

- Informed by the above-mentioned training, the WPA (with, where feasible, the close collaboration of WHO) will organize a series of workshops on the prevention and management of the mental health consequences of disasters and conflicts, on the occasion of major WPA meetings.
- The WPA and the WHO will have a regular and structured collaboration in dealing with the mental health and psychosocial consequences of major disasters, following the model of the response to the Gaza emergency.

4. Collaboration in the area of substance abuse

- The WPA will collaborate with the WHO in the conduction of the Global Survey on Prevention and Treatment Resources for Substance Use Disorders (ATLAS Project).
- The WPA will support the WHO in the dissemination and implementation of WHO normative and other documents regarding substance abuse.
- The WPA will provide technical and programmatic input in the implementation of the joint UNODC-WHO programme on drug dependence treatment.

5. Partnership on involvement of users and carers

- The WHO will make available to the WPA its experience and access to its network of users and carers towards assisting the WPA in its project to draft guidelines about best practices in working with users and carers.

■ WPA RESPONSE TO THE GAZA EMERGENCY

Drs. Benedetto Saraceno, Shekhar Saxena and Mark Van Ommeren, of the Department of Mental Health and Substance Abuse of the World Health Organization (WHO), and Prof. Mario Maj, President of the World Psychiatric Association, met in Geneva on January 19, 2009.

They shared the following information concerning the current situation in Gaza:

1. Three out of five mental health centers in Gaza are functioning regularly.
2. Gaza's government mental health professionals are working in crisis teams (in particular, supporting patients in general hospitals, and accepting referrals from the United Nations Relief and Works Agency, UNRWA).
3. The Mental Health Directorate in Gaza has emphasized the need for psychotropic drugs and vehicles for crisis intervention teams. WHO is coordinating and following up on such requests.
4. The WHO is in daily contact with the UNRWA, and both organizations are deeply concerned about the expected uncoordinated influx of mental health and psychosocial NGOs to Gaza.
5. Two staff of the WHO Department of Mental Health and Substance Abuse are on standby to travel to support WHO in Gaza and/or Jerusalem.
6. Traveling to Gaza is currently made difficult by entry permissions by the Israeli government.

It was agreed that:

1. WHO has invited WPA to be involved in the mental health and psychosocial support response to the emergency in Gaza as outlined

in point 2 below. This involvement will be recognized as such, where appropriate, in relevant official documents.

2. The WPA will provide the WHO and the UNRWA, as part of its contribution to the mental health response to the emergency, with a list of trained mental health professionals who are able to speak Arabic and are available to work in Gaza. For each professional, the nationality, the availability in terms of days which can be spent in Gaza, and a concise information about expertise should be provided.

3. The WPA will be in contact with the Gaza Community Mental Health Programme, in order to support its activity, both in the current acute phase and in the reconstruction phase, in consultation with the local coordination mechanism, which is co-chaired by WHO West Bank and Gaza Office.

4. The interventions coordinated by the WHO and the UNRWA will be based on the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings, available in several languages, including Arabic, at http://www.who.int/mental_health/emergencies/en.

It was further agreed that:

1. The WPA and the WHO will co-organize in Geneva a three-day train-the-trainers workshop on the prevention and management of the mental health and psychosocial consequences of disasters and conflicts according to the IASC Guidelines, with the participation of professionals from various regions.

2. Informed by the training mentioned in the previous point, the WPA (with, where feasible, the close collaboration of WHO) will organize a series of workshops on the prevention and management of the mental health consequences of disasters and conflicts, on the occasion of major WPA meetings.

■ REPORT OF THE WPA TRAIN-THE-TRAINERS WORKSHOP IBADAN, NIGERIA, JANUARY 26-30, 2009

The 5-day WPA training workshop for the teachers of mental health in community health officers' training institutions in the southwest of Nigeria took place at the University of Ibadan Conference Centre, Ibadan from 26 to 30 January 2009. There were 25 participants selected from the 6 southwestern states (Lagos, Ogun, Ondo, Osun, Oyo, and Ekiti) and the two Yoruba speaking north-central states (Kogi and Kwara).

The workshop aimed to provide the participants with: a) knowledge, skills and competencies around mental health and mental disorders as well as common neurological disorders, and their contribution to physical health, economic and social outcomes; b) understanding of linkages between mental health and child health, reproductive health, malaria and HIV; c) understanding of the general policy and implementation contexts for primary care; d) understanding of mental health policy and legislation; e) skills about working with the community, and supporting volunteer community health workers; f) skills about disaster management.

Selection of participants was made through the National Primary Health Care Development Agency working with the heads of the various institutions. The selected participants were experienced, senior teachers serving in colleges of health technology, community health officers' training programs in teaching hospitals, and community health officer tutors' courses in the University College Hospital Ibadan. There were also representatives of the Community Health Officers' Registration Board (the agency responsible for developing community health officers' curriculum and licensing of practitioners) and the National Primary Health Care Development Agency.

The program ran daily from 8.00 am to 5.00 pm using an adapted curriculum, following a general health systems approach and compatible with the WHO-PHC guidelines. The curriculum had been previously developed by R. Jenkins for Kenya, and subsequently adapted for and used in Ghana (V. Doku), Malawi (F. Kauye) and Pakistan (R. Taj and R. Jenkins). Short didactic lectures were augmented with 23 role plays and case vignette discussions. The resource persons were O. Gureje, R. Jenkins and V. Doku. Participants were administered a pre- and post-workshop questionnaire to assess their knowledge of mental health issues and evaluate the changes due to the training. The analysis of the tests will be conducted in due course.

An important highlight of the workshop was the requirement for the participants to develop specific plans of action that build on the outcome of the training. The following were the plans collectively agreed upon:

- Provision of written report on the workshop to the authorities at their institutions within one week of completion of workshop.
- Plan to incorporate the contents of the WHO-PHC guidelines into their lecture notes on mental health within the next academic session.
- Plan to improve their teaching skills by employing role plays and discussions by their students.
- Having understood the relationship between mental health and reproductive health, malaria, HIV/AIDS and child health, the participants resolved to sensitize teachers of other subjects in their institutions to the relevance of mental health to the other courses and subjects.
- Specific plan to forward to Ibadan the academic timetable of their institutions indicating when mental health courses would be taught so as to facilitate monitoring and support visit by O. Gureje and his team in Ibadan.



Group photo of participants and trainers, Ibadan, Nigeria.

It was agreed to have periodic monitoring, evaluation and boosting of the knowledge already acquired through scheduled visits to the participants in their respective institutions to observe them teaching their students using the skills acquired during the training.

■ WPA-WHO WORKSHOP ON MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN AREAS AFFECTED BY DISASTERS AND CONFLICTS (WHO HEADQUARTERS, GENEVA – JULY 27-31, 2009)

CALL FOR APPLICATIONS

The World Psychiatric Association (WPA) and the World Health Organization (WHO) will organize in Geneva, from 27 to 31 July 2009, a workshop on mental health and psychosocial support in areas affected by disasters and conflicts according to the Inter-Agency Standing Committee (IASC) Guidelines (see www.who.int/mental_health/emergencies/en).

Twenty psychiatrists will be admitted to the workshop, which will be held in English.

Selection criteria will be: a) being a certified psychiatrist; b) living in an area at high risk for disasters or conflicts; c) having previously worked in emergency settings; d) being potentially available to work abroad in emergency settings under difficult circumstances for at least two months; e) being available to orient other psychiatrists at WPA meetings on the content of the IASC Guidelines.

Applications, accompanied by a short curriculum vitae (no more than 2 pages, covering the above five criteria), should be received at the WPA Secretariat (wpasecretariat@wpanet.org) no later than June 8, 2009.

Successful applicants will be admitted to the workshop free of charge and will receive a maximum contribution of 2,500 Euros towards their travel and accommodation expenses.

■ CHOOSING PSYCHIATRY AS A CAREER A WPA INTERNATIONAL CALL FOR RESEARCH PROPOSALS

The World Psychiatric Association (WPA) is the largest association active in the mental health field worldwide, with 134 Member Societies (national psychiatric societies), representing more than 200,000 psychiatrists, and 65 Scientific Sections.

In the WPA Action Plan 2008-2011, one of the institutional goals is to enhance the image of psychiatry worldwide among the general public, health professionals and policy makers, counteracting some negative messages – often biased by ideological prejudice – which are affecting the motivation of persons with mental disorders and their families to seek for psychiatric advice and help and to adhere to

psychiatric interventions, as well as the motivation of medical students to choose psychiatry as a career.

As one of the activities pursuing this institutional goal, the WPA will fund an international project aimed to assess the factors facilitating and those hampering the choice of psychiatry as a career by medical students, and to suggest strategies to encourage this choice.

Proposals from individuals, departments or societies are welcome. They will have to include a description of the project (max. 1200 words), a list of the participating centres, a timetable, a detailed budget, and a short curriculum vitae of the proposed principal investigator(s). Proposals will have to be sent by e-mail to the WPA Secretariat (wpasecretariat@wpanet.org) by June 30, 2009.

■ CALL FOR PROPOSALS OF RESEARCH PROJECTS TO BE SUPPORTED BY THE WPA AND CONDUCTED BY ITS SCIENTIFIC SECTIONS

The World Psychiatric Association (WPA) is the largest association active in the mental health field worldwide, with 134 Member Societies (national psychiatric societies), in 122 countries, representing more than 200,000 psychiatrists.

The scientific backbone of the Association is represented by its 65 Scientific Sections, covering practically every aspect of psychiatry. According to the WPA statutes, one of the purposes of these Sections is the promotion and conduction of international collaborative research, a purpose which has been only partially achieved up to now, mainly due to financial constraints.

The WPA is going to fund two high-quality research projects proposed by its Scientific Sections. The projects will have to deal with one of the following issues highlighted in the WPA Action Plan 2008-2011:

1. Depression in persons with physical diseases.
2. Stigmatization of psychiatry and psychiatrists.
3. Integration of mental health care into primary care.
4. Protection and promotion of physical health in persons with severe mental disorders.
5. Assessment and development of talents and strengths of persons with mental disorders.

Proposals from individual Sections or networks of Sections are welcome. They will have to include a description of the project (max. 3000 words, including an introduction, the objectives, the methodology and some references), a list of the participating centres, a timetable, and a detailed budget. A short curriculum vitae of the proposed principal investigator(s) is also requested (no more than one page). Proposals will have to be sent by e-mail to the WPA Secretariat (wpasecretariat@wpanet.org) by June 30, 2009.

**HAVE YOU RECENTLY VISITED
THE WPA WEBSITE?
→ WWW.WPANET.ORG**

■ CALL FOR APPLICATIONS FOR A RESEARCH FELLOWSHIP

World Psychiatric Association

Department of Psychiatry & Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center (UMPC)

The World Psychiatric Association, as part of its Action Plan 2008-2011, has launched a programme of research fellowships for early-career psychiatrists from low- or lower-middle income countries, in collaboration with internationally recognized Centers of Excellence in Psychiatry.

Within this programme, the World Psychiatric Association is funding a research fellowship at the Department of Psychiatry & Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center (UMPC).

The successful candidate will spend one year at the UMPC, and will be expected to conduct research in the field of mood disorders.

Applications are invited from psychiatrists less than 40 years of age or with less than five years elapsed since completion of residency training. The list of eligible countries (low- or lower-middle income countries) is available on the World Bank website (<http://www.worldbank.org>).

The fellowship holder will receive a subsidy of 30,000 Euros plus coverage of travel expenses (economy class). He/she will commit himself/herself to report to the World Psychiatric Association about the results of his/her activity, and to apply in his/her country of origin what he/she has learnt.

Applicants should submit by e-mail their curriculum vitae to the WPA Secretariat (wpasecretariat@wpanet.org). The deadline for applications is June 30, 2009.

News from Member Societies, Zonal Representatives, and Affiliated Associations

Contact: WPA Secretary General, Levent Küey, wpasecretariat@wpanet.org

■ LATEST NEWS FROM THE KYRGYZ PSYCHIATRIC ASSOCIATION

The esteemed Professor V. V. Solojenkin was the founder and leader of Kyrgyz Psychiatric Association (KPA) until 2007. After the elections that had taken place in 2007 a new Executive Committee was formed. Now under the presidency of Doctor Abjalal Begmatov the KPA EC consists of seven members including the Secretary for International Relations, Doctor Tamilla Kadyrova.

Activities of KPA cover various aspects of the field of psychiatry and mental health. One

priority of KPA is the organization of activities especially in coordination with WPA, and also in coordination with its members within the country. Recently in November 14, 2008, a scientific meeting called "Psychiatric Readings", dedicated to the memory of V.V. Solojenkin, was held.

Scientific activities of KPA include the development and organization and support of research in psychiatry, including child psychiatry and narcology, holding a reformati perspective.

Educational activities focus on organization of clinical case discussions, and educational and training seminars, aiming to cover all of the regions of the country. Besides, developing international relations on education in psychiatry and narcology is also aimed.

Tamilla Kadyrova
Secretary for International Relations
Kyrgyz Psychiatric Association



■ NEWS FROM THE RUSSIAN SOCIETY OF PSYCHIATRISTS

The Annual Conference of the Russian Society of Psychiatrists was held on 28-30 October 2008 in Moscow. The title was: Realization of subprogramme "Mental disorders" of Federal dedicated programme "Prevention and control of socially significant diseases." The issues connecting with new classification and treatment approaches were discussed during sessions of the Conference.

The Russian Society of Psychiatrists has began to prepare for the 2nd Congress of PAEEB (Psychiatric Association of Eastern Europe and Balkans) "Collaborating for Mental Health" which is planned to be in Moscow on 27-30 October 2009 and to the WPA Regional Congress "Traditions and Innovations in Psychiatry" in St Petersburg on 17-19 June 2010.

■ THE NORWEGIAN PSYCHIATRIC ASSOCIATION

The Norwegian Psychiatric Association celebrated its 100th anniversary in 2007. One of the most successful initiatives we undertook during the celebration was to make a ten point manifesto on health policy. This manifesto has since the celebration often been cited by the media and has proven useful in explaining our plans for the future direction of psychiatry in our country.

Manifesto on health policy from the Norwegian Psychiatric Association (NPA)

1. No more stigma and prejudices

We need a national strategy for continuous work to fight stigma and prejudices through / by information.

2. Mental disorders can be prevented

We need a national plan of action aimed at preventing mental disorders, drug related diseases and suicides.

3. Mandatory education on mental health in schools

Knowledge about mental health, psychology and treatments must be mandatory in high schools.

4. Early detection and treatment of severe mental disorders

Hospitals must develop systems for early detection and treatment of psychosis.

5. Better accessibility and low threshold

Patients should be able to come directly to the hospitals and be assessed by a psychiatrist concerning the need for further treatment.

6. Plan for professional upgrading

This upgrading must be done in close collaboration with the user organisations to make sure that the patients' point of views is taken into account (or consideration). Psychiatry must be based upon best evidence.

7. Secure and expand the room for psychotherapy and other psychosocial treatments

In times when the health care services are focusing more on short term economic

results, the softer and more time consuming aspects of treatments are under pressure.

8. Reduce coercion

Reduction in involuntary treatment can be achieved through an easier access to the services in mental health care.

9. Users should be given a real possibility to influence treatment. Right to work

We want to work towards more influence from and closer collaboration with the users. Workplaces should be organized in a way that is more including and accepting towards all kinds of people.

10. Quality indicators to measure results of the treatment and customer satisfaction

We want quality indicators that actually measure how our patients fare in both the short and long run. Continuous feedback in the form of patient satisfaction questionnaires.



Norsk psykiatrisk forening

DEN NORSKE LEGEFORENING

■ PSYCHIATRY BOARD CERTIFICATION IN TURKEY

Psychiatry board certification examinations were initiated in Turkey in 2006. The aim was to motivate psychiatrists who had already been qualified in psychiatry to be up to date in recent developments in the field, thus improving good clinical practice and quality of psychiatric services in the country. As of 2008, residents in the final year of their residency program are allowed to take the first step of the exam, they are qualified for taking the second step after completing their program.

Turkish Board of Psychiatry organized the certification exams with the collaboration of Ege

University, Faculty of Medicine, Department of Medical Education. Certification examinations are performed in two steps. The objective of the first step is to assess knowledge and second step is to evaluate skills and attitudes. The first step consists of 100 multiple choice questions, covering main topics of Psychiatry Residency Curriculum, which has been developed by Educational Program Development Commission of Psychiatry Board. Candidates who succeed in the first step are eligible for taking the second step examination. The format of the second step is objective structural clinical examination (OSCE). Six stations are designed for the second step of the certification exams. After the

main topics are established; scripts for simulated patients, instructional guides and checklists for the observers and instructional guides for the candidates are prepared. Simulated patients take part in five stations. One station is designed to evaluate the candidates' skills in psychiatric forensic report writing. Candidates stay in each station 10-20 minutes.

As far as we know, Psychiatry Board of Turkey is the first in incorporating OSCE in board certification exams.

Aylin Uluşahin
Coordinator, Board Certification
Psychiatry Board of Turkey
Psychiatric Association of Turkey

■ NEWS FROM NIGERIA

Oyewusi Gureje PhD, DSc, FWACP(Psych), FMCPsych, FRCANZPsych, FRCPsych, Professor and Head, Department of Psychiatry, University College Hospital, Ibadan and College of Medicine, University of Ibadan, Ibadan who is also the President of the Association of Psychiatrists in Nigeria was conferred with the award of the Nigerian National Order of Merit (NNOM) by the President of Nigeria, His Excellency Alhaji Umaru Musa Yar'Adua on the 16th of December 2008 for exceptional industry and academic excellence in the field of Medicine. The conferment followed his selection in a highly competitive and rigorous process, by the Nigerian National Merit Award Committee, among several distinguished national and international aca-

demics who were nominated for awards. The NNOM is the highest honour given to academicians who have distinguished themselves in their field of endeavor by the Government of Nigeria. Professor Gureje, the youngest of the three winners of the 2008 prizes, shared the turf with the Nobel Laureate Professor Wole Soyinka and Professor Chuwuemeke Ike whose contributions are in the literary arts. By this award, Professor Oye Gureje has joined the league of 57 most distinguished Nigerians recognized for their excellent contributions in academia within and outside the country since the commencement of the award 25 years ago. The WPA Zone 13 members congratulate their immediate past representative and wish him more success in life even as he uses his new status to project the specialty positively in Nigeria and beyond.

JD Adeyemi
WPA Representative for Central and West Africa (Zone 13)



Left to Right: His Excellency, Alhaji Umaru Musa Yar'Adua, President of the Federal Republic of Nigeria, and Professor Oye Gureje displaying the prize at the conferment of the award of Nigerian National Order of Merit at Aso Rock Abuja, Nigeria.

■ A PSYCHIATRIST WANTED FOR GREAT CAUSE

The Department of Psychiatry, Jimma University which is situated in Jimma town (350km southwest of Addis Ababa) is planning to launch a two year innovative graduate training program for mid-level health professionals. The program aims at reducing the huge mental health treatment gap through developing human resource capacity in the area of mental health care in Ethiopia. Jimma University has only one psychiatrist who is busy teaching medical students and all other trainees in the area of health sciences. He is also keen to start a new program to train mental health professionals with master's degree. However, it has been difficult for one person to start this important program. Thus, we are looking for a psychiatrist who could help this situation.

The Planned Program

The program will enroll mid level health professionals (Bachelor degree holder health officers) who have worked at primary health care centers for at least two years. The program integrates training clinical, primary care and community psychiatry.

Duties of the Psychiatrist upon employment

- Clinical supervision of graduate students (case presentations, morning rounds, ward rounds)
- Supervising community and primary care activities by students
- Offering didactic lectures and moderating seminars
- Supervising graduate students' research undertaking
- Involving in assessment of the program and revision of curriculum.

Benefits

- The University will offer fully furnished house and local transportation within the town

- Salary of 2000 USD per month (which is four times a local psychiatrist would earn for the same post)
- Round trip ticket from home country will be covered
- Working in a University with an enormous culture in community based research activities where faculties get both logistic and financial support to undertake research on their own.
- Living the beautiful and evergreen Jimma town where cost of living is cheaper than most parts of the world

The contract

The eligible candidate will sign a one or two year contract with Jimma University that could be renewed.

Contact person: Atalay Alem
(atalayalem@yahoo.com).

■ ACTIVITIES OF THE HELLENIC PSYCHIATRIC ASSOCIATION

The Hellenic Psychiatric Association is the National Psychiatric Association of Greece, representing 1500 psychiatrists.



Prof. Nikolaos Tzavaras, President Hellenic Psychiatric Association

Its activities include the major national scientific event in the area of mental health, namely the Panhellenic Congress of Psychiatry, held every two years, other scientific events organized locally by the regional branches of the Association and training courses organized by the sections. In addition, the Association has organized a very successful WPA Regional Congress and the first Intersectional Congress in the history of the WPA which was also the first WPA Electronic Congress.

The Association has a rich record of international activities. Within this context it has organized the World Congress of Psychoso-

matic Medicine in Athens and has been authorized to organize in collaboration with the Society of Preventive Psychiatry, the World Congress of Mental Health of the World Federation of Mental Health (WFMH) in Athens (2-6 September 2009). The site of the Congress is www.wmhc2009.com and the deadline for submission of abstracts is the 15th March 2009.

Another important educational initiative of the Association is the Training initiative addressed to all psychiatric trainees in the country. These courses are organized every



Prof. George Christodoulou Honorary President Hellenic Psychiatric Association

four months, they are held each time in a different Greek city, they cover a great variety of fields (incorporating topics that are not addressed by the official specialty curriculum) and they provide trainees with the opportunity to come in contact with various teachers and not solely these of the facility to which they are allocated for training. This scheme has been greatly appreciated by the trainees.

The study tours to facilities abroad constitute yet another initiative of the Association



World Congress of Mental Health, Athens 2-6 September 2009

which aims at familiarization of the membership with clinical and research practices in other countries. Up to now, the Association has organized study tours to UK, USA, Morocco, China, Hong-Kong, Argentina, Peru and we are now planning a study tour to Russia (St. Petersburg and Moscow) in association with

the Second Psychiatric Congress for Eastern Europe to be held in Moscow from 27 to 30 October 2009 (www.paeb2009moscow.ru).

In addition to the above educational activities, the Association is also active in the field of prevention and treatment of the psychosocial consequences of Disasters and within the context of the man-made Middle East disasters it has taken initiatives along with the WPA Institutional Program on Disasters and the WPA Taskforce on Mass Violence for issuing of anti-war statements by the Israeli and Lebanese psychiatric Associations, with the approval of the Palestinian Psychiatric Association. These activities have been accompanied by local visits and related conferences and will be continued in view of the recent Mass Violence situation in the Middle East.

■ SERBIAN PSYCHIATRIC ASSOCIATION



The Institute of Mental Health, Belgrade, Serbia, together with the Serbian Psychiatric Association is organizing its fourth Forum. This year it will be the **FORUM ON PSYCHOTHERAPY - 70 years after Freud**. The Forum will be organized under the auspices of The Ministry of Health, Republic of Serbia, at the Belgrade Drama

Theatre from 23-24 April 2009. The President of the organizing committee is Prof. Dusica Lecic-Tosevski, WPA Zonal Representative for Central Europe. Plenary lectures will be given by guest speakers from Netherlands, UK, France and USA.

■ 2ND EASTERN EUROPEAN PSYCHIATRIC CONGRESS OF PAEEB, 27-30 OCTOBER 2009, MOSCOW, RUSSIA

We are very pleased to invite you to join us for the 2nd Eastern European Psychiatric Congress of the Psychiatric Association for Eastern Europe and Balkans (PAEEB) which will take place in Moscow, Russian Federation, October 27-30, 2009 in conjunction with the Annual Conference of Russian Society of Psychiatrists.

High prevalence of socially significant mental diseases and the wide range of treatment

approaches set a mission to integrating efforts of mental health professionals for improving the quality of care to patients. So we have a good opportunity to discuss the actual problems in the friendly atmosphere of mutual respect and understanding.

Looking forward to welcoming the Congress participants from all over the world in Moscow in October 2009!

Prof. George Christodoulou, President of the Psychiatric Association for Eastern Europe and Balkans (President of the Congress)

Prof. Valery Krasnov, President of Russian Society of Psychiatrists (Chair of the Organizing Committee)



Saint Basil the Blessed.

Deadline for on-line abstracts submission – 15 May 2009

Contacts: City Tourist Office – Tel: +7 495 960 21 90. Fax: +7 495 960 21 91

E-mail: alex@tavelmoscow.ru (Alexey Ryabtsev);

paeb2009@gmail.com (Secretary of Organizing Committee – Dr. Maya Kulygina)

Website: www.paeb2009moscow.ru

News from WPA Sections

Contact: WPA Secretary for Sections, Miguel R. Jorge, migueljorge@terra.com.br



■ FROM THE WPA SECTION ON WOMEN AND MENTAL HEALTH: THE INTERNATIONAL CONSENSUS STATEMENT ON WOMEN'S MENTAL HEALTH AND THE WPA CONSENSUS STATEMENT ON IMPLEMENTATION VIOLENCE AGAINST WOMEN

DONNA E. STEWART
University Health Network Women's Health Program, University of Toronto, Canada

In 1999, women's mental health leaders from Europe, Asia, Africa, North and South America and Australia began a fact finding process to determine the psychosocial, cultural and environmental factors which were most salient to women's mental health and mental illness. At the 2001 First World Congress on Women's Mental Health in Berlin, they rank ordered these factors. Discussion among women psychiatrists, psychologists, social workers, mental health nurses, policy experts, non-governmental organizations (NGOs) and consumers resulted in a published summary (1).

In 2003-2004, further discussions were held that culminated in a March 2004 roundtable at the Second World Congress on Women's Mental Health in Washington, sponsored by the International Association for Women's Mental Health. A decision was made to develop an International Consensus Statement on Women's Mental Health that described the issues and concluded with recommendations.

A Consensus Statement on Interpersonal Violence against Women was also written by the WPA Section on Women's Mental Health, and submitted to the WPA Executive Committee and Member Societies for their comments. Work on the International Consensus Statement on Women's Mental Health was further facilitated by a WPA meeting at Metropolitan Hospital in New York City in April 2004 and a subsequent meeting hosted by the American Psychological Association in September 2004. This International Consensus Statement on Women's Mental Health was approved by the American Psychological Association and the American Psychiatric Association by December 2004 and then

rapidly approved by a number of national mental health associations, NGOs and individuals. Both the International Consensus Statement on Women's Mental Health and the Consensus Statement on Interpersonal Violence Against Women were approved by the WPA at its General Assembly in Cairo in September 2005.

We urge all WPA Member Societies to disseminate these Consensus Statements by posting them on their websites and distributing them to their members, in their journals and other written communications. Even more importantly, we urge WPA Member Societies, individual psychiatrists and other mental health workers to begin work to implement the recommendations to improve women's mental health. Please let us know how we can help (donna.stewart@uhn.on.ca).

INTERNATIONAL CONSENSUS STATEMENT ON WOMEN'S MENTAL HEALTH

Preamble

The 1995 United Nations (UN) Beijing Platform for Action states that "Women have the right to the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and wellbeing..." (2). In September 2000, UN agencies, 189 member countries of the UN, as well as multilateral and bilateral agencies unanimously endorsed the Millennium Declaration (3). The Millennium Development Goals, made up of 8 Goals and 48 Targets, are recognized as the road map for implementing the Millennium Declaration. The Goals include the achievement of universal primary education, the promotion of gender equality, reduction of child mortality, improving maternal health and combating HIV/AIDS, among others. Mental well-being of the mother is integral to the health, nutrition and educational outcomes of their children, violence against women erodes gender equality and the empowerment of women, as well as putting women at increased risk for HIV infection. It is thus imperative that women's mental health be prioritized, if the Millennium Development Goals are to be achieved.

Women's mental health must be considered within the context of women's lives and cannot be achieved without equal access to basic human rights: autonomy of the person, education, safety, economic security, property and legal rights, employment, physical health, including sexual and reproductive

rights, access to health care, and adequate food, water, and shelter. Women's mental health requires the elimination of violence and discrimination based on sex, age, income, race, ethnic background, sexual orientation or religious beliefs. While both sexes benefit from the above factors and the overall rates of mental illness are similar in men and women, women's unique roles in reproduction, the family and society, and their often lower socioeconomic status, necessitate special considerations for their mental health.

Even in optimal circumstances, some women will experience mental health problems and illnesses for which adequate diagnosis and treatment are essential. The identification of women's mental health problems should ideally start with women themselves who should be provided with accurate, understandable information about mental health, psychological distress, illnesses, and available services and treatments. Evaluation of mental health problems in women must consider the full context of their lives, as distress in women often has social origins and diagnoses should not be stigmatizing. The role of violence and discrimination in the genesis of mental health problems in women requires special consideration. Social and psychological services and primary care physicians should be able to undertake evaluation, diagnosis and treatment or offer referral to appropriate specialty services. Women should have access to respectful, knowledgeable mental health care in a timely fashion, in a nonstigmatizing, suitable setting within their economic means, by adequately skilled health professionals with access to appropriate treatments.

Treatment settings should be safe, and free from breaches of fiduciary trust by health care providers and staff. Women's preferences for informed medical decision making should be respected whenever possible, and the quality of care should be assessed by indicators that are consistent with best current knowledge, informed by gender-sensitive research. Women who have been sexually abused, or who have strong preferences for female health care providers, should be accommodated whenever possible. Appropriate services for adolescent, peripartum, midlife, older, immigrant, refugee, disabled and incarcerated women are essential. Acute and continuing care, supportive and rehabilitative mental health services across the life span are essential to enable mentally ill women to achieve their optimal level of functioning and well-being. Positive women's mental

health benefits the health of women themselves, their families, and the general population and promotes women's participation in professions and leadership.

Recommendations

Accordingly, we recommend that professional mental health and health organizations and providers, governments, the UN system, the World Health Organization, other international health and social organizations and appropriate nongovernmental organizations integrate girls' and women's mental health as a priority in policy and program development and...

- Support psychological health promotion programs that encompass the life context of girls and women to include equal access to basic human rights, education and employment, the elimination of violence and discrimination and the reduction of poverty.
- Support women's marital, sexual and reproductive choices and ensure access to safe motherhood.
- Support public education and awareness campaigns that increase recognition and reduce the stigma of mental illness in girls and women.
- Support safe, respectful, appropriate, gender sensitive comprehensive mental health and physical health services for girls and women across the life cycle irrespective of their economic and social status, race, nationality or ethnocultural background.
- Support timely access to adequately skilled mental health professionals who provide quality of care consistent with best current knowledge and availability of appropriate therapy, technology or drugs and who take women's special needs into consideration.
- Support the development and use of culturally appropriate diagnostic systems that consider the sociocultural context of women's lives, and biological differences when they are salient.
- Support the provision of accurate information and respect choices in treatment decision making by girls and women whenever possible.
- Support the provision of mental health care for girls and women that is free from breaches in fiduciary responsibility.
- Support increased attention to research on girls' and women's mental health including those factors which enhance or inhibit the development of resiliency.
- Support the provision of core training and education about gender issues for health, and mental health, professionals.
- Support gender equality in practice and

promotion within mental health services and organizations including equal opportunities for advancement and eradication of gender harassment, intimidation or unjustified discrimination on the basis of sex.

WPA CONSENSUS STATEMENT ON INTERPERSONAL VIOLENCE AGAINST WOMEN

Interpersonal violence is a critical public health challenge throughout the world that causes distress, reduced quality of life, physical and mental health consequences, and even death (4,5).

Although men, women and children may all be victims of violence, the perpetrators and consequences of violence are usually different for men and women. While men are most likely to be injured by strangers during the commission of a crime, or in war; women are most likely to be injured by their male partners or other family members; often someone they live with and love. In fact, women are more likely to be murdered by their intimate partners than by strangers. In addition, men's greater size and strength, and their more frequent use of weapons, result in more serious injuries to women from interpersonal violence between men and women (6). All these differences require special consideration for prevention, amelioration and policy for each gender, and accordingly, this consensus statement has been developed on interpersonal violence against women.

Research reveals a high prevalence of acute and chronic physical and mental health consequences of violence against women. Women who are victims of violence are more likely to suffer from depression, anxiety, post-traumatic stress disorder, borderline personality disorder, substance abuse, sexual dysfunction, low self-esteem, and psychological distress, as well as a host of acute and chronic physical disorders. Violence and abuse in early life are strong predictors of later mental illness, especially depression. Moreover, being assaulted, or witnessing an assault on family members in childhood, or adolescence, increases the risk of mental disorders, low self-esteem and subsequent involvement in abusive relationships for both men and women. Violence against women also has negative secondary effects for families, communities, society and the economy (4-9).

Violence against women takes many forms: battery, sexual assault, psychological abuse and harassment. Cultural norms, social expectations, and gender roles and relations may promote such violence against women and these social forces may determine the consequences to the woman and the response of society. Media and advertising too

often portray violence against women as acceptable. Although religion may be used as a rationalization for violence against women, reference to core religious documents, such as the Bible, the Koran and the Torah, reveal in many parts that violence against women is not acceptable (4-9).

Understanding male violence against women requires an examination of the physical, legal and economic power inequality between men and women. Poor and older women, mentally ill women, women with disabilities, women in institutions, ethnic minorities, sex workers, trafficked women, and other disadvantaged women, including women during armed conflict, are all disproportionately at risk for violence (7,8).

As psychiatrists and other mental health professionals play vital roles as mental health care service providers, educators, researchers and policy advocates, who help shape mental health professional practice and public opinion, be it resolved that the World Psychiatric Association:

- Issue a policy statement that recognizes violence against women as a major determinant of mental distress and psychiatric illness in women and strongly condemns all forms of violence against women.
- Support programs to improve the education of practicing and training psychiatrists to recognize and treat victims of violence. This education should include, as a starting point, the routine inquiry about violence and victimization in all psychiatric assessments, the recognition of the role of violence and rape in the genesis of many psychiatric illnesses and as a treatment issue.
- Promote safe, respectful, non-blaming, ambulatory and inpatient treatment programs for women victims of violence.
- Support research to develop and evaluate the best treatments for women who have suffered from violence, and for their children and the perpetrators.
- Support health professionals' and public awareness of violence against women as a critical women's mental health determinant.
- Explore opportunities for greater interprofessional collaboration (legal, social, medical, and policy makers) on an international level to prevent and ameliorate violence against women, including violence during armed conflict.
- Explore wide ranging psycho-educational and socio-cultural interventions designed to change the objectification of women, which is a major determinant of violence against women.
- Censure public statements which seek to normalize violence against women as acceptable or a cultural norm.

References

1. Stewart DE, Rondon M, Damiani G et al. International psychosocial and systemic issues in women's mental health. *Archives of Women's Mental Health* 2001;4:13-7.
2. United Nations. The Beijing platform for action. Report of the Fourth World Conference on Women. New York: United Nations, 1995.
3. United Nations. The millennium declaration. New York: United Nations, 2000.
4. United Nations. Report of the special rapporteur on violence against women, its causes and consequences. New York: United Nations, 2003.
5. World Health Organization. World report on violence and health. Geneva: World Health Organization, 2002.
6. Stewart DE, Robinson GE. Violence against women. In: Oldham JM, Riba MB (eds). *Review of psychiatry*, Vol. 14. Washington: American Psychiatric Press, 1995: 261-82.
7. Jecks N. Ending violence against women: regional scan for East and Southeast Asia. New York: United Nations Development Fund for Women, 2002.
8. Committee on the Elimination of Discrimination against Women. General recommendation No. 19. New York: United Nations, 1992.
9. Parliamentary Assembly of the Council of Europe. Domestic violence against women. Recommendation 1582. Strasbourg: Council of Europe, 2002.

■ FROM THE WPA SECTION ON TRANSCULTURAL PSYCHIATRY: A BOOK BY GLADET (GROUP OF LATINO AMERICAN FOR STUDY OF TRANSCULTURAL PSYCHIATRY)

Psychiatry, Nature and Culture, From Singular to Universal



This book is the product of the First International Congress that has been organized by GLADET, which was successfully held on April 17-20, 2008 in Guadalajara, Mexico.

GLADET or Group Latino Americano de Estudios Transculturales, A.C. (Group of Latino American for Study of Transcultural Psychiatry) is revived under the leadership of Professor Sergio J. Villaseñor Bayardo, a cultural psychiatrist and anthropologist, presently working as a faculty member at the University of Guadalajara, Mexico. The committee members of GLADET are composed of a group of colleagues from Mexico and various countries in South America, including: Bolivia, Brazil, Chile, Columbia, Ecuador, Perú, and Venezuela.

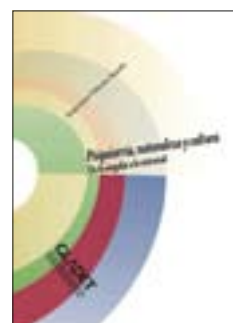
The first international congress included many colleagues not only from Central and

South America mainly, but also from Spain with a Latino background. Furthermore, many international colleagues from Europe, North America and Asia took a part of the congress to support this special event. For the scientific program, in addition to plenary lectures, 20 symposia were held including topics of various kinds, as reflected by its theme: Psychiatry, nature and culture: from singular to universal.

This book is composed of selected articles from papers that were presented at the congress. The authors are mainly from Mexico, Brazil, Chile, and Venezuela. It also includes articles presented by colleagues from Spain, France and Andorra in Europe and USA and Canada in North America. The articles not only included issues related to Latin America but also those related to culture and literature, human psychology and others.

The need of concern and attention to cultural aspects of human psychology and behavior as well as clinical assessment and care of patients has become a common knowledge and forceful movement around the world. It is very important not only to develop cultural psychiatry knowledge and experience locally in its own region but also particularly pertinent to compare with that derived from other regions and cultures. There is a great need of communication, sharing, and comparison to obtain the higher level of understanding. This is the base for the establishment of World Association of Cultural Psychiatry, to promote the development of cultural psychiatry around the world.

In this regard, the reviving of GLADET for the Latino American is very significant and



the publication of the product of the congress is very important. It provides the opportunity for colleagues from Mexico and various countries in South America to get together, to identify them

a group, to examine and learn together what the cultural issues that need attention related to people living in Central and South America with Latino cultural background. But furthermore, it provides an opportunity to connect to cultural psychiatrists from various regions of the globe. We are very pleased that GLADET is affiliated with the World Associations of Cultural Psychiatry, to work together with colleagues from Europe, North America, Asia and other parts of the globe to promote the knowledge and experiences relating to culture and mental health and cultural psychiatry.

We congratulate under the editorship of Professor Sergio J. Villaseñor Bayardo, this book is published which will be enjoyed not only by colleagues with Latino American background but also by colleagues with other regions and cultural background.

Wen-Shing Tseng, M.D.

Professor, Department of Psychiatry, University of Hawaii School of Medicine, and President, World Association of Cultural Psychiatry

■ EXEMPLARY EXPERIENCES IN MENTAL HEALTH AND PSYCHIATRY ACROSS THE WORLD: THE ASIA-PACIFIC COMMUNITY MENTAL HEALTH DEVELOPMENT (APCMHD) PROJECT

Introduction

The Asia-Pacific Community Mental Health Development (APCMHD) project has been established in 2005 to explore diverse leading models or approaches to community mental health service delivery in the Asia-Pacific region. The objective is to illustrate and promote best practice in mental health care in the community through use of information exchange, current evidence and practical experience in the region.

The project is based on the work of an emerging network of mental health leaders from 14 countries or regions in the Asia-Pacific, working to build culturally appropriate mental health policy frameworks and workforce in the implementation of community mental health services. Initiated in collaboration with the WHO Western Pacific Regional Office, the APCMHD project is led by Asia-Australia Mental Health, a consortium of the University of Melbourne (Department of Psychiatry and Asialink), and St. Vincent's Health.

The project, which brought many key mental health bodies to work collaboratively, is consistent with the WHO Global Action Programme for Mental Health. A key outcome is the documentation of the current status, strengths and needs of community mental health services in the region, in the hope to translate current understanding into practical changes in the future. The result is a collection of exemplary community mental health models and key guiding principles for development of services in the region.

A best practice example from each participating country/region is provided in this section to illustrate the diversity of community mental health approaches. The Summary Report of the APCMHD Project and the Full Country Report can be found on the website www.aamh.edu.au.

Commentary from WPA President Professor Mario Maj

Although the steps, the obstacles to remove and the mistakes to avoid in the implementation of community mental health care are to some extent similar worldwide, there are certainly some differences from one region to another, which limit the transferability of models and experiences. Being knowledge-

able of successful experiences implemented in other regions and of guidelines produced by international organizations such as the WHO, while at the same time being aware of the specific challenges posed by local realities and of the strategies which have already proved to be effective locally, is probably the best which can be done to foster the development of community mental health care at the regional level.

This lively and interesting collection of exemplary experiences can be extremely useful to psychiatrists, other mental health professionals and policy makers of the Asia-Pacific region as well as of other areas of the world, representing a source of inspiration and encouragement.

The World Psychiatric Association will be pleased to support the further development of this initiative, and to provide its help and advice to other regions wishing to follow this example.

Australia

Editor: Rosemary Calder, First Assistant Secretary, Mental Health and Workforce Division, Australian Government Department of Health and Ageing.

Sub-Editors: Nathan Smyth, Colleen Krestenssen, Lana Racic; *Contributors:* Aaron Groves, Ruth Vine, David McGrath, Jake Matthews, Simon Wells.

Australia's Mental Health System

The Commonwealth Government priorities for mental health include working in partnership with States and Territories on an integrated national approach to service delivery; developing an open, transparent system of evaluation and accountability of existing mental health services; and ensuring that mental health services are well integrated with other primary care and specialist services. The Commonwealth Government recognises the vital need for initiatives to prevent or delay the onset of mental illness, to intervene early, and to ensure access to and continuity of appropriate treatment and care for people with mental health problems.

State and Territory governments have primary responsibility for direct delivery of public mental health services. Hospital and community mental health services include accommodation, outreach support for people in their own homes, residential rehabilitation, recreational programs, carer respite and self-help.

Total spending on mental health services in 2004–05 was \$3.9 billion, representing 7.3% of government health spending. Subsidy of psychiatric medicines contributed 17% of total mental health funding.

A Best Practice Example

Housing and Accommodation Support Initiative (HASI), New South Wales (NSW)

HASI was established in 2003, with key objectives to:

- Improve housing stability for participants;
- Reduce demand on psychiatric inpatient services;
- Reduce calls to emergency services;
- Demonstrate an independent living, community-based model of psychosocial rehabilitation, support and case management;
- Improve quality of life through social, vocational, educational, life-skills development and family connections.

HASI is a three-way partnership between:

- Specialist mental health non-government organisations funded by NSW Health providing support and psychosocial rehabilitation;
- Specialist local mental health services (part of Area Health Services) providing clinical mental health care and rehabilitation;
- Public and community housing, funded by NSW Housing, providing long-term, secure, affordable housing, and property and tenancy management.

The purpose of the HASI partnership is to:

- Co-ordinate care;
- Enhance the interface between specialist mental health services, General Practitioners and non government organizations;
- Provide stable housing outcomes;
- Facilitate consumer, family and carer participation.

HASI is targeted to individual needs, with a staged support continuum ranging from very high support of 8 hours per day, 7 days per week to lower support of up to 5 hours per week.

Accommodation options include:

- Individual self-contained accommodation;
- One or two bedroom places;
- 'Salt and pepper' approach: HASI properties are sprinkled through the community;
- Small clusters (up to four HASI places in one site) are acceptable when deemed to be clinically viable. Virtual clusters are the preferred options, e.g. several HASI places within a few streets.

HASI does not support "asylums in the community" or congregate care. In conjunction with the local Area Mental Health Service, HASI support services:

- Provide comprehensive, client-centred, strengths-based assessment, care planning and intervention which target self-maintenance, productivity levels including education and employment and leisure needs;
- Are based on the principle of consumer recovery through fostering hope, supporting consumer empowerment and supporting self-determination;

- Ensure intervention strategies utilise mainstream community service networks and resources to encourage community inclusion.

Eligibility criteria for HASI:

- 16 years of age or more until age-related frailty inhibits ongoing involvement in the program;
- Diagnosis with a mental illness or functional impairment due to psychological disturbance identified by a mental health professional;
- Eligibility for social (public) housing;
- High levels of psychiatric disability and low level of functioning;
- Capacity to benefit from accommodation support services; and
- Informed consent to participate in the program.

Achievements and outcomes:

The Social Policy Research Centre (University of NSW) undertook a two-year longitudinal evaluation of the initial stage (100 high support places) of the Housing and Accommodation Support Initiative. The final report has now been published on www.health.nsw.gov.au/pubs/2007/hasi_evaluation.

Findings show:

- HASI has provided secure, affordable housing with 85% of participants remaining with the same housing provider;
- 94% of people had established friendships at completion of evaluation;
- 73% of participants were participating in social and community activities;
- 43% of participants were working and/or studying at the end of the evaluation;
- Hospitalisation rates of admission and length of stay were reduced for 84% of participants;
- Time spent in hospital and emergency departments decreased by 81%.

From 2008, the HASI in the Home stage will increase to over 1,000 places across NSW.



Graeme Doyle (Australia), No title, 1990, oil on masonite, 50.5 x 40.5 cm Artwork supplied courtesy of the Cunningham Dax Collection

Graeme Doyle states openly that he suffers from schizophrenia. He believes that his art should be shown to help others understand the experience of mental illness in order not to be afraid of it. The artist wants audiences to appreciate that people with mental illness can still be very creative.

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Cambodia

Editor: Sophal Chhit, Deputy Director, National Mental Health Program Cambodia.

Sub-Editor: Lo Veasna Kiry; *Contributors:* Staff of the National Mental Health Program Cambodia.

Cambodia's Mental Health System

The National Programme for Mental Health aims to improve the quality of life for people with mental illness through education and promotion of mental health care and substance abuse services, with a special emphasis on equity, quality and efficiency.

Funding for Mental Health has recently been heavily supported by international bodies, most notably WHO and Norway, with other organisations running independent projects. Many private hospitals also exist in Cambodia; however there is no formal information as to how many of these provide mental health services.

Cambodia's turbulent past has caused not only great trauma and loss for its people, but also destroyed any pre-existing mental health resources and prohibited the development of a new mental health system. The Pol Pot regime of 1975–1979 was responsible for mass genocide and the complete degradation of Cambodia's infrastructure. Of the 1,000 doctors trained prior to 1975, less than 50 survived, none of whom were mental health professionals. Cambodia's only mental health hospital, and the only access point for mental health care, was also destroyed by the Pol Pot regime.

The mental health workforce deficit caused by Cambodia's turbulent past has resulted in most mental health care being provided by physicians who can often offer only basic care. Traditional healers are often a point of contact for people with mental illness in the community; however it should be noted that these healers do not have explicit men-

tal health training and may therefore cause harm. NGOs have worked to forge links between primary care and traditional workers; however a mechanism for an effective, sustainable system of communication has not been found.

To address these deficits, the Mental Health Policy and Strategic Plan includes the Mental Health Care Service Package, which is a vertically integrated system with services both within the general health care system and the community-based health care centres. Developed for use within referral hospitals, the Complementary Package of Activities (CPA) provides specialised mental health care services which are distinct and complementary to general health care. The CPA allows management of complex health problems, provides follow-up and continuing care, and supports the health care system with mental health clinical training and supervision. Additionally, the Minimum Package of Activities (MPA) was developed for community health care centres and aims to provide integrated, high-quality mental health care which is both efficient and affordable.

A Best Practice Example

A New Model for Mental Health in Cambodia

Due to limited human and financial resources, the delivery of mental health care in Cambodia has previously focused on primary mental health care. The new Mental Health Care model aims to extend this care to an integrated community service through the use of several guiding principles:

- Integrated approach to service delivery – including community health centres and systems such as education and social services.
- Universal access to care – equitable, affordable and high-quality care that is geographically accessible, culturally relevant and culturally competent.
- Upholding a right to confidentiality – ensuring that all information gathered about a person including identity shall be kept confidential by the mental health provider.
- Informed consent – including the right to make decisions regarding treatment.
- Quality assurance – mental health issues such as diagnosis and choice of treatment shall be assessed in accordance with nationally accepted principles and standards.
- Community-based care – emphasis on care in the least restrictive environment possible and use of restrictive environments only when necessary for the safety of the client and public, and only for as long as that situation exists.

- Efficiency and accountability – resource allocation and their use will be examined in a transparent manner according to agreed principles.

The new Mental Health Care model highlights the importance of strong leadership to allow effective patient advocacy and lobbying. The model also highlights the importance of integrating mental health issues into all levels of medical training to increase the mental health knowledge and skill base of general health practitioners.

By strengthening community links, the model aims to encourage the role of families, NGOs and community agencies in mental health care. Further, the model aims to coordinate interaction between mental health care and local resources such as primary care and traditional healers to avoid fragmentation of care. It is anticipated that these measures will also result in a decrease in stigma and discrimination for both patients and service providers.

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China

Editor: Jin Liu, Chief of Executive Office, National Center for Mental Health, China-CDC (Peking University Institute of Mental Health), China.

Sub-Editors: Hong Ma, Xin Yu, Mingyuan Zhang, Yanling He, Bin Xie, Yifeng Xu, Lianyuan Cao, Wei Hao, Min Li.

China's Mental Health System

In China, where primary mental health care or community mental health is not well developed, development of community based mental health services has been led through the psychiatric hospitals, supported by general hospitals and the Centre for Disease Control. A national centrally driven program is a very rapid way to implement a new service model throughout a large and diverse country.

The sheer numbers of people who experience mental illness indicate the pressing need for improved mental health services. It is estimated that 16 million people suffer from psychotic illness, with 0.3 million new cases per year, of which between 50 – 70% have been untreated (source: National Institute of Mental Health, Peking University).

In April 2002, the first Mental Health Plan (2002–2010) was signed by the Ministries of Health, Security and Civil Affairs and the China Disabled Persons' Federation. In 2004, there were 565 psychiatric hospitals, 499 psychiatric departments in general hospitals, 57 mental health stations and 19 mental health clinics. There were also 16,103 psychiatrists and 24,793 psychiatric nurses, however the professional competence of many of them is limited.

A Best Practice Example

The 686 Project

After SARS, the Chinese Government rebuilt the public health system. In 2004, the China–Centre for Disease Control (CDC) and Peking University visited community mental health services in Melbourne, and decided to use the Victorian Model for reference. In September 2004, after competing with over fifty proposals, the Mental Health Service Model Reform Program was the only non-communicable disease program included in the national public health program.

In December 2004, the Mental Health Reform Program was formally supported by the Ministry of Finance, and named the “686 Program” because of its funding of 6.86 million RMB. The National Centre for Mental Health and China-CDC took charge of the program and established a national working group as well as a foreign consultant group with experts mainly from the University of Melbourne.

In 2005, 60 demonstration sites were established in 30 provinces in China: one urban and one rural site in each province, covering a population of 43 million. 602 training courses were held and nearly 30,000 people were trained, including psychiatrists, community physicians, case managers, community workers, public security staff and family members of the patients. A national computerised case database was established.

In 2006, this program received increased funding of 10 million RMB, enabling improved monitoring and intervention for psychoses, as well as the establishment of a local comprehensive prevention and treatment team in each demonstration area. Staff including 15% psychiatrists and psychiatric nurses from over 12,000 facilities were trained. Nurses were recruited from psychiatric hospitals or departments, community and village health centres, and neighbourhood or village committees.

By December 2006, more than 65,000 patients were registered, nearly 22,000 patients with

violent tendencies received regular follow-up, over 9,000 poor patients with violent tendencies received free medication, over 2,600 people exhibiting violent behaviours received free crisis management and more than 1,000 poor patients with violent behaviours accessed free hospitalisation. For patients who received follow-up, the level of violent incidents decreased.

In 2007, the budget was increased to 15 million RMB for continued service provision across the 60 sites. Case-management training for the demonstration areas was provided jointly by The University of Melbourne and the Chinese University of Hong Kong (CUHK). The budget for 2008 is 27.35 million RMB, enabling more patients to receive free medication and hospitalisation, and the establishment of a new demonstration area in Xinjiang Province.

It is projected that new demonstration areas will gradually be set up across China. Future directions may also include the National Mental Health Reform Program Office delegating its management role to each province to oversee its own demonstration area, thereby delegating the rapidly increasing workload as the program expands. More officials will be encouraged to provide local resources to enable mental health to become core business and to adapt the reform model to their local context. As the Program develops, staff training and project management will become more challenging, and local experts will need to take responsibility for supervision and monitoring. The Ministry of Health has already established standard evaluation forms and all provinces will use these forms to report their progress.

As a result of this program, more local officials pay attention to mental health issues and psychiatric hospitals now consider integrated prevention and comprehensive treatment. A community-based network has been established, led by the psychiatric hospitals, and supported by general hospitals and the CDC. Further, the program has benefited patients, particularly those of low-socioeconomic status, and has promoted social harmony.



686 Annual Meeting in November 2006.

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Hong Kong

Editor: Se-fong Hung, Chief Executive, Kwai Chung Hospital, and President, Hong Kong College of Psychiatrists, Hong Kong.

Sub-Editor: Wing-yuen Tse; Contributors: Chi-chiu Lee, Po-man Chan.

Hong Kong's Mental Health System

In Hong Kong, mental health care is largely provided in the public sector through the Hospital Authority (HA), a statutory body established in 1991 to manage all the public hospitals and institutions in Hong Kong. Through its network of 74 general out-patient clinics and seven hospital clusters, people with mental illness can seek help at the primary care level and if necessary be referred to specialist clinics. Inpatient, ambulatory and community psychiatric services are also provided in all seven clusters to ensure continuity of care.

The Government spends about HK\$3 billion (0.24% of GDP) on mental health care per annum, which is allocated to the Hospital Authority and eleven Non-Government Organisations (NGOs) for medical treatment, residential support and rehabilitation for patients with mental illness.

In accord with Government policy to strengthen both community care and primary care in mental health, a strategic plan was formulated to downsize the two largest stand-alone psychiatric hospitals in Hong Kong. Following completion of the plan in 2006, Hong Kong now has approximately 4,600 psychiatric beds (6.4 per 10,000 population), consisting of a mix of large mental hospitals and psychiatric units in general hospitals. The target is now to shorten the length of stay of acute inpatients. Increasing the community psychiatric team workforce is crucial for providing more intensive care to patients following discharge as well as for urgent psychiatric referrals. Having a range of well-differentiated community treatment options will enable more patients to be cared for in the community.

A Best Practice Example

Extended-care patients Intensive Treatment, Early diversion and Rehabilitation Stepping Stone (EXITERS) Project

Despite advances in pharmacological and community psychiatric treatments, a large proportion of psychiatric inpatients remained long-term in mental hospitals in Hong Kong. In a survey in June 2000 by the Hospital Authority on the length of stay of psychiatric in-patients, it was revealed that 1138 (23.1%) had an average length of stay greater than

four years. Commencing in 2000 in three phases, EXITERS is a pilot project aimed at early integration of long-stay inpatients back to the community.

A Multidisciplinary Team including two medical doctors, seven nurses, two medical social workers, one occupational therapist, and a team of twelve supporting staff for each hospital unit were recruited to address the patients' complex needs.

In Phase I, vacant hospital quarters at three major mental hospitals in Hong Kong were converted to create supported group homes with home-like settings to facilitate intensive rehabilitation. In Phase II, appropriate patients with a hospital length of stay over 6 months were recruited and each was assigned a case manager. These patients were often not suitable for half-way-houses, or had frequent admissions and discharges from half-way houses. Those with illicit drug addiction, moderate or severe mental handicap and dementia were not included. Intensive rehabilitation was provided to improve social and vocational functioning, and various community options were explored to bridge the gaps in residential services that were available. In Phase III, active community support and follow-up were offered for discharged patients. Several evaluation tools for assessing symptoms, needs, function and quality of life were administered quarterly to evaluate outcomes.

During the first three years, 387 patients were discharged from the three hospitals. The discharge destinations included living at home, either singly or with relatives, resettling in a private housing unit, re-housing in a public housing unit or staying in a private hostel. Analysis of the first 190 patients discharged from hospital in one year showed significant improvement in the patients' psychiatric symptoms, behavioural problems, functioning levels and quality of life. However these patients remained quite functionally disabled on discharge, with a large number remaining unemployed and requiring financial support from social welfare.

The project identified a group of patients with complex disabilities that required flexible matching of resources in the community. It utilised the case management model in the reintegration of patients to the community. The EXITERS hostels situated in the neighbourhood of the hospital provided a home-like environment for disabled patients to adapt slowly to community living, and with adequate resources it demonstrated that difficult-to-place patients could be successfully reintegrated back to the community. Despite having some persistent disability, the discharged patients have an improved quality of life outside mental hospitals.



Ching Wai (Hong Kong) b. 1972 Breakthrough the darkness, head into the sunlight 145 x 190 mm sign pen Notes accompanying the artwork: Emerging from the darkness comes a bright broad avenue. Life contains bitterness and joy, sadness and happiness. Be determined and brave, only through an unyielding spirit can you head into brightness.

Bitterness is inevitable, but as long as you have the strength to somehow recognise it for what it is, one can endure, turning negative to positive. At the low tide of your life wipe the tear, it will be soon sweet.

After stepping over your difficulties you will see the sunlight... life is more brilliant. Life is a blessing no matter if it contains bitterness or joy!

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India

Editor: R.N. Salhan, Additional Director, General of Health Services, Directorate General of Health Service, Ministry of Health and Family Welfare, India.

Sub-Editors: S.K. Sinha, Jagdish Kaur.

India's Mental Health System

The prevalence of mental disorders in the population is in the range of six to seven percent, which represents a huge number of people. Before 1960, mental health services were mostly provided by mental hospitals. With the advent of psychotropic drugs, General Hospital Psychiatry Units were established in many hospitals in the sixties and following decades. Community-based mental health services began in the seventies on a small scale by incorporating mental health in primary health care through short-term training of general health personnel.

In 1987, a modern Mental Health Act was enacted. Its implementation is being moni-

tored by the Central Mental Health Authority. Disability benefits for persons with mental disorders are covered under the 'Persons with Disability Act' (1995).

A comprehensive community-based mental health service, the District Mental Health Programme (DMHP) was started in 1996. The DMHP was expanded to 27 districts across 22 States and Union Territories in the Ninth Five-Year Plan period from 1997–2002.

A Best Practice Example

The District Mental Health Programme

The District Mental Health Programme (DMHP) was launched in 1996 under the National Mental Health Programme. Its objectives are:

- To provide sustainable basic mental health services to the community and to integrate these services with other health services.
- Early detection and treatment of patients within the community itself.
- To avoid patients and their relatives having to travel long distances to hospitals or nursing homes in the cities.
- To reduce pressure on the mental hospitals.
- To reduce the stigma attached towards mental illness through change of attitudes and public education.
- To treat and rehabilitate mental patients discharged from mental hospitals within the community.

The DMHP is run by a core team of mental health professionals including a psychiatrist, a clinical psychologist, a psychiatric social worker, a psychiatric nurse, a nursing orderly and a record keeper. The Programme's catchment area is the district and adjoining areas.

The components of the Programme are:

- Community Mental Health Services - these include a psychiatric Outpatient Department at the district hospital as well as outreach services in Primary Health Centres on designated days that provide follow-up care of patients, dispensing of psychotropic medication, record keeping and referral to an appropriate level of care as needed.
- Training of general physicians, paramedical workers and non-medical workers in mental health care.
- Information, communication and education services.
- Technical and managerial support from the district medical college/ psychiatric institution.

The State Government monitors the programme through the nodal institution, and the Central Government monitors the

program through WHO Consultants in the Ministry of Health.

Basic mental health services are also provided by the extensive network of trained health staff in the general health care system. The DMHP model has demonstrated that, by training primary care physicians, basic mental health care delivery can be provided in primary care settings. Provision of supervision and support from the mental health program officer and/or the psychiatrist, empowers staff in the public health care system to respond to the mental health needs of the population.

Several reviews and consultations have identified barriers to implementation of the DMHP as well as identifying the need for mental health promotion. This has led to modification of the DMHP in the Eleventh Plan.

In the Eleventh Plan, the DMHP team is able to hire trained medical officers if a psychiatrist is not available for the programme. Other members of the team will include a psychologist, a social worker, a nurse and an office assistant, who will receive brief skill-based training with a uniform curriculum at identified centres. According to demand, new mental health promotion services will be added, and credible organisations and private practitioners will actively participate in providing services and implementing the DMHP. In order to address the shortage of trained mental health practitioners, government doctors will be trained as sub-specialists in Psychiatry through the introduction of one year in-service certificate courses in Psychiatry. In addition, Institutes of Mental Health and Neurosciences will be established to develop the mental health workforce. Upgrading of psychiatry facilities of medical colleges and general hospitals and modernisation of mental hospitals will continue. A strategy with strong emphasis on information, education and communication is needed to improve awareness of mental health issues and to reduce stigma.



Banner at an Awareness and Diagnostic Camp organized through the District Mental Health Programme in Delhi.

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Indonesia

Editor: HM Aminullah, Director of Mental Health, Directorate General Medical Service, Ministry of Health, Indonesia.

Sub-Editor: Eka Viora; *Contributors:* Pandu Setiawan, Yulizar Darwis, Albert Maramis, Suryo Darmono, Diding Sawaludin, Hervita Diatri.

Indonesia's Mental Health System

The number of mental health beds in Indonesia is insufficient to meet the needs of the population, such that many people with mental illness live in the community without proper treatment. Further, the poorly developed primary health care system is insufficient to support the integration of primary mental health care. Building the capacity of the health workforce to deliver mental health services has become a major focus. Training programs for primary care physicians in treating mental disorders have been established, with some primary care professionals now receiving regular training in mental health. In the last two years approximately 500 personnel received training, especially in Aceh, South Sulawesi and West Sumatra.

A Best Practice Example

Community Mental Health Nursing in Aceh, Indonesia, following the tsunami and earthquake

The earthquake and tsunami disaster in Nanggroe, Aceh, Darussalam, and Nias has had lasting effects on the mental health of the Indonesian community. This is compounded by an absence of effective and adequate community mental health services even prior to the disaster. Prior to 2004, Aceh, the Indonesian province most affected by the tsunami, had only one mental hospital for a population of 4,220,000. In keeping with international good practice and recommendations from WHO, it was regarded as important to take the opportunity of external funding coming into Aceh to develop an integrated system of services for the first time. Three months after the tsunami, a programme was developed to train community mental health nurses (CMHN) based at the Puskesmas (Public Health Centre) to deliver a range of mental health services. The curriculum is divided into three phases: Basic Course Community Mental Health Nursing (BC-CMHN), Intermediate Course Community Mental Health Nursing (IC-CMHN), and Advanced

Course Community Mental Health Nursing (AC-CMHN). The CMHN project has also been kindly supported by HSPP USAID, WHO and ADB-ETESP.

Community Mental Health Nursing (CMHN) training is divided into 3 steps:

- Basic: focuses on caring for the patient and family.
- Intermediate: management of psychosocial problems, training of community leaders to form a cadre of mental health providers, develop village awareness of mental health issues via the Desa Siaga Sehat Jiwa ('Village of Mental Health Alertness') project. To date the community mental health nurses have identified 8016 patients with severe mental health problems, and awareness has been raised in 343 villages.
- Advanced: leadership, advocacy, research, mental health promotion, and case management training.

The successes of the Community Mental Health Nurse Training Program include:

- Increase in resources to provide mental health services in the community.
- Improvement in community services:
 - o Many patients received treatment and support for the first time.
 - o Families had an opportunity to discuss problems in coping with their family members and to receive support.
 - o Enhanced community awareness.
 - o Improvement in community members' ability to take care of and refer patients.
 - o Improved community cooperation with CMH nurses.
 - o Enhanced CMH nurse motivation and satisfaction.
 - o A greater percentage of patients received regular medication and supervision in some areas.
 - o Prevention of admission to mental hospitals for many patients visited by a CMH nurse.
- Improved resources through collaboration with other stakeholder organisations:
 - o Provision of motorbikes for CMH Nurses by NGOs (CBM) to improve access to patients in more remote areas.
 - o Funding in some districts for CMHN training at the intermediate level and advanced level covered by USAID.
 - o Funding of training for nurses in psychiatric intensive care for the acute units in district hospitals covered by USAID.

The challenges faced in implementation include:

- An inadequate referral system largely due to limited pre-existing services and poor secondary services.
- Problems in access to the Public Health Centre owing to geographical conditions and transportation limitations.
- Limited range of medications.
- Inadequate recording-reporting/monitoring-evaluation in some districts.
- Inadequate allocation of funds for mental health as it is not a mandatory programme.
- An irregular supply of medication in some areas because of inadequate logistical planning.

Future directions include:

- Creating networks of care with local NGOs.
- Involvement of religious and female leaders.
- Maintaining advocacy to ensure that future budgets allow for allocation of finances to community mental health nursing activities.
- Working towards CMHN becoming a compulsory program at the primary care level.

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Japan

Editor: Tadashi Takeshima, Director, Department of Mental Health Administration Studies, National Institute of Mental Health, National Centre of Neurology and Psychiatry, Japan.

Sub-Editor: Yutaro Setoya.

Japan's Mental Health System

The Japanese government has recently released, in rapid succession, policies, laws and regulations relevant to mental health. This process began in 2002, stemming from a Ministry of Health, Labour and Welfare report called Future Direction of Mental Health and Welfare Policy, which aims to shift from hospital-based medical treatment to community centred health care and welfare.

Japan has one of the highest number of psychiatric beds per capita in the world. 1,379 (83%) of hospitals are privately owned, and 1,086 are stand-alone psychiatric hospitals. Though community mental health services are increasing rapidly, they remain inadequate.

Future directions for expansion of community mental health are:

- Support for consumers to build consumer-centred services;
- Development of more community services especially housing support, vocational rehabilitation and outreach services;
- Dissemination of good quality care management and building close community networks;
- Quality improvement such as staff training, consumer and carer involvement and outcome measurement.

A Best Practice Example

Mitaka, Tokyo — Sudachi-kai

This program is chosen as an example of best practice because community mental health services provided by NGOs in the urban setting is a key issue. However, other practice examples in Japan are no less important.

Based in Mitaka city of Tokyo, Sudachi-kai (Japanese for 'Flight from the Nestgroup') is a social welfare corporation which actively promotes discharge from hospital. Over its 15 years of history, more than 130 long stay inpatients have been discharged. Its housing and vocational facilities are located in Mitaka city (population: 178,000; area: 16.5 km²) and Chofu city (population: 21,600; area: 21.5 km²). Both cities are located in the centre of Tokyo Metropolis.

Sudachi-kai started in 1992, when there was strong stigma against people with mental disorders who faced much difficulty in housing rental. The first group home was started with cooperation between the landlord, hospital staff and families. With their support, many patients were discharged to group homes and other neighbouring rooms.

Importantly, a sheltered workshop was opened in response to a need for vocational activities during the day. From these facilities, the basic concept of Sudachi-kai as a place for consumers to live, work, and find support from both staff and peers was formed. Their activities were gradually expanded and they currently have eight housing facilities (capacity 61) and three vocational facilities (capacity 90), with about 20 full-time and 20 part-time staff.

From their experience, Sudachi-kai has developed the following model pathway for discharge from hospital:

- First, the staff and peer supporters (past inpatients) of Sudachi-kai deliver talks to inpatients in hospital. The stories the peer consumers tell about their lives outside the hospital convey strong messages to the inpatients, thus motivating them towards discharge from hospital.
- Next they consult with the candidate and their family to make a support plan with them.
- When candidates are motivated, discharge training is provided and they begin attending the vocational facility in the community during the day.
- Next, Sudachi-kai helps the candidate find suitable housing which could be a group home or other rooms. Overnight training using a short stay facility also begins.

- Preparation for discharge takes place, such as a patient managing own medications, money.
- After discharge from hospital, staff (24 hour coverage) and peers support them to live in the community.

Data of 126 patients discharged from hospital with the support of Sudachi-kai is as follows: the average length of hospital stay was 11.5 years and the longest was 42.2 years; 59 patients were in their fifties (46%) when the support started, 39 patients (31%) were in their forties and 17 patients (13%) were in their sixties. 65% were men, and the majority had schizophrenia (88%). Of the 126 patients, 61 (48%) were discharged to group homes, 48 (38%) to affiliated rooms rented by Sudachi-kai, 10 (8%) to private rooms and 7 (6%) went to other residential facilities. Of the discharged patients, 85 (68%) utilised Sudachi-kai's services, 12 (13%) terminated their use of services due to moving to other rooms or facilities, 10 (8%) had a hospital admission, 11 (9%) were deceased and 3 (2%) discontinued use of the services. The Sudachi-kai program has shown that many inpatients can be discharged and successfully live in the community if there is continuous support and a place to stay available on a 24 hour basis.



Y. A. (Japan), b. 1969, No title, oil on masonite, 45 x 38 cm.

Notes accompanying the artwork: The artist learned to paint from another artist during group work for patients with mental illness at a public health centre. He doesn't like to leave indoors, so his work is mainly of people and landscapes as seen through windows.

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Korea

Editor: Tae-Yeon Hwang, Director, WHO Collaborating Centre Yongin Hospital and Head, Mental Health Division, Korean Neuropsychiatric Association. Sub-Editor: Dong Hyeon Kim.

Korea's Mental Health System

Strategic collaboration between the public and private sectors has involved public sector funding and professional human resources and community mental health programs from the private sector. Since 1995, 151 community mental health centres, 170 rehabilitation centres and 56 long-term residential facilities have been established. Community Mental Health Centres provide counselling, home visits, case management, psycho-education, vocational rehabilitation and mental health promotion activities. Rehabilitation services are also provided by the private or nongovernment sector. Funding for community care is increasing and community care is planned to increase tenfold over the next decade. Vocational rehabilitation programs including sheltered workshops and supported employment are also increasing, with support from the Korea Employment Promotion Agency for the Disabled.

Despite the growth in community-based mental health services in Korea, large-scale deinstitutionalisation is not yet in sight. Under the present circumstances, private mental hospitals and asylums are unlikely to discharge patients into community-based services, to shorten the average length of patients' stay or voluntarily decrease the number of beds. It is very important that the government declare its intentions to support the development of community-based mental health programs by presenting a long-term plan for deinstitutionalisation.

A Best Practice Example

Seoul Metropolitan Mental Health Centre from Gangnam Community Mental Health Centre

The first community mental health centre was established in the southern area of Seoul in 1995. Through a contract between the Seoul Department of Health and Seoul Municipal Mental Hospital in Yongin Mental Hospital, the Seoul city government provided funding to establish the Gangnam Community Mental Health Centre (CMHC) and Yongin mental hospital sent trained staff, including a psychiatrist, nurses and a social worker. The Centre was located in an area where the City of Seoul had constructed apartment complexes for rental to poor citizens. The

mental health problems of this population were great compared to other parts of the city. The Centre assessed the mental health needs of chronically mentally-ill people and their families and started psychosocial rehabilitation services and home-visiting programs for alcohol-dependent patients isolated from the community.

Seoul City also increased funding for other CMHCs and, by 1998, there were seven CMHCs with each area providing 'semi-metropolitan' mental health services. Located in the Public Health Centre, these CMHCs provided primary mental health services, established psychosocial rehabilitation services for the chronically mentally-ill population, mental health promotion for the general population and gradually increased services for children, adolescents and old people. These CMHCs were funded by the local districts and Seoul City and operated autonomously in each local district. As a result, there was a need to develop a system to coordinate and integrate the operation of these CMHCs. The mental health planning committee and city government officials discussed the metropolitan mental health service system in order to expand the community mental health services to other districts of the city.

Seoul City commissioned the Gangnam CMHC to develop a centralised data gathering and management system, and evaluation was conducted through the Mental Health Information System (MHIS) to examine mental health outcomes separately from general services to the local community.

In response to the increasing demands on the metropolitan mental health centre, which was responsible for supporting and coordinating all the CMHCs and the development of new mental health policies and programs, Seoul City established the Seoul Metropolitan Mental Health Centre (SMMHC) in the downtown area in 2004. Staff from the Gangnam CMHC moved to this metropolitan mental health centre and commenced service provision.

In 2004, a Taskforce Team established the Seoul Mental Health 2020 Project, so that the City of Seoul could develop mental health services to meet future needs. The goals of the Seoul Mental Health 2020 Project are to:

- Analyse the present state of Seoul Mental Health Services and predict demand for future resources and infrastructure;
- Establish the Metropolitan Mental Health Centre to facilitate deinstitutionalisation and crisis management systems;
- Establish an organisation to support the development of policy and research.

The model for organising the SMMHC has been adapted from St. Vincent's Mental Health in Melbourne, Australia, through a contract between Seoul and Melbourne. The SMMHC now has four teams: the Community Assessment and Linkage System (CALs), the Crisis Intervention Team (CIT), the Mental Health Promotion Team (MHPT) and the Homeless Mobile team (HM).



Promotion of SMMHC Mental health brand, "Blutouch", October 2007.

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Malaysia

Editor: Suarn Singh a/l Jasmit Singh, Chief Psychiatrist, Ministry of Health, Malaysia. *Sub-Editors:* Ahmad Rashidi Saring, Cheah Yee Chuang, Chandra Mohan, Salina Abdul Aziz, Nor Hayati Ali, Ruzanna Zam Zam, Marhani Midin.

Malaysia's Mental Health System

Funding for mental health services in Malaysia is provided largely by the Government. Malaysia spends 5% of its GDP on health-care, of which about 3% is spent on mental health care. Most insurance agencies do not cover treatment for mental illness.

The government facilities providing psychiatric care include four mental institutions and twenty-six government hospitals. Of 5428 psychiatric beds in Ministry of Health facilities, 4640 (85.5%) are in mental institutions and 748 (14.5%) are in general and district hospitals. In addition, the three University Hospitals have about 130 acute care beds. Psychiatric care covers acute episodes, follow-up and long-term care, and includes outpatient, community and home-care services. These services were strengthened in the 1990s and are currently available in almost all hospitals with resident psychiatrists.

The Ministry of Health is in the process of integrating psychiatric care with mainstream general hospital and primary health care ser-

vices. In 2005, a total of 763 Health Clinics (88.9%) provided mental health services in the community, including mental health promotion, follow-up of stable cases and tracing of non-compliant patients. In addition, twenty-five of these clinics also provided psychosocial rehabilitation services for patients with severe mental illnesses. NGOs also provide residential care, day-care services and psychosocial rehabilitation services in the community. There are concerted efforts towards promotion of mental health in both the psychiatric units and primary health care settings.

A Best Practice Example

Hospital-based community psychiatric services in a psychiatric institution – Hospital Bahagia Ulu Kinta, Perak

Hospital Bahagia Ulu Kinta (HBUK) demonstrates how a large psychiatric hospital can reorganise its services to incorporate comprehensive community outreach services for a large population. In 1970s, the Community Psychiatric Unit (CPU) was established to provide domiciliary services. Evening psychiatric clinics were operated by staff of HBUK after regular office hours in public places such as a church, community hall or temple. Peripheral psychiatric clinics operating during regular office hours at distances more than 30 kilometres from HBUK were established to provide psychiatric follow-up care services nearer to patients' homes. In 1997, follow-up of stable psychiatric patients commenced in primary health care centres in Perak, including assessment and review of patients, provision of medication, psycho-education and support, and defaulter tracing to ensure that patients were compliant with prescribed medication.

In March 2001, HBUK started home-care services which aimed to provide continuous and comprehensive services at home, catering for the needs of the patients and carers. The specific objectives are to:

- Provide treatment and rehabilitation to psychiatric patients.
- Enlist family members in the management of patients at home, improving communication and problem-solving skills.
- Reduce relapses and re-hospitalisation to less than 30%.
- Promote adherence to medication and illness self-management for which the compliance rate should be more than 60%.
- Provide supported employment (job search, job match and job coach) for at least 10% of the patients.

Home-care services in HBUK are provided through clearly delineated geographical zones, serving a population of about 800,000 in the Kinta district. There are seven zones based on geographical locality. Each zone is headed by a psychiatrist, working together with two to four medical officers, two full-

time medical assistants, two fulltime staff nurses and two full-time attendants. There are two nursing supervisors for the nursing staff. The home-care team operates during office hours and the case-load for each nursing staff is 1: 15–20 patients.

The home-care services in HBUK consist of five components: Acute home care, Early discharge program (EDP), Assertive community treatment (ACT), Family intervention programme (FIP), and Follow-up services for stable cases with complex needs.

The HBUK home-care service has successfully reduced patients' relapses and readmission rates within 6 months after discharge, from about 25% before services were started, to 0.56% in 2005 and 0.5% in 2006.

This service model is in line with plans to down-size the mental institution. Our strategies include: reduction of acute admissions by setting up small acute units with home-care services (e.g. resident psychiatrists at district hospitals); development of alternative appropriate residential facilities with varying levels of care (high-level support, low-level support, respite care and group homes); supported education and employment; and strengthening inter-sectoral collaboration between related agencies (such as social welfare, education, labour department), carers, and NGOs.



Community mental health education in Malaysia.

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Mongolia

Editor: G. Tsetsegdary, Senior Officer, Mental Health Department of Ministry of Health, Mongolia. *Sub-Editors:* L. Erdenebayar, S. Byambasuren, Nalin Sharma; *Contributors:* N. Altanzul, V. Bayarmaa, B. Ayushjay, N. Tuya, Lieve Strager.

Mongolia's Mental Health System

Currently, Mongolia spends 2% of its total health budget on mental health. Within the

mental health budget, funding is mainly directed towards mental hospitals, accounting for 64% of all mental health expenditure. All severe and some mild mental disorders are covered by social insurance schemes.

The mental health system in Mongolia is still largely hospital-based. Mental hospitals treat 17.7 patients per 100,000 population and have an occupancy rate of above 80%. The majority of beds are provided by stand-alone mental hospitals, followed by community-based psychiatric inpatient units.

A number of good results have been achieved in the development of community mental health services, such as the establishment of a mental health database and the introduction of psychosocial rehabilitation services. Deinstitutionalisation has been gradually implemented but is not currently comprehensive. The percentage of patients who receive primary mental health care and the number of primary health care units that provide mental health care have slightly increased but have not reached the targeted goals. In addition, mental health programs in schools have been developed and now economic entities and organisations with more than 50 employees implement mental health sub-programs and projects according to the Government mental health framework.

A Best Practice Example

Ger Project

Community-based day centres in Mongolian tented and portable round houses called gers were started in 2000 in the grounds of two district health care centres and four regional health centres. The Ger Project is staffed by general health care staff (nurses and occupational therapists) and a psychiatrist, and funded by WHO and the SOROS Foundation. The aim of the Ger project is to give people with chronic mental illness an opportunity to increase their social and living skills through psychosocial rehabilitation activities focusing on life skills, such as self-care, cooking and leisure skills (handicraft, vegetable growing and other vocational training).

Ger day programs are placed in the community especially near the sub-districts where people are living in gers. 15 to 20 people with mental illness per month are involved in the program. The Ger Project is staffed by a psychiatrist, nurse and an occupational therapist who are paid by the government. The program runs from 9.00 am to 3.00 pm each day.

With the patient's consent, psychiatrists in outpatient settings and general practitioners can refer patients to the Ger project.

On their first day at the Ger project, the psychiatrist, nurse and occupational therapist

assess the patient's life skills, self care and social life to determine what activities will benefit them. The occupational therapist and nurse, who have attended psychosocial rehabilitation training for one to three months, are responsible for teaching and monitoring the patient's physical exercise and relaxation, life skills, self care and vocational skills, such as handicraft, vegetable-growing, gardening, carpentry and embroidery.

The Ger project also provides psycho-education, counselling, continuing psychiatric treatment and family support for patients and their families. The psycho-educational program provides patients and their families with information about mental illness, coping skills and how to manage stress.

The Ger project not only includes medical services, but also employment services, social welfare and transportation services.

A total of 500 clients have attended the Ger project and relapse of mental disorders has been reduced by 95% from 2002 to 2007.

Through these psychosocial programs, the principal lesson learnt is that there are reduced rates of relapse for patients with mental illness, when they are cared for in community settings. Also people with mental illness can be supported in the community and through inter agency collaboration and cooperation. We need to increase the participation of families, consumers and NGOs in community based psychosocial rehabilitation programs. Government funding should be provided for the Ger program.

The Ger project successfully delivers psychosocial programs close to the patient's home at the district level. Key advantages include the low cost of the ger, its mobility and the reduction of stigma and discrimination through the involvement of the community and families. Advocacy at the government level is important for the sustainability of the project.



Tented and portable round houses (Gers) used in the Ger Project.

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Singapore

Editor: Kim-Eng Wong, Chair, Medical Board, Institute of Mental Health, Singapore.

Sub-Editors: Hong-Choon Chua, Derrick Heng.

Singapore's Mental Health System

Singapore has reached a somewhat balanced psychiatric care model, where the Institute for Mental Health (IMH), a large psychiatric hospital with a daily census of around 1600 patients is responsible for the care and management of 33,000 outpatients in the community. In all, IMH is responsible for close to 80% of public mental health care, with the remaining 20% provided by the psychiatric departments of the general hospitals.

The National Mental Health Blueprint for 2007–2011 is helping to galvanise the development of community-based programmes with the establishment of community mental health teams for patients of all ages. For children and adolescents, multidisciplinary teams work closely with school counsellors to detect and manage early problems in schools. For adults with established serious mental disorders such as schizophrenia, multidisciplinary community mental health teams provide support in the community with case management, home visits, psychosocial rehabilitation and crisis management in their homes. For the elderly, community psychogeriatric teams work with social agencies and primary care physicians to detect and manage the elderly with mental disorders, either in their own homes or at clinics in the community. For those with addiction disorders, the Community Addiction Management Programme (CAMP) manages the patients in the community with a multidisciplinary team.

A Best Practice Example

Early Psychosis Intervention Programme (EPIP)

The Ministry of Health awarded Singapore's Institute of Mental Health a special 5-year fund in 2001 to run the EPIP, a programme to provide early intervention for young adults and tertiary students with emerging mental illnesses within the community. EPIP offers three key activities: provision of clinical services to persons with early psychosis, training to frontline staff in schools and social agencies to allow them to identify young people with mental health problems, and training of primary care physicians to conduct initial screening and to manage stable persons with mental health problems.

The frontline staff are trained to identify and refer young people with suspected mental health problems to primary care physicians. They include counsellors from various educational institutions, officers from the Police

Force and Ministry of Defence, counsellors from Family Service Centres, Community Development Councils and other grass root organisations. Training includes major mental illnesses (mood disorders, anxiety and psychosis), and refresher courses are also conducted for new staff. Joint case conferences with referring agencies are also organised to ensure continuity of care for the client.

Although historically Singapore's primary care physicians had not been involved in the management of mental disorders, EPIP managed to engage their participation through training in diagnosing psychoses and referral to EPIP for timely intervention. Patients identified with other mental health problems are either managed by the primary care physicians, or are referred to public hospitals. They are also trained to manage stable patients from EPIP for continued treatment. A support system of telephone/email consultations for EPIP's community partners has been established.

EPIP ensures that patients with early psychosis are given community-based treatment, including a case manager to enhance appropriate follow-up and compliance with therapy and to reduce defaults. Through early detection and early intervention in psychosis, the outcome is improved along with a reduction in the duration of untreated psychosis. Case management ensures integrated and individualised care for first-episode psychosis patients, as well as continuity of care through the different phases of the illness. Evidence-based treatment is provided by a multi-disciplinary team.

The focus is on promoting recovery and integrating patients back to the community. EPIP is widely acclaimed as a successful community-based programme, recognised internationally by WHO and awarded the inaugural State of Kuwait Prize for Research in Health Promotion in 2006. It has shown a significant reduction in patient default rates, with improved functioning and increased employment of patients. Based on this success, EPIP has continued beyond the initial five years, to enable expansion of the programme nation-wide. It blazed the trail in Singapore's mental health services for training and deploying case managers and primary care physicians in its programme.

Current challenges faced by the programme include the engagement of non-traditional healthcare providers (folk and religious healers), who are seeing a number of individuals when they first present with mental disturbances, and persuasion of employers and educational institutions in Singapore to accept individuals who have received or are receiving psychiatric treatment.

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Taiwan

Editor: Erin Chia-Husan Wu, Taiwanese Society of Psychiatry, Taiwan.

Sub-Editors: Ming-Jen Yang, Joseph Jror-Serok Cheng, Chang-Jer Tsai, Steve Chih-Yuan Lin, Jia-Shin Chen, Keh-Ming Lin, Chiao-Chicy Chen.

Taiwan's Mental Health System

As of March 2007, Taiwan had 37 psychiatric hospitals with 19,127 psychiatric beds (6,130 acute beds and 13,132 chronic beds, 2.6 and 5.5 beds per 10,000 population), of which 55.9% are located in public hospitals. Psychiatric day care centres are available in all psychiatric hospitals, regional hospitals and some district hospitals. In addition, 61 community rehabilitation centres and 81 half-way houses operated by psychiatric institutions or non-professional groups provide community care for people with severe mental illnesses. The existing mental health network has been extended to meet the varied community mental health needs of a rapidly changing society.

Two major noteworthy events made such developments possible: the Mental Act enacted in 1990 and the National Health Insurance (NHI) launched in 1995. The Mental Act represents a significant advance, as it ensures the protection of human rights and calls for ethical practice of all mental health professionals. The NHI reimburses a wide range of medical expenditure related to the treatment of mental illnesses, including the fees for psychiatric rehabilitation. People with severe mental illnesses such as schizophrenia and bipolar affective disorder do not need to provide the co-payment, which usually constitutes 10% of the total medical expenses.

A Best Practice Example

The Taipei City Psychiatric Center (TCPC)

The Taipei City Psychiatric Center (TCPC), founded in 1969, has been dedicated to provide psychiatric services to 2.6 million residents in Taipei City. Professor E.K. Yeh, the first superintendent of this municipal hospital, established the innovative and widely known 'Taipei Model' for community care of psychiatric patients in 1970s.

The key element of the 'Taipei Model' is the development of a network between the hospital and the public health sector, and facilitation of follow-up visits by public health workers from twelve district health

institutes to patients with severe mental illness discharged from the TCPC. Mentally ill patients are continuously tracked, evaluated and treated in a hierarchical style of management. Utilisation of other social resources is made as individual needs change. Health information and resources related to disease, drugs, family planning and occupational rehabilitation are provided to individuals and family members.

The psychiatrists from TCPC, as well as core hospitals in the city, provide a range of supervision in a fixed-term period. The involvement of public health nurses in the assessment, planning, implementation and evaluation of the community psychiatric services has been a key element for the success of the 'Taipei Model'.

To provide optimal treatment for people with common mental disorders, TCPC initiated the Taipei City Depression Collaborative Care System under the endorsement of the health authorities of the city government in 2003. Primary care physicians, mostly internists and family medicine specialists, were invited to participate in the training workshop to form an inter-divisional and inter-professional network. In 2005, all the municipal hospitals and 177 primary care clinics joined the collaborative care network while TCPC continued its role of providing educational courses. In addition, the executive board continued to facilitate referral between mental health services and primary care, and to negotiate with National Health Insurance for a study project looking at incentives and outcomes of the program.

In July 2005, the TCPC commenced 'individual psychological consultation services' at the twelve district health institutes, which made psychological consultation available, affordable and easily accessible for the community.

The 'Research and Development Center for Suicide Prevention' was established to work with social workers in the district social welfare centres to follow up persons who attempted suicide and presented to the emergency rooms at the hospitals in the city.

The harm-reduction anti-drug policy (methadone maintenance program) was introduced to the community in 2006, when the number of HIV-infected patients (mostly needle-sharing heroin users) sharply increased. Since 1993, TCPC has built a rehabilitation model which includes physical detoxification, psychological rehabilitation and follow-up counselling. At the same time, an information system was established to monitor drug abuse trends.



Taipei City Psychiatric Center.

© 2008 Asia-Pacific Community Mental Health Development Project. A full country report can be found at www.aamh.edu.au.

Thailand

Editor: M.L. Somchai Chakrabhand, Director General, Department of Mental Health, Ministry of Public Health, Thailand.

Sub-Editors: Phunnapa Kittirattanapaiboon, Suchada Sakornsatien, Taweelin Visanuyothin, Pattama Sirivech, Wiranpat Rattanasatien, Apisamai Srirangson; Contributors: Udom Laksanavicharn, Sujarit Suvanashiep, Apichai Mongkol, Wachira Pengjuntr, Seree Hongyok, Yongyud Vongpiromsarn, Achara Fongkhum, Benjaporn Panyayong, Boonchai Nawamongkolwatana, Damrong Waealee, Duangta Graipaspong, Dusit Liknapichitkul, Kiattibhoom Vongrachit, Krissana Jantree, Nattakorn Jampathong, Oraphun Lueboonthavatchai, Panpimol Lotrakul, Paritat Silpakit, Pichet Udomratn, Pitakpol Boonyamalik, Prasert Palitpongpanim, Somkuan Hanpatchayakul, Somrak Choovanichvong, Suchitra Usaha, Supavadee Nuanmanee, Thavatchai Kamoltham, Unchalee Silaket, Wasana Pattanakumjorn.

Thailand's Mental Health System

Community mental health services in Thailand have been integrated into the public health service system throughout the Ministry of Public Health administrative infrastructure, from village to regional levels.

Primary mental health care at the village level is provided by village health volunteers, who are the main community mental health care personnel and who encourage community participation in mental health activities. At the sub-district level, primary care units and health centres staffed by health personnel provide primary medical services, including mental health screening and monitoring to ensure psychiatric continuity of care.

Community hospitals at the district level and general hospitals at the provincial level pro-

vide outpatient services for common psychiatric disorders, continuity of care for chronic patients and mental health care to general hospital patients. Specialised comprehensive psychiatric care is provided by regional hospitals, university hospitals and psychiatric hospitals or institutes. Total psychiatric beds number 8,700 (13.8 beds per 100,000 population), with 9% of beds reserved for children and adolescents.

A Best Practice Example

Crisis mental health intervention following the Tsunami

On 26 December 2004, the Tsunami severely affected the south-western area of Thailand: 5,395 individuals died, 2,991 were unaccounted for, and 8,457 were injured. People living in the disaster area were psychologically affected to varying degrees. A crisis mental health intervention plan was established by the Department of Mental Health (DMH).

The objectives were:

- To provide mental health support for survivors of the Tsunami.
- To establish a mental health care delivery system in collaboration with other organisations and community networks.

The phases of intervention were the following:

1. Emergency Phase

During this phase, the aim was to provide emotional support. Mobile mental health teams were sent out to evaluate the situation, gather information, work closely with local health personnel and provide psychological first-aid, triage and acute mental health care.

The 'Mental Health for Thai Tsunami Centre' was established in the Department of Mental Health, and a front-line centre was established in the South to facilitate daily teleconferences for developing work plans and reporting data for policy and decision-making.

2. Post-Impact Phase (two weeks to three months after the Tsunami)

The aim in this phase was to provide mental health assessment and early intervention. Outreach services focused on 'at risk' groups. The most severe cases were referred to psychiatric centres. The Ministry of Public Health established a 'Surveillance Centre' in the South to coordinate service activities and develop health monitoring information systems including general health, disease control, physical and mental health care and identification of dead bodies.

3. Recovery Phase (three months after the Tsunami)

The aim in the Recovery phase was to reduce psychological morbidity and improve quality

of life. The 'Mental Health Recovery Centre' was established in the most seriously affected area, to collaborate with other organisations involved with mental health rehabilitation.

Collaborative research between the DMH and the US Centre for Disease Control and Prevention Collaboration, to assess the mental health problems among adults in affected area, found an elevated rate of post-traumatic stress disorder (PTSD), anxiety and depression two months after the Tsunami.

At follow-up after nine months, the rates of these symptoms decreased. The DMH developed a 'National Guideline for Mental Health Intervention in Natural Disasters' based on the lessons learnt from the response to the Tsunami.

Key success factors were the following:

- A well-established chain of command.
- A well-developed existing health and mental health care delivery system with the village health volunteer network working in the community.
- A comprehensive data and information-gathering system.
- Participation of partners, such as teachers and monks.
- One commander-in-charge to minimise staff confusion.
- A lead coordinator who is identified to work with the different organisations involved in order to prevent secondary trauma from repeated interviews.
- Appropriate mental health interventions for each phase or time period.
- Health personnel are sensitive and aware of the beliefs, religion and culture of the local people.
- The Centre reports all urgent physical needs other than mental health to the organisations responsible for meeting these needs.
- The mobile team is rotated every week and works less than twelve hours a day to prevent burnout.
- The Village Health Volunteers are the main personnel to deliver psychosocial relief efforts to the community.



Mental Health Recovery Center, Thailand.

© 2008 Asia-Pacific Community Mental Health Development Project. A full country report can be found at www.aamh.edu.au.

Vietnam

Editor: Than Thai Phong, Line Direction and Training Department, National Psychiatric Hospital No. 1, Vietnam.

Sub-Editor: Tran Van Cuong.

Vietnam's Mental Health System

Currently there are thirty psychiatric hospitals, including three major on-call duty centres run by the National Psychiatric Hospital No. 1, National Psychiatric Hospital No. 2 and the Bach Mai Mental Health Institute. Twenty-seven provinces in Vietnam have hospitals with psychiatric services, of which twenty-six are also involved in prevention of public health-related illnesses. There are a total of 5000 psychiatric beds and 2500 beds for serious mental illness nation-wide (for chronic mental illness). There are also 850 doctors with varying levels of specialty training; a ratio of one mental health doctor for every 100,000 people.

A Best Practice Example

Community-based mental health care project (CMHCP)

In 1998, Prime Minister Phan Van Khai approved this national community-based project.

Although from 2001 to 2005 the expenditure only met 38.6% of the project design cost, there was extra financial support from every province. The CMHCP received enthusiastic support from the provinces, districts and villages. Family members of people with mental illness were particularly interested because they were mostly from underprivileged backgrounds and could not afford medications for long-term treatment. Therefore, the CMHCP achieved good results from 2001 to 2005 despite a low budget and short duration.

Results of an epidemiological study of 10 common psychiatric illnesses from 2001 to 2003 were as follows: Schizophrenia 0.47%; Epilepsy 0.33%; Head Trauma/Postconcussion syndrome 0.51%; Mental Retardation 0.63%; Dementia 0.88%; Major Depressive Disorders 2.8%; Anxiety Disorders 2.6%; Conduct Disorders in Adolescents 0.9%; Alcohol Abuse 5.3%; Opioid abuse 0.3%.

The factors that facilitated the progress of the project were:

- The Party, Government, and Ministry of Health have provided support towards mental health from the beginning of the project.
- Strong support given by various public organisations.
- Despite being low in numbers and capacity, the specialist teams were enthusiastic and highly responsible in carrying out the project.

- Although still inadequate, the mental health care network in the whole country has gradually been established and spread from the central to the regional areas.

The obstacles and challenges encountered were:

- The system of mental health networks remains insufficient. Several regional areas remain unsupported and lacking in local treatment centres.
- Mass public education and communication are still limited, especially in mountainous and rural areas.
- Specialist doctors and the mental health workforce are still inadequate.
- Public awareness of mental illnesses is limited, leading to prejudices towards patients with psychiatric illnesses. Further, a large proportion of psychiatric patients in the community are still not being treated.
- Resources for travelling for administration, and examination and supervision of patients are non-existent.

The Project is a driving force for the development of networks and services for mental health in the community, covering the whole country (64 provinces). The priority is to increase public awareness of mental illness, early detection and access to treatment centres, so there are better opportunities for patients to be re-integrated in the community without neglect or abuse.

The Project has also enabled psychiatric patients from remote areas to benefit from community-based mental health care. Serious mental health illnesses like schizophrenia, epilepsy and depression were diagnosed and treated without cost to families.

The achievements have been possible due to the attention to mental health given by The Party, Congress, Government and Ministry of Health, as well as the hard work and dedication of the mental health staff.

The next stage of the project aims to increase the quality of services for people with mental health problems. Although the emphasis during the period 2006–2010 is still on schizophrenia, there are plans to include other non-transmissible illnesses, such as epilepsy and depression, within the CMHCP.

From the end of the 20th century, in line with WHO recommendations, many countries stopped building large scale psychiatric hospitals and increased the management of psychiatric illnesses in the community. This is consistent with the aim of the CMHCP.

Other future strategies of the project include: establishing mental health counselling centres or telephone help lines, increasing mental health service research to improve quality of care, increasing community mental health care, advocating for the development of mental health legislation, increasing inter-

national collaboration, and from 2008 to expand mental health care for children and older people. As there is currently only a small capacity to train mental health workers and social workers, there is a great need to build up the workforce to meet the needs of people with mental health problems.



National Psychiatric Hospital No. 1, Vietnam.

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■ DR. PEDRO RUIZ RECOGNIZED



Dr. Pedro Ruiz received the “Distinguished Service in Psychiatry Award” from the American College of Psychiatrists on February 28, 2009, in Tucson, Arizona, during the Annual Meeting of the American College of Psychiatrists. This award is conferred annually to a psychiatrist who has distinguished himself or herself for outstanding achievements in the field of psychiatry. The awardee does not have to be a member of the American College of Psychiatrists to receive this recognition.

Dr. Ruiz is a Past President of the American College of Psychiatrists (2000-2001), as well as a Past President of the American Psychiatric Association (2006-2007), a Past President of the American Board of Psychiatry and Neurology (2002-2003), and Past President of The American Association for Social Psychiatry (2000-2002). Currently, Dr. Ruiz is a Tenured Professor and Interim Chair of the Department of Psychiatry and Behavioral Sciences of the University of Texas Medical School at Houston, as well as President Elect and Vice President of the World Psychiatric Association (2008-2011). Dr. Ruiz is also a well known international scholar with over 600 publications, including being one of the editors of the well recognized textbook “Substance Abuse: A Comprehensive Textbook” and also of the Ninth Edition of the “Kaplan & Sadock’s Comprehensive Textbook of Psychiatry” which is currently in press.

■ EXEMPLARY EXPERIENCES IN MENTAL HEALTH AND PSYCHIATRY ACROSS THE WORLD: SCHIZOPHRENIA RESEARCH FOUNDATION

SCARF is the acronym for the Schizophrenia Research Foundation, a non-governmental, non-profit organization based in Chennai (formerly Madras) in South India. SCARF was established in 1984 by a group of philanthropists and mental health professionals led by Dr. M. Sarada Menon, an internationally renowned psychiatrist. In the twenty five years since, SCARF has reinforced itself as a center of repute in rehabilitation and research in disorders of the mind. The present team



Inauguration of IConS 2008

led by Dr. R. Thara (Director) includes psychiatrists, psychologists, social workers, rehab personnel, administrative and support staff.

SCARF is one of few NGOs in the world to be named as a Collaborating Centre of the World Health Organization (WHO) for Mental Health Research and Training. SCARF is also recognised by the Department of Science and Technology of the Government of India and is the Indian co-ordinating site for the anti-stigma programme of the World Psychiatric Association.

In recognition of its outstanding services for the welfare of the disabled, SCARF received the "National Award to Outstanding Employer 1995" from the President of India. In 2001, SCARF was the recipient of the Helen Keller Award instituted by the National Centre for the Promotion of Employment of Disabled People in New Delhi. In 2006 SCARF became the first and only Indian organization to receive a Certificate of Excellence from the Geneva Human Rights Association for its work in protecting and promoting the rights of the mentally ill.

Treatment and Rehabilitation

SCARF provides its services to the mentally ill through an out-patient clinic, a day care centre and a comprehensive rehabilitation centre that provides social and vocational training. Additionally, SCARF offers edu-

cational assistance to children of disabled clients as well as family empowerment programs and job placement for sufficiently recovered clients. All these services are provided absolutely free of cost to the patients and their families.

SCARF also runs three residential centers, with a combined capacity of 150 beds. Each center is manned by a qualified multidisciplinary team who offer rehabilitation inputs to discharge patients at the earliest, and reunite them with their families.

Community outreach programs

Over the past 15 years, SCARF has established community mental health programs in several distinct geographical areas, both rural and urban. More recently, SCARF has extended the reach of this program by establishing a telemedicine network that connects remote areas to a central hub in Chennai. At present the community outreach program of SCARF covers a population of about 200 villages and 5 urban slums. SCARF aims to cover an additional 200 villages under its program in the coming years.

SCARF is also working in schools and colleges to improve the mental health of students, through the School Mental Health Program.

Anti stigma and Awareness programs

SCARF's core objectives include educating the public about schizophrenia to create awareness and understanding, facilitate early detection, and help eliminate social stigmatization. To achieve this, SCARF launched *Frame of Mind* in 2006, a film festival on mental health issues. Over the last three years, the festival has brought in newer audiences, and initiated public discussions about mental illness.

SCARF has organized several awareness programs using indigenous modes of communication such as street plays and folk theater, as well as screening specially made educational films and other audiovisual material. Manuals have been brought out for primary health care workers, teachers and families.

Training and Teaching

SCARF offers internship and training for students of Social work, Psychology, Oc-

cupational therapy and Nursing. Students gain valuable experience in working with the chronic mentally ill, through SCARF's treatment and rehabilitation programs.



The President of India Dr. Abdul Kalam inaugurating the Anti-stigma program of SCARF

SCARF also trains primary care physicians, multi-purpose workers and health workers in both urban and rural areas to enable early detection. As part of a collaborative effort with the Disability Commissioner of the Government of Tamil Nadu, several groups of professionals including doctors, nurses, staff of NGOs and teachers have been trained.

Research

SCARF has completed several research projects on biological, social and psychological aspects of Schizophrenia in collaboration with reputed national and international organizations including the World Health Organization, the Institute of Psychiatry, London, Douglas Hospital, Canada, Crichton Royal Hospital, Dumfries, Scotland and many more. SCARF has over 200 publications to its credit in peer reviewed international journals and has also been instrumental in designing several scales and instruments to measure different aspects of schizophrenia.

Every two years, SCARF hosts the *International Conference on Schizophrenia (ICONS)*, bringing together delegates from around the world to debate current issues in mental health. In 2008, the third edition of ICONS was attended by over 300 delegates, including representatives from over 15 countries. Inaugurated by Dr. Benedetto Saraceno, Director of the Mental Health Division (WHO), ICONS was co-sponsored by the World Health Organisation, the World Psychiatric Association and the Indian Psychiatric Society.

Lobbying

SCARF continues to actively lobby with the Government and other apex bodies for new programs that will benefit the mentally disabled. SCARF has successfully ensured that disability caused by mental illness is recognized by the Indian Government and included in the Persons with Disabilities Act.

For more details, please visit our website: www.scarfindia.org



Frame of Mind - A film festival on mental health organized by SCARF

Upcoming WPA Major Meetings

June 2009

II Thematic Conference on Legal and Forensic Psychiatry 16-20 June 2009, Madrid, Spain

Organizer: Spanish Society of Legal Psychiatry
Contact: Dr. Alfredo Calcedo Barba
E-mail: forensicpsychiatry2009@gmail.com
Website: www.forensicpsychiatry2009.org

October 2009

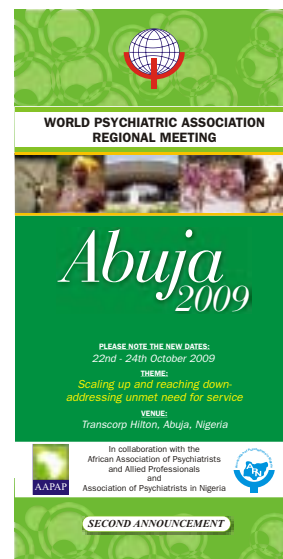
Abuja meeting now holds in October 2009!

WPA Regional Meeting 22-24 October 2009 Abuja, Nigeria

The WPA Regional Meeting in Abuja now holds on 22nd to 24th October 2009. It is being held in collaboration with the African Association of Psychiatrists and Allied Professions (AAPAP) and hosted by the Association of Psychiatrists in Nigeria (APN). The theme is "Scaling Up and Reaching Down - Addressing Unmet Need for Service". The meeting will bring together not only

researchers and clinicians in the fields of mental health and psychiatry, but also policy makers at national and international levels. It will therefore include lectures, symposia and poster presentations as well as high level roundtable policy discussions and workshops.

Details are available at: www.aapap.org/abuja2009



January 2010

WPA Regional Meeting and 2nd International Conference of South Asian Forum International on Mental Health and Psychiatry, 21-23 January 2010 Dhaka, Bangladesh

Community Mental Health: Goals and Challenges



The Cox's Bazar sea beach, the longest sea beach in the world, and about 350 kilometers from Dhaka.

The Bangladesh Association of Psychiatrists (BAP) announces with pleasure to hold the WPA Regional Meeting from 21-23 January, 2010 in Dhaka, Bangladesh, a very prestigious meeting in the South Asia region on mental health. Along with this the South Asian Forum International on Mental Health and Psychiatry will hold its 2nd international conference. We hope the leaders of WPA, various international organizations on mental health, and the Member Societies of different countries in the region will take part in the scientific and social interaction of this meeting to make the conference a great success.

Organized by:

- Bangladesh Association of Psychiatrists (BAP)
- South Asian Forum International on Mental Health & Psychiatry- (SAF) Bangladesh Chapter
- World Association for Psycho-social Rehabilitation (WAPR)
- Asian of Federation of Psychiatric Associations (AFPA)

Contact persons:

- (1) **Prof. Dr. AH Mohammad Firoz (Bangladesh)**
Tel: 880-1713-111234. Fax: 880-2-9111362. E-mail: bap@agni.com
Website: www.bap.org.bd;
- (2) **Dr. E. Mohandas (India)**
Tel: 00919447086355. E-mail: emohandas53@gmail.com;
- (3) **Dr. Afzal Javed (U.K.)** Tel: 0044787946203.
E-mail: afzal.javed@ntlworld.com

June 2010

WPA Regional Meeting, 17-19 June 2010 St Petersburg, Russia

Organizer: Russian Society of Psychiatrists
Contact: Dr. Valery Krasnov
E-mail: krasnov@mtu-net.ru

September 2010

WPA Regional Meeting Beijing, China 1-5 September 2010

Organizer: Chinese Society of Psychiatry
Contact: Dr. Wang Gang
E-mail: gangwangdoc@yahoo.com.cn
Website: www.psychiatryonline.cn

September 2011

XV World Congress of Psychiatry 18-22 September 2011 Buenos Aires, Argentina

The World Congress of Psychiatry, organized by the World Psychiatric Association every three years, is the most ecumenical scientific meeting in the field of psychiatry. It aims to promote exchange of information among psychiatrists from all parts of the world; to promote educational activities; to boost collaborative research by bringing together

investigators from all over the world; to make psychiatry more visible at the international level. Its attendance usually varies from 6,000 to 10,000 participants.

The 15th World Congress of Psychiatry, taking place in Buenos Aires in September 2011, aims to provide a comprehensive overview of those achievements which have stood the test of time (our heritage) and of the most promising current trends (our future) in the various areas of psychiatric research and practice (e.g., classification, mental health promotion, genetics, neuroimaging, pharmacotherapy, psychotherapies, advocacy, etc.). The most prominent experts of the various topics will be invited to provide their contribution.



Other Upcoming Events

June 2009

IPOS 11th World Congress of Psycho-Oncology Vienna, Austria 21-25 June 2009

Dear friends and colleagues,

It is a great pleasure for us to invite you cordially to the IPOS 11th World Congress of Psycho-Oncology in Vienna, Austria, 21 - 25 June 2009.

It is our mission to advance and to optimize the standards of care for cancer patients as well as to encourage ongoing research. IPOS activities inspire collaboration between professionals in cancer care and science using IPOS World Congresses as a platform to communicate.

The theme of this upcoming Congress, "Multi-disciplinary Perspectives in Psycho-Oncology:

Interaction and Integration," will give us the opportunity to share the varied expertise and different experiences of professionals worldwide who are involved in the care of patients with cancer and their families and in psycho-oncology research. The Psychosocial Academy, 21 - 22 June 2009, will offer the opportunity to participate in interactive workshops lead by international experts and will include different practical, methodological and scientific topics.

We are looking forward to welcoming and meeting you in Vienna!

Elisabeth Andritsch PhD
Hellmut Samonigg MD
Chairs of the Congress

2nd European Conference on Schizophrenia Research – From Research to Practice

Joint thematic congress of the German Competence Network on Schizophrenia, the German Society of Psychiatry, Psychotherapy and Nervous Diseases and the European Psychiatric Association

21 – 23 September 2009 | Berlin, Germany



The 2nd European on Schizophrenia Research (ECSR) will be held from 21 to 23 September 2009 Conference in Berlin. This year's ECSR will be a joint thematic conference of the Competence Network on Schizophrenia and the German and the European Psychiatric Association. The WPA and its section on schizophrenia are co-sponsoring this scientific event as they had already done in 2007. Prof. Wolfgang Gaebel is the congress president of the ECSR 2009.

The ECSR 2009 is themed "From Research to Practice" and is explicitly meant to bridge basic research and clinical application. Accordingly, the scientific program will have a research track as well as a clinical track in order to address the interests of both researchers and clinicians. Keynote lectures by distinguished speakers

– Jim van Os on gene-environment interactions, Patrick McGorry on early detection and intervention and Philippa Garety on psychotherapy in schizophrenia – are already confirmed. Besides symposia arranged by the organizers, the concept of the ECSR allows for active participation from the scientific community. Slots are spared for symposia, oral presentations and posters submitted to the scientific committee.

- **Submission of proposals for symposia will be accepted until 16 February 2009**
- **Submission of abstracts for oral presentations and posters is possible until 16 March 2009**

To handle online submission and registration, and for more information see: <http://www.schizophrenianet.eu>

European Conference on Children of Parents with Mental Illness Vilnius, Lithuania 26-27 November 2009

For more information, please log onto the EUFAMI website:

www.eufami.org
or mail: vilnius2009@eufami.org

Tel: +32 16 74 50 40
Fax: +32 16 74 50 49

Due to the mental illness of their parents, these children are put at greater risk of experiencing mental disorders, school and adjustment problems. Furthermore, the family often lives in a stigmatising atmosphere.

There are many good practices in existence which support the development of these children, but these are not in widespread use across Europe. This conference aims to publicise more widely the existence of such good practices, especially to mental health policy makers and to promote their use in medical, psycho-social, school and NGOs environments. The conference will draw on good practices in fields such as maternity/early infancy, school (detection/prevention), parenthood training, children facing their parents' illness (understanding, suppressing feeling of guilt, supporting resilience, psycho-social intervention, respite, peer to peer groups).

The conference will also examine the children's protection question - first in its legal framework, then in relation to the professional and family environments.

Notwithstanding the International Convention on the Rights of the Child, in Europe children of parents with mental illness come under national laws. The conference will endeavour to analyse the practice of courts and social services in fields such as parental rights, custody, visitation, home support, temporary shelter and placement. The conference will address the consequences of the complex situation of families who have a member with mental illness - for example, the balance between child protection and support of the ill parent. The conference might also expose some of the effects of prejudices relating to mental illness.

With respect to the professional environment, the conference will strive to identify simple forms of cooperation between professionals resulting in a better protection of the children who are either ignored or divided between several agents (interest of adult psychiatry for its patients' families, dialogue between adult psychiatry and childhood protection services, communication adult psychiatry/school/social services, training combining knowledge in adult psychiatry and child development). The general view is that children are generally best cared for within their own families whenever this is possible. Moreover, many children living with parents who have a mental illness cope reasonably well. The conference will approach the position of the enlarged family and try to determine the functions it may efficiently assume.

Future WPA Scientific Meetings

Prof. Tarek Okasha, Secretary for Meetings, Professor of Psychiatry, Institute of Psychiatry Faculty of Medicine, Ain Shams University, 3 Shawarby Street, Kasr El Nil, Cairo, Egypt Tel: +202 29200900/1/2/3/4 Fax: +202 29200908 **E-mail:** tokasha@internetegypt.com

March 2009

14 March 2009: "Covering mental health needs: Challenges of an emerging relationship between the public and the private sector", Veroia, Greece. Organizer: International Society on Neurobiology and Psychopharmacology (ISNP). Collaboration: WPA Section on Private Practice. Contact: Dr. Kostas N. Fountoulakis. E-mail: kfount@med.auth.gr Website: www.psychiatry.gr

20-21 March 2009: "Sexual Disorders and their Treatment", Beirut (Hospital of the Cross), Lebanon. Organizer: Lebanese Association for CBT. Collaboration: Lebanese Society of Psychiatry. Contact: Prof. Charles Baddoura. E-mail: Charlesb@dm.net.lb

27-29 March 2009: "Ninth Workshop on Costs and Assessment in Psychiatry – Quality and Outcomes in Mental Health Policy and Economics", Venice, Italy. Organizer: WPA Section on Mental Health Economics. Contact: Dr. Massimo Moscarelli. E-mail: moscarelli@icmpe.org Website: <http://www.icmpe.org>

28-29 March 2009: "Third Italian International Workshop of Franciacorta on Mood Disorder", Iseo, Italy. Organizer: Centro Studi Psichiatrici. Collaboration: WPA Private Practice Section. Contact: Dr. Giuseppe Tavormina. E-mail: dr.tavormina.g@libero.it Website: www.censtupsi.or

April 2009

1-4 April 2009: WPA International Congress "Treatments in Psychiatry: A New Update", Florence, Italy. Organizer: Italian Psychiatric Association. Contact: Dr. Mario Maj. E-mail: majmario@tin.it Website: www.wpa2009Florence.org

7-11 April 2009: 5th Ain Shams International Congress on Psychiatry with the theme "New Strategies in Psychiatric Practice", Cairo, Egypt. Organizer: Institute of Psychiatry, Ain Shams University. Collaboration: a) Egyptian Psychiatric Association (EPA) b) World Health Organization (WHO). Contact: Prof. Afaf H. Khalil. E-mail: profkhafaf@yahoo.com Website: www.asuip.net

17-19 April 2009: "Stress and its Management", Beirut (Hospital of the Cross), Lebanon. Organizer: Lebanese Society of Psychiatry. Collaboration: Saint Joseph University. Contact: Prof. Charles Baddoura. E-mail: Charlesb@dm.net.lb

23-26 April 2009: "XXV Argentinean Psychiatric Congress", Sheraton Mar del Plata Hotel, Argentina. Organizer: Argentinean Psychiatrists Association (APSA). Contact: Dr. Alfredo H. Cía. E-mail: alfredocia@apsa.org.ar Website: www.apsa.org.ar

28-30 April 2009: 5th International Conference on Psychiatry "Challenges in the outcome of Psychiatric Disorders", Jeddah, Kingdom of Saudi Arabia. Organizers: a) Saudi German Hospital b) Saudi Psychiatric Association. Collaboration: World Federation of Societies of Biological Psychiatry b) Egyptian Psychiatric Association c) Arab Federation of Psychiatrists. Contact: Dr. Mohamed Khaled. E-mail: moh.khaled.hamed@gmail.com

May 2009

27-31 May 2009: "IV Macedonian Psychiatric Congress and International Meeting", Ohrid, Macedonia. Organizer: The Psychiatric Association of Macedonia (FYROM). Contact: Dr. Antoni Novotni. E-mail: anovotni@yahoo.com Website: www.mpaohrid2009.com.mk

29-30 May 2009: "XI Jornada Nacional de Patología Dual (AEPD)", Madrid, Spain. Organizer: Spanish Association of Dual Pathology. Contact: Dr. Nestor Szerman. E-mail: szerman@patologiadual.es Website: www.patologiadual.es

June 2009

3-5 June 2009: Annual Meeting of the Egyptian Psychiatric Association "Mental Health versus Mental Disorders", Cairo, Egypt. Organizer: Egyptian Psychiatric Association. Collaboration: Arab Federation of Psychiatrists. Contact: Dr. Tarek Okasha. E-mail: tokasha@internetegypt.com Website: www.psychiatryegypt.com

3-6 June 2009: "XXIV Congreso de la Asociación Española de Neuropsiquiatría", Cadiz, Spain. Organizer: Spanish Society of Neuropsychiatry. Contact: Dr. Fermin Perez. E-mail: presidente@ann.org.es Website: www.24congresoan.es

15-19 June 2009: "16th ISPA Congress Differentiation Integration and Development", Copenhagen, Denmark. Organizer: International Society for the Psychological Treatment of Schizophrenias and Other Psychosis (ISPS). Contact: Dr. Erik Simonsen. E-mail: es@regionsjaelland.dk Website: www.ISPS2009.ics.dk

16-20 June 2009: "II Thematic Conference on Legal and Forensic Psychiatry", Madrid, Spain. Organizer: Spanish Society of Legal Psychiatry. Contact: Dr. Alfredo Calcedo Barba. E-mail: forensicpsychiatry2009@gmail.com

21-25 June 2009: 11th World Congress of Psycho-Oncology "Multidisciplinary Perspectives in Psycho-Oncology: Interaction and Integration", Vienna, Austria. Organizers: The International Psycho-Oncology Society (IPOS) and Österreichische Plattform für Psychoonkologie (ÖPPO). Contact: Jennifer Alluisi, IPOS (Program Director). E-mail: info@ipos-society.org Website: www.ipos-society.org/ipos2009

22-26 June 2009: "VIII Symposium on Biological and Pharmacological Aspects of Mental Disorders", Havana, Cuba. Organizer: Colegio Cubano de Neuropsicofarmacología. Contact: Dra. Ana Sarracent. E-mail: anasar@infomed.sld.cu

26-27 June 2009: "Third Simposium de Psiquiatría Transcultural: Salud Mental en el Paciente de América Central y Caribe", Barcelona, Spain. Organizer: University Hospital Vall d'Hebron. Collaboration: University Autònoma of Barcelona. Contact: Dr. Miguel Casas. E-mail: mcasas@vhebron.net

July 2009

5 July 2009: "Interdisciplina – Mass Media and Salud Mental", Buenos Aires, Argentina. Organizer: WPA Section on Mass Media and Mental Health. Collaboration: FINTECO. Contact: Dr. Miguel A. Materazzi. E-mail: materazzi@arnet.com.ar

23-25 July 2009: "III Congreso Latinoamericano de Adicciones", Santiago, Chile. Organizer: Asociacion Latinoamericana de Adiccionologia (ALAD). Contacts: a) Claudia Bravo Riquelme; b) Dra. Elvia Velazquez. E-mail: congresoalad2009@gmail.com

September 2009

2-6 September 2009: "World Federation of Mental Health World Congress", Athens, Greece. Organizer: World Federation of Mental Health. Contact: Dr. George Christodoulou. E-mail: gchristodoulou@ath.forthnet.gr

11 September 2009: "FINTECO Annual Meeting: Truma, Social y Salud Mental", Buenos Aires, Argentina. Organizer: WPA Section on Mass Media and Mental Health. Collaboration: FINTECO. Contact: Dr. Miguel A. Materazzi. E-mail: materazzi@arnet.com.ar

21-23 September 2009: "Second European Conference on Schizophrenia Research (ECSR)", Berlin, Germany. Organizer: German Research Network on Schizophrenia. Contact: Dr. Wolfgang Gaebel. E-mail: schizophrenia@cpo-hanser.de Website: <http://www.schizophrenianet.eu>

23-27 September 2009: "Annual Meeting of the International Society of Addiction Medicine (ISAM)", Calgary, Canada. Organizer: International Society of Addiction Medicine (ISAM). Contact: Nady El-Guebaly, M.D. E-mail: office@isamweb.com Website: www.isamweb.org

24-26 September 2009: "VII World Congress of Depressive Disorders and International Symposium on Posttraumatic Stress Disorder", Mendoza, Argentina. Organizer: University of Cuyo. Contact: Dr. Jorge Nazar. E-mail: jorge_nazar@hotmail.com

October 2009

6-9 October 2009: "16th World Congress of the World Association for Dynamic Psychiatry (WADP)", Munich, Germany. Organizer: World Association for Dynamic Psychiatry. Contact: Dr. Sabine Funk. E-mail: sa.funk@t-online.de Website: www.wadp-congress.de

19-24 October 2009: "XIII Spanish Congress of Psychiatry", Madrid, Spain. Organizer: Spanish Society of Psychiatry. Collaboration: Spanish Society of Biological Psychiatry. Contact: Prof. Jeronimo Saiz. E-mail: secretaria@psiquimadrid2009.org Website: <http://www.psiquimadrid2009.org/>

22-24 October 2009: "WPA Sponsored Regional Meeting", Abuja, Nigeria. Organizer: African Association of Psychiatrists and Allied Professions. Collaboration: Association of Psychiatrists in Nigeria. Contact: Dr. Oye Gureje. E-mail: ogureje@comui.edu.ng

November 2009

4-7 November 2009: "XXVII Congresso Brasileiro de Psiquiatria", Sao Paulo, Brazil. Organizer: Brazilian Psychiatric Association. Contact: Prof. Joao Alberto Carvalho. E-mails: congreso@abpbrasil.org.br and congreso2@abpbrasil.org.br

12-15 November 2009: "10th World Congress of the World Association of Psychosocial Rehabilitation", Bangalore, India. Organizer: World Association of Psychosocial Rehabilitation. Contacts: a) Dr. Afzal Javed; b) T. Murali. E-mails: a) afzal@afzaljaved.co.uk b) muralithyloth@gmail.com Website: www.wapr.info

25-28 November 2009: "Mental Health in Iberoamerica: Science, community and human rights", Guayaquil, Ecuador. Organizer: Ecuadorian Psychiatric Association (AEP). Collaboration: Latin American Psychiatric Association (APAL). Contact: Fabrizio Delgado, MD. E-mail: infozone4wpa@gmail.com

25-28 November 2009: "DGPPN Congress 2009", Berlin, Germany. Organizer: German Society for Psychiatry, Psychotherapy and Nervous Disorders (DGPPN). Contact: Ms. Bettina Heidemann. E-mail: dgppn09@cpo-hanser.de Website: www.dgppn-kongress.de

26-29 November 2009: "First International Congress on Neurobiology and Clinical Psychopharmacology and European Psychiatric Association Congress on Treatment Guidance", Thessaloniki, Greece. Organizer: International Society on Neurobiology and Psychopharmacology (ISNP). Collaboration: WPA Section on Private Practice. Contact: Dr. Kostas N. Fountoulakis. E-mail: kfount@med.auth.gr Website: www.psychiatry.gr

January 2010

A.H. 21-23 January 2010: "WPA Regional Meeting", Dhaka, Bangladesh. Organizer: Bangladesh Association of Psychiatry. Contact: Prof. A.H. Mohammad Firoz. E-mail: bap@agni.com

February 2010

25-27 February 2010: "III Congreso Internacional de Medicina y Salud Mental de la Mujer", Medellin, Colombia. Organizer: Universidad CES. Contact: Dra Silvia L. Gaviria. E-mails: a) informacion@eventosperfectos.com.co b) sgaviria1@une.net.co Websites: a) www.eventosperfectos.com.co b) www.saludmentaldelamujermedellin2010.com.org

April 2010

5-9 April 2010: "Psicohabana 2010", Habana, Cuba. Organizer: WPA Section on Classification, Diagnostic Assessment and Nomenclature. Collaboration: Cuban Society of Psychiatry. Contact: Dr. Wilfredo Castillo Donate. E-mail: hph@infomed.sld.cu

June 2010

16-19 June 2010: "20th International Federation for Psychotherapy World Congress of Psychotherapy", Lucerne, Switzerland. Organizer: International Federation for Psychotherapy (IFP). Collaboration: Swiss Association for Psychiatry and Psychotherapy. Contact: Dr. Ulrich Schnyder. E-mail: Ulrich.schnyder@psyp.uzh.ch Website: <http://www.ifp.name>

17-19 June 2010: "WPA Regional Meeting", St. Petersburg, Russia. Organizer: Russian Society of Psychiatrists. Contact: Dr. Valery Krasnov. E-mail: krasnov@mtu-net.ru

25-26 June 2010: "Fourth Symposium of Transcultural Psychiatry", Barcelona, Spain. Organizer: University Hospital Vall d'Hebron. Collaboration: University Autonoma of Barcelona. Contact: Dr. Miguel Casas. E-mail: mcasas@vhebron.net

July 2010

7-11 July 2010: "IV Pan-American Congress on Child and Adolescent Mental Health", Havana, Cuba. Organizer: Cuban Society of Psychiatry. Collaboration: Cuban National Group for Child and Adolescent Psychiatry. Contact: Dr. Cristobal Martinez Gomez. E-mail: felices@infomed.sld.cu

10 July 2010: "Arte, Salud y Comunidad", Buenos Aires, Argentina. Organizer: WPA Section on Mass Media and Mental Health. Collaboration: FINTECO. Contact: Dr. Miguel A. Materazzi. E-mail: materazzi@arnet.com.ar

September 2010

1-5 September 2010: "WPA Regional Meeting", Beijing, China. Organizer: Chinese Society of Psychiatry. Contact: Dr. Wang Gang. E-mail: gangwangdoc@yahoo.com.cn Website: www.psychiatryonline.cn

18 September 2010: "Sociedad, Multitud Y Salud Mental", Buenos Aires, Argentina. Organizer: WPA Section on Mass Media and Mental Health. Collaboration: FINTECO. Contact: Dr. Miguel A. Materazzi. E-mail: materazzi@arnet.com.ar

October 2010

28-31 October 2010: "Pacific Rim College of Psychiatrists (PRCP) 14th Scientific Meeting", Brisbane, Queensland, Australia. Organizer: Pacific Rim College of Psychiatrists. Collaboration: a) Australian and New Zealand Association of Mental Health; b) Royal Australian and New Zealand College of Psychiatrists. Contact: Prof. Philip Morris. E-mail: pmorris@iprimus.com.au Website: <http://www.prcp.org>

25-27 February 2010: "III Congreso Internacional de Medicina y Salud Mental de la Mujer", Medellin, Colombia. Organizer: Universidad CES. Contact: Dra Silvia L. Gaviria. E-mails: a) informacion@eventosperfectos.com.co b) sgaviria1@une.net.co Websites: a) www.eventosperfectos.com.co b) www.saludmentaldelamujermedellin2010.com.org

January 2011

26-28 January 2011: "WPA Regional Meeting", Cairo, Egypt. Organizer: Egyptian Psychiatric Association. Contact: Dr. Tarek A. Okasha. E-mail: tokasha@internetegypt.com

April 2011

14-17 April 2011: "WPA Regional Meeting", Yerevan, Armenia. Organizer: Armenian Association of Psychiatrists. Contact: Dr. Armen Soghoyan. E-mail: soghoyan@yahoo.com

June 2011

9-12 June 2011: "WPA Thematic Conference: Rethinking Quality in Psychiatry: Education, Research, Prevention, Diagnosis and Treatment", Istanbul, Turkey. Organizers: a) Psychiatric Association of Turkey; b) Turkish Neuropsychiatric Association. Contact: Dr. Levent Küey. E-mail: kuey1@superonline.com

September 2011

18-22 September 2011: "XV World Congress of Psychiatry", Buenos Aires, Argentina. Organizers: a) Argentina Association of Psychiatrists (AAP) b) Association of Argentinean Psychiatrists (APSA) c) Foundation for Interdisciplinary Investigation of Communication (FINTECO). Contact: Mariano R. Castex. E-mail: mcastex@congresosint.com.ar Website: www.congresosint.com.ar

November 2011

12-13 November 2011: "WPA Regional Meeting", Taipei, Taiwan. Organizer: Taiwanese Society of Psychiatry. Contact: Dr. Chiao-Chicy Chen. E-mail: twpsyc@ms61.hinet.net

February 2012

9-11 February 2012: "Community Psychiatry and Family Medicine: Joint Promotion of Mental Health Care", Granada, Spain. Organizers: a) World Psychiatric Association b) Spanish Association of Neuropsychiatry. Collaboration: a) WONCA International & WONCA Europe b) University of Granada. Contact: Dr. Francisco Torres. E-mail: ftorres@ugr.es

March 2012

29-31 March 2012: WPA Thematic Meeting "Addiction Psychiatry", Barcelona, Spain. Organizer: Socidrogalcohol. Contact: Dr. Julio Bobes Garcia. E-mails: a) bobes@ctv.es b) bobes@uniovi.es

WPA EDUCATION ACTION PLAN FOR 2008-2011

Allan Tasman, MD
Secretary for Education

Upgrade and Revise the WPA website: Over the last two years, I have worked with the WPA executive committee, Anna Engstrom of our Secretariat staff, John Cox, former WPA Secretary General, and a technical consultant, Kathie Sauer of Lumins Associates, to completely revise and upgrade the website. New technical advances now allow more ease of use by those with both fast and slow connections. Capacity to develop online interactive CME, and to post online lectures and seminars is now available, bringing many new opportunities for online CME. Also, enhanced availability of list serves, online conferencing, and eventually, online teleconferences have been accomplished. These and many more technical changes provide the potential to vastly expand the utility of our website as an organizational communicational tool. Further revision of the website has now moved to the oversight of the new Secretary General, Levent Kuey, with staff support from the WPA Geneva office. The Secretary for Education will consult as needed on this project.

Revision of the WPA Educational Program in Depression: The original program was produced in the 1990's. With the major advances in diagnosis and treatment of depression and bipolar illness since that time, a revision was needed. Funded by a substantial unrestricted educational grant from Lilly, one of the only extramurally funded WPA projects over the 2005-2008 period, a task force co-chaired by Professors Norman Sartorius, past WPA President, and Allan Tasman has produced an extensive program for use around the world. The program will be translated into Spanish, French, Russian, Chinese, and Arabic as part of the project. The entire program, including power point slides, will be made available throughout the WPA in 2009.

An important component of this project will be the development of a major initiative to improve education of primary care clinicians around the world in the recognition and treatment of depression. Collaboration with global primary care organizations and the WHO is being developed in this regard. Further, a small, inexpensive handbook for primary care clinicians will be produced in 6 languages for global distribution with the collaboration of Helen Hermann, WPA Secretary for Publications.

CME Advances: WPA CME credits can now be made transferable for UEMS and APA CME credits, vastly expanding CME opportunities for WPA members who participate in WPA sponsored or co-sponsored CME programs. We have developed a system whereby WPA certified programs can apply and qualify for both UEMS and APA CME credits. This new system opens a wealth of new possibilities for CME for members living in UEMS affiliated countries in Europe and the United States who attend WPA CME certified congresses. The Secretary for Meetings will work with applicants for sponsorship by the WPA, to ensure the process is more widely utilized, making more sanctioned opportunities available for members around the world.

Projects initiated by Education Committee members:

- **Dan Stein** has initiated a Wikipedia project to develop a WPA education committee sponsored open access textbook for medical students in psychiatry. This will be a major educational contribution for medical students. Since it will be posted on Wikipedia, the online encyclopedia website, it will be available free of charge for medical students.
- **Brian Martindale** has put together a work group to on the draft of an educational program on Early Intervention in Psychosis. The program has been highly regarded by several WPA section reviews, and final revisions are being undertaken prior to WPA executive committee approval.
- **Savita Malhotra**, responding to a national need in her home country of India, has developed a WPA education committee sponsored series of workshops on psychotherapy training. The first of these was held in mid September, 2008. Plans include future annual or semiannual programs.

Other Activities of the Secretary for Education: A close collaboration has developed with WPA publication activities, collaborating with WPA Secretary for Publications Helen Herrmann, on planning for WPA education related publication activities. There is an ongoing collaboration with the WPA young psychiatrists group and the World Association for Young Psychiatrists and Trainees (WAYPT). Other collaborations have been developed to further the initiative for primary care education in recognition and treatment of psychiatric illnesses in the primary care setting.

Education Initiatives and Programs Related to the 2008-11 WPA Action Plan:

- Plans have been formulated to initiate a revision of the WPA curricular guidelines for medical student and post graduate training, based on the proposed triennial plan of incoming WPA president Mario Maj. The task force in charge of development will be chaired by pro-

fessor Jerald Kay, USA, and co-chaired by Professor Pichet Udomratn, Thailand.

- There will be a major initiative regarding public education activities, particularly focused on use of the WPA web site for materials based in the major national languages in use around the world. Eventually the goal is to have the material available in the native languages of each WPA member society. This will include a collaborative effort with the WPA Section on Education and a variety of national societies.
- WPA will develop interactive online CME activities through the WPA website. This will be developed in conjunction with the WPA Secretary General, Levent Kuey.
- A collaboration to develop web based educational materials in child and adolescent psychiatry is being developed with the Middle East Kids Initiative, a project organized by globally prominent psychiatrists including Tarek Okasha, Sam Tyano, and David Fassler. The liaison with WPA is Dr Siham Muntasser, at the University of Pittsburgh in the US.

■ A MEDIA CONSULTANT FOR THE WPA

Considering the need to promote the voice of the WPA, for the benefit of the people with mental health problems and mental health professionals across the world, WPA has taken an innovative action. The Association has recently engaged a health communications consultant to highlight to the international media news relating to WPA activities and to communicate the organization's perspective on topical issues in mental health.

Emma Ross, a former medical correspondent for the Associated Press and news team leader at the World Health Organization, will act as media liaison for the WPA. In addition to highlighting news emerging from the World Psychiatry journal, WPA scientific congresses and other projects, she will be developing a database that will offer a WPA resource to journalists seeking expert sources on a variety of mental health topics.

WPA PUBLICATIONS

Contact: WPA Secretary for Publications, Helen Herrman, h.herrman@unimelb.edu.au



■ THE WPA PUBLICATIONS PROGRAM: PAST, PRESENT, FUTURE

Helen Herrman, Secretary for Publications

The WPA publications program aims to promote the goals of the Association and specifically to: 1) disseminate information about clinical, service and research developments in the mental health field to the largest possible number of psychiatrists and health professionals across the world; 2) promote and give visibility to good quality research carried out in low and middle income countries; and 3) upgrade the publishing capacity of WPA.

These goals are pursued through the official journal of the Association, *World Psychiatry*, continuation of successful book series, the publication of books on topics relevant to the ethical and successful practice of modern psychiatry and illustrating partnerships with important groups in doing this, efforts to promote online availability and wider dissemination of published materials, and offering support to psychiatric journals in low- and middle-income countries.



World Psychiatry, edited by WPA President Prof Mario Maj, continues to develop as a high quality journal of international mental health, widely disseminated to all countries. It supports publication of material from authors of all regions and countries. It publishes research articles from around the world,

balanced with a significant proportion of Special Articles, Forums, Mental Health Policy Papers, Section Reports and WPA News, with the participation of many of the most highly cited authors in our field, aiming to keep the readership informed on significant clinical, service and research developments in mental health as well as on WPA initiatives. It is now distributed to more than 32,000 psychiatrists worldwide. It is produced in English, Spanish and Chinese languages. The long-term possibilities of publishing World Psychiatry

in other languages are under exploration. The journal is now indexed by Pub Med, and full articles and abstracts from its inception in January 2002 are available online through PubMed as well as the WPA website. In July 2006 *World Psychiatry* was accepted for inclusion in the Current Contents and in the Science Citation Index.

The series *Evidence and Experience in Psychiatry* is a highly successful publishing venture that compares research evidence and clinical experience concerning the diagnosis and management of the most common mental disorders. Each volume of the series covers a specific mental disorder, by means of a set of systematic reviews of the research evidence, each followed by commentaries produced by psychiatrists from various countries and representing different schools of thought. Nine volumes exist, several in second edition and several translated into various languages including Russian, Spanish, Portuguese, Italian and Turkish. The third edition of the volume on Depressive Disorders, editors H Herrman, M Maj, N Sartorius 2009. A new volume is planned on Substance Abuse Disorders and a program established for issuing new editions of existing volumes in the next triennium and beyond.

Volumes originating from the 13th World Congress of Psychiatry. *The Mental Health of Children and Adolescents: An area of global neglect*, documents the extensive work from the WPA Institutional Program on Child and Adolescent Mental Health. The book was launched and distributed to attendees at the WPA Regional Meeting in Nairobi Kenya in March 2007. It was also distributed to attendees at the WPA Regional Congress in Shanghai September 2007. *Contemporary Issues in Women's Mental Health and Psychiatric Diagnosis: Patterns and Prospects* will be published by Wiley-Blackwell in 2009.

The series *Anthologies of International Psychiatric Texts* (*Series Director D. Moussaoui*) and ***Anthologies Online***. The books in this series include classical texts produced by psychiatrists of a given country or group of countries published in English for the first time, accompanied by essays on their authors. In recognition of their value to psychiatrists everywhere, electronic versions of the first three volumes in the series, that is the French,

Spanish and Italian volumes, are now published online by Wiley-Blackwell. The electronic versions are available through the WPA website and link to Wiley-Blackwell Interscience. *The German Anthology of Psychiatric Texts*, editor Henning Sass was published in April 2007 and electronic publication by this same means is in discussion.

Other books are forthcoming in 2009 from the WPA Scientific Sections including Public Policy and Psychiatry, Transcultural Psychiatry and Religion and Psychiatry, and the Institutional Program on Psychiatry for the Person.

The program for new books publication in the current triennium will be outlined in the next issue of *World Psychiatry*.

A project to promote research dissemination through support for psychiatric journals from low- and middle-income countries has been established with appointment of a Task Force in 2008. A report on the first phase of the work, preliminary to appointment of the Task Force, was published in *World Psychiatry* in February 2009 'Indexation of psychiatric journals from low- and middle-income countries: a survey and a case study' (Kieling, Herrman, Patel, Mari). The Task Force met at the XIV WCP with invited editors of journals selected after a process developed in consultation with the WPA Board.

Publishing developments in partnership with WPA. All Wiley-Blackwell books published for WPA are available online and form part of the HINARI offering to low- and middle-income countries. People in some of these countries have free access, others pay a small amount. Publishing agreements with Rowman & Littlefield allow books published by Rowman & Littlefield to be placed on the WPA website for free access 18 months after publication date. Translation into additional languages (current for *World Psychiatry* and volumes in Evidence and Experience series), and appropriate ways to disseminate books and electronic content to colleagues in low- and middle-income countries are under continuing discussion with publishers.

WPA Publications by Wiley-Blackwell

Available through link from www.wpanet.org/publications

Forthcoming

Recovery in Mental Health: Reshaping scientific and clinical responsibilities. Michaela Amering and Margit Schmolke. Translation: Peter Stastny. June 2009 / Hardback / 280 pages. ISBN 9780470997963

Depressive Disorders, 3rd Edition. Editors: Helen Herrman, Mario Maj and Norman Sartorius. September 2009 / Hardback / 344 pages. ISBN 9780470987209

Contemporary Topics in Women's Health: Global perspectives in a changing society. Editors: Prabha S. Chandra, Helen Herrman, Jane Fisher, Marianne Kastrup, Unaiza Niaz, Marta Rondon and Ahmed Okasha. September 2009 / Hardback / 544 pages. ISBN 9780470754115

New

Handbook of Service User Involvement in Mental Health Research. Editors: Jan Wallcraft, Beate Schrank and Michaela Amering. Foreword: George Szumukler. April 2009 / Hardback / 272 pages. ISBN 9780470997956

Psychiatrists and Traditional Healers: Unwitting partners in global mental health. Editors: Mario Incayawar, Ronald Wintrob and Lise Bourchard. Honorary Editor: Alfredo Bartocci. March 2009 / Hardback / 296 pages. ISBN 9780470516836

Psychiatric Diagnosis: Challenges and prospects. Editors: Ihsan M. Salloum and Juan E. Mezzich. March 2009 / Hardback / 328 pages. ISBN 9780470725696

Already Published

Disaster and Mental Health. Editors: Juan José López-Ibor, George Christodoulou, Mario Maj, Norman Sartorius and Ahmed Okasha. 2004. ISBN 9780470021231

Early Detection and Management of Mental Disorders. Editors: Mario Maj, Juan José López-Ibor, Norman Sartorius, Mitsumoto Sato and Ahmed Okasha. 2005. ISBN 9780470010839

Families and Mental Disorder: From Burden to Empowerment. Editors: Norman Sartorius, Julian Leff, Juan José López-Ibor, Mario Maj and Ahmed Okasha. 2005. ISBN 9780470023822

Psychiatry as a Neuroscience. Editors: Juan José López-Ibor, Wolfgang Gaebel, Mario Maj and Norman Sartorius. 2002. ISBN 9780471496564

Psychiatry in Society. Editors: Norman Sartorius, Wolfgang Gaebel, Juan José López-Ibor and Mario Maj. 2002. ISBN 9780471496823

Psychiatric Diagnosis and Classification. Editors: Mario Maj, Wolfgang Gaebel, Juan José López-Ibor and Norman Sartorius. 2002. ISBN 9780471496816

The Mental Health of Children and Adolescents: An area of global neglect. Editors: Helmut Remschmidt, Barry Nurcombe, Myron Lowell Belfer, Norman Sartorius and Ahmed Okasha. 2007. ISBN 9780470512456

Evidence and Experience in Psychiatry Series:

Bipolar Disorders. Editors: Mario Maj, Hagop S. Akiskal, Juan José López-Ibor and Norman Sartorius. 2002. ISBN 9780471560371

Dementia, 2nd Edition. Editors: Mario Maj and Norman Sartorius. 2003. ISBN 9780470849637

Depressive Disorders, 2nd Edition. Editors: Mario Maj and Norman Sartorius. 2003. ISBN 9780449657

Eating Disorders. Editors: Mario Maj, Katherine Halmi, Juan José López-Ibor and Norman Sartorius. 2003. ISBN 9780470848654

Obsessive-Compulsive Disorders, 2nd Edition. Editors: Mario Maj, Norman Sartorius, Ahmed Okasha and Joseph Zohar. 2003. ISBN 9780470849668

Personality Disorders. Editors: Mario Maj, Hagop S. Akiskal and Juan E. Mezzich. 2005. ISBN 9780470090367

Phobias. Editors: Mario Maj, Hagop S. Akiskal, Juan José López-Ibor and Ahmed Okasha. 2004. ISBN 9780470858332

Schizophrenia, 2nd Edition. Editors: Mario Maj and Norman Sartorius. 2003. ISBN 9780470849644

Somatiform Disorders. Editors: Mario Maj, Hagop S. Akiskal, Juan E. Mezzich and Ahmed Okasha. 2005. ISBN 9780470016121

Anthologies and Online Anthologies of International Psychiatric Texts (Series Director D. Moussaoui) Online at: www.interscience.wiley.com/onlinebooks (via link from www.wpanet.org/publications)

Anthology of German Psychiatric Texts. Editor: Henning Sass. 2007 / 526 pages. ISBN 9783000204258

Anthology of French Language Psychiatric Texts. Editors: François-Régis Cousin, Jean Garrabé and Denis Morozov. 2008 / 552 pages. Adobe E-Book. ISBN 9780470986721

Anthology of Italian Psychiatric Texts. Editors: Mario Maj and Filippo M. Ferro. 2008 / 432 pages. Adobe E-Book. ISBN 9780470986707

Anthology of Spanish Psychiatric Texts. Editor: Juan José López-Ibor, Carlos Carbonell Masiá and Jean Garrabé. 2008 / 552 pages. Adobe E-Book. ISBN 9780470986745

Other WPA Publications

Advances in Psychiatry. Editor: George N. Christodoulou, Beta Medical Arts, Athens, Greece, 2002 (232 pages).

Advances in Psychiatry, Second volume. Editor: George N. Christodoulou, World Psychiatric Association, Paris, France, 2005 (282 pages).

Advances in Psychiatry, Third volume. Editors: George N. Christodoulou, Miguel Jorge, Juan E. Mezzich, Beta Medical Arts, Athens, Greece, 2009 (in preparation).

Essentials of Clinical Psychiatry for sub-Saharan Africa. Editors: Frank G. Njenga, Wilson Acuda, Vikram Patel and Mario Maj. Published by Masson, Milano 2005.

Images in Psychiatry: An Arab Perspective. Editors: Ahmed Okasha and Mario Maj. Co-editors: Aida Seif El Dawla and Tarek Okasha. Published by Scientific Book House, Cairo 2001.

Images of Psychiatry: The Caribbean. Editors: Frederick W. Hickling and Eliot Sorel. Published by Stephenson's Press Limited, Jamaica 2005.

Images in Psychiatry: Poland. Editors: Adam Bilikiewicz and Janusz Rybakowski. Published by Via Medica, Gdansk 2002.

Images of Psychiatry: Romania. Editors: Eliot Sorel and Dan Prelipceanu. Published by InfoMedica, Bucharest 2004.

Images of Spanish Psychiatry. Editors: Juan José López-Ibor, Carmen Leal Cercós and Carlos Carbonell Masiá. Editorial Glosa 2004.

Psychiatry and Sexual Health: An Integrative Approach. Editors: Juan E Mezzich and Ruben Hernandez-Serrano on behalf of the WPA Educational Program on Sexual Health. Published by Jason Aronson, USA 2006 (an imprint of Rowman & Littlefield Publishers). Available on-line at www.rowmanlittlefield.com.

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Ms. Anna Engstrom (Sweden)

Deputy Administrator

Ms. Pamela Atiase (Switzerland)

Geneva University Psychiatric Hospital

Bâtiment Les Voirons

2 Chemin du Petit Bel-Air

1225 Chêne-Bourg, GENEVA

Switzerland

Tel: +41 22 305 5737

Fax: +41 22 305 5735

Email: wpascretariat@wpanet.org

WEBSITE: WWW.WPANET.ORG

The World Psychiatric Association (WPA)

The WPA is an association of national psychiatric societies aimed to increase knowledge and skills necessary for work in the field of mental health and the care for the mentally ill. Its member societies are presently 134, spanning 112 different countries and representing more than 200,000 psychiatrists.

The WPA organizes the World Congress of Psychiatry every three years. It also organizes international and regional congresses and meetings, and thematic conferences. It has 65 scientific sections, aimed to disseminate information and promote collaborative work in specific domains of psychiatry. It has produced several educational programmes and series of books. It has developed ethical guidelines for psychiatric practice, including the Madrid Declaration (1996).



What are its Aims?

The core missions of WPA include the following:

- To encourage the highest possible standards of clinical practice
- To increase knowledge and skills about mental disorders and how they can be prevented and treated
- To promote mental health
- To promote the highest possible ethical standards in psychiatric work
- To disseminate knowledge about evidence-based therapy and values based practice
- To be a voice for the dignity and human rights of the patients and their families, and to uphold the rights of psychiatrists
- To facilitate communication and assistance especially to societies who are isolated or whose members work in impoverished circumstances