# Contents

"LIVING WITH SCHIZOPHRENIA":
The Theme For World Mental Health Day 2014

*George Christodoulou*

BRIEF HISTORY OF WORLD MENTAL HEALTH DAY

SCHIZOPHRENIA FACTSHEET

FINDING RECOVERY WITH SCHIZOPHRENIA

*Janet Paleo*

LETTER FROM A FAMILY MEMBER

*Spyros Zorbas*

A MESSAGE FROM THE VICE PRESIDENT FOR CONSTITUENCY DEVELOPMENT

*Mohammed Abou Saleh*

NEWS FROM WFMH VOTING MEMBER ORGANIZATIONS

- Advocacy Group For The Mentally Ill, Cyprus
- American Psychological Association
- Banjara Academy, India
- Enosh, Israel
- Hellenic Psychiatric Association
- Hong Kong Association Of Doctors In Clinical Psychology
- Mental Health America
- Mental Health Carers Arafmi Australia
- Mental Health Association In Taiwan
- New Life Psychiatric Rehabilitation Association, Hong Kong
- NGO Forum For Health, Switzerland
- Royal Australian And New Zealand College Of Psychiatrists
- South African Federation For Mental Health
At a time when budgets for mental health services have been under pressure, WFMH will use World Mental Health Day (10 October) this year to draw attention again to the needs of people with severe mental illness. Schizophrenia was chosen as the theme for World Mental Health Day to improve public understanding of this troublesome, complicated but treatable mental illness. It is a disorder that imposes a tremendous burden of suffering and social isolation on the people who experience it. It causes disruption in the lives of families – parents, siblings and children.

There is a growing appreciation that, because of the variable and usually chronic nature of this complicated illness, treatment could be improved by providing an integrated, comprehensive network of medical and social support services that address different aspects of the illness. Where such services are available—and in many low-income countries there are no services at all—they are usually provided in a disjointed fashion and can be hard to access.

Schizophrenia has not been viewed kindly by society—or the media—and it attracts enormous stigma and discrimination. This adds to the burden imposed by the illness itself. Yet gradual advances in care have made it possible for many with the illness to live in the community with some symptoms that do not substantially prevent them from leading a normal everyday life.

This is not to ignore the problems they face. The illness usually starts in late adolescence or in young adults, and affects both economic prospects and social and family relationships. Care is often provided in a fragmented manner, and can be hard to access (especially by people with a mental disability). Unemployment rates are very high. Lack of income often contributes to homelessness. Lifespans are typically shorter than normal; people with schizophrenia die 15-20 years earlier than the general population, mainly because of co-existing physical illnesses and smoking. Suicide is frequent, often a consequence of the mental pain and distress caused by the disorder.

The focus of modern treatment is improving quality of life and achieving recovery. “Recovery” can be variously defined—medical professionals and patients have different definitions. Recovery in medicine means living without the illness whilst “psychosocial” recovery means living despite the illness. If appropriate treatment is available, about half of those with the illness can experience substantial improvement. Many are able to carry on their lives while still experiencing some symptoms and coping with them. This can be achieved through a combination of strategies including medication, psychosocial therapies, attention to physical illnesses, efforts to end smoking and curb drug and alcohol abuse, and the involvement of peer-led support groups. Patient participation in care decisions generally helps to produce better outcomes. Early recognition of the illness, leading to intervention at an early point in its course, is also helpful.

Dealing with unemployment remains a serious gap in the support picture. Much more could be done to provide options such as volunteer work, part-time work and full-time employment. More opportunities for supported employment are needed. Only 10-20% of those with the disorder are in competitive employment, and the rate of unemployment compared with the general population is very high.

Financial issues are important with a chronic illness like this. Family budgets are impacted. Health service budgets are also affected (or should be, if appropriate treatment is provided). The direct and indirect costs are high, but policy-makers should be more open to the case that treatment is cost-effective in reducing many of the long-term indirect costs.
In many countries families take on major responsibility for providing care. Help centered in the family can provide invaluable support. However families often experience stress as they cope with the long-term demands of the disorder. The primary caregiver’s own health is often affected. Family members benefit from education about the illness, and care for the caregivers is a necessary corollary to treating people with a serious illness like schizophrenia.

WFMH hopes that the focus on schizophrenia in this year’s World Mental Health Day campaign will contribute to a better understanding of the illness, and to a reduction in stigma and discrimination. Information about the nature of the illness and the possibilities for treatment will lead to greater empathy with the people who experience it. The issues raised will also, by implication, extend to improving care pathways for people with other serious mental illnesses as well.

BRIEF HISTORY OF WORLD MENTAL HEALTH DAY

■ World Mental Health Day was established by the World Federation for Mental Health in 1992 through the efforts of the Deputy Secretary General, Richard Hunter. He had the foresight to see that the Day could become, in his own words, “a focal point around which global mental health advocacy could gain maximum public attention.” It is the occasion for events on 10 October around the world, is noted at the United Nations, and observed at various offices of the World Health Organization.

■ In 1994 the Secretary General, Professor Eugene Brody, M.D., decided that WFMH should provide information on specific annual mental health themes. WFMH staff recruited experts to prepare special packets of material each year on topics like women’s mental health; mental health and work; emotional and behavioral disorders of children and adolescents; suicide; depression; culture and diversity; and mental health and ageing.

■ The campaign materials that WFMH develops based on the annual theme are distributed, without charge, to thousands of people and organizations around the world. These organizations plan and conduct their own World Mental Health Day campaigns on or around 10 October, tailored to local circumstances, and at the same time have the satisfaction of knowing that they are engaged in a large international enterprise. Government health departments use the occasion to launch national information campaigns. Many organizations launch week-long, month-long or year-long mental health awareness, education, and advocacy programs.

■ In 1993 the Pan American Health Organization arranged the first translation of the material into Spanish for use in Latin America. Since then WFMH has at various times arranged translations for French, Spanish, Russian, Hindi, Japanese, Chinese and Arabic. The material is divided into individual topic sections so that organizers can easily arrange to translate short amounts of information for local use.

■ This year’s material will be placed on the WFMH website (www.wfmh.org) in July. If you wish to receive the material by email attachment contact the World Mental Health Day coordinator, Deborah Maguire (dmaguire@wfmh.com). Introductory material about “Living with Schizophrenia” has been included in this Bulletin.
ACCORDING TO THE WORLD HEALTH ORGANIZATION SCHIZOPHRENIA AFFECTS SOME 26 MILLION PEOPLE WORLDWIDE, AND RANKS SEVENTEENTH ON THE ORGANIZATION’S MOST RECENT ESTIMATE OF THE LEADING GLOBAL CAUSES OF YEARS LOST TO DISABILITY.

MORE THAN HALF OF THOSE WITH THE CONDITION DO NOT RECEIVE APPROPRIATE CARE, AND ABOUT 90% OF THOSE WHO GET NO TREATMENT LIVE IN DEVELOPING COUNTRIES.

SYMPTOMS OF SCHIZOPHRENIA TYPICALLY APPEAR IN A PERSON’S LATE TEENAGE YEARS OR EARLY TWENTIES, THE PERIOD WHEN MANY YOUNG PEOPLE ARE COMPLETING EDUCATIONAL QUALIFICATIONS OR STARTING TO WORK.

IT IS A LONG-TERM CONDITION, WITH PERIODS OF REMISSION AND RELAPSE. THE CAUSES OF THE ILLNESS ARE UNCLEAR, AND ITS COURSE IN THE LIFESPAN OF EACH INDIVIDUAL IS UNPREDICTABLE.

THERE ARE A WIDE VARIETY OF SYMPTOMS – WHICH CAN INCLUDE “POSITIVE” OR “NEGATIVE” SYMPTOMS – AND THERE ARE USUALLY COGNITIVE DEFICITS.

POSITIVE SYMPTOMS:
- Delusions (thinking things are happening that are not real)
- Hallucinations (hearing or seeing things that are not real)
- Disorganized speech – rambling speech that lacks a coherent train of thought

NEGATIVE SYMPTOMS:
- Emotional flatness (sometimes called “flat affect”)
- Lack of motivation
- Withdrawal from social interaction
- Lack of attention to appearance – poor hygiene and grooming, little attention to clothing
- Inability to take pleasure in life

COGNITIVE DEFICITS:
- Problems with attention, memory, planning, organization, inability to complete activities
- “Lack of insight” – inability to realize that anything is wrong; this is a major obstacle to effective treatment

TREATMENT:
- The best treatment will provide a broad range of care for various aspects of the illness. It can include antipsychotic medication to control delusions and hallucinations; cognitive behavioral therapy to help a person to cope with symptoms; psychosocial help to improve ability to live and work in the community; peer support; and family education and support.

- It should place a high priority on providing care for co-existing physical health conditions as well as mental health treatment.
FINDING RECOVERY WITH SCHIZOPHRENIA

Schizophrenia. Even the mention of the word can send a shudder through a person, a wave of fear through a crowd, or alienation in a community. When the word is being said about you, there is a shock of disbelief, anger and fear. I know. I was diagnosed with schizophrenia.

This was not a good time in my life. I was hospitalized with severe acute major depression and while still in the hospital a year later that diagnosis was changed to the big S (schizophrenia). All in all, I have had nine different diagnoses. The big S scared me the most. I had heard about people with schizophrenia. They were nothing short of uncontrollable monsters and now I was one of them. I always tried to be a good girl. I never told the secrets when I was young. I never hurt other people even if they were hurting me. I had met a lot of monsters and I never thought that would include me.

I sank into despair and that is all I could see in my world which almost left me comatose. At the same time my insurance ran out, my daughter went from living with friends to being in a foster care system and my job, which had been held for me, closed. The house I had been paying my share of the rent on was no longer available as my roommates decided they didn’t want to live there anymore.

My world turned chaotic. Voices filled my head. Shadows of people haunted me and only I could see them. Bugs crawled on my skin and I could not see them. I remember withdrawing into a fantasy world where I couldn’t hear or see anyone. I was lost in a world and wandered aimlessly in my mind only wanting life to stop.

I tell you this, not to scare you but to have you understand my experience. Doctors gave up on me and so did most family and friends. This is what the big S felt like from inside of me. There was no hope, no future and no reason to even breathe. Most of all, I wondered why God hated me so much.

I never heard the word recovery or anything about getting better. I was in a psych hospital for two years. I lied to get out. I got my daughter and retreated to my home state and began a multi-year process of trying to hide from everyone and everything. During this time I easily had over 50 hospitalizations. I hated life and everything about life. There was one thing I hated more than life and that was me.

A psych tech once asked me to describe the pain in me. Where was it located? How did it feel? How could I ever express to anyone this overwhelming, piercing agony that lived within me? There was no relief, no respite; no escape except for the retreat within my head. Some called it psychosis, I called it relief.

Through a series of events that offered my first glimpse of hope, I finally found the road to recovery. To be sure it was a long road full of potholes and at times I had to go backwards to go forwards. I found tools and skills to neutralize my past. Nothing could make me forget, but the power those memories had over me disappeared. I found a purpose in life. I realized what strength I had to survive the life I had been given. I also realized that God had not forsaken me, but was preparing me for the life I have now. I had to go through all of that misery to become the person I am today. Like a diamond, I was put under extreme pressure for an extended period of time, and emerged a hard crystal that can shine brilliantly.
It was not the medication I was given, and there was a lot. It was not the therapy I was given, and there was a lot of that as well. It was a person who had gone through her own version of hell who had an understanding of what it was like to be me. My road to recovery really began with that human connection and understanding. Recovery was learning from others who had experienced schizophrenia and gone on to have a life worth living. Recovery was people seeing the potential in me and investing in me. Recovery was beginning to see hope and a future. When we start focusing on those elements, I believe we can make a significant difference in the world. Recovery is possible. I know. I am the proof.

Today my life is full, rich with hope and dreams. I work full time for the Texas Council of Community Centers as the Director of Recovery Based Services. I sit on the Board of the World Federation for Mental Health. I am the founder of Prosumers International and have created a three-day resiliency training called Focus for Life, along with Anna Gray. I own a home in San Antonio and keep an apartment in Austin. I travel around the world, often as an invited speaker. At the age of 57 I swam with the dolphins. I am an instructor in Mental Health First Aid and in Intentional Peer Support. I sit on state policy committees and testify before legislators. I am busier than people half my age. I love my life. More importantly, I finally love me. I no longer need to protect myself from the pain. When I say recovery, I mean having a life worth living. The time has come for us to make recovery available to everyone. Everyone deserves that chance.

**LETTER FROM A FAMILY MEMBER**

*VICE PRESIDENT, KINAPSI (Siblings of People with Mental Illness in Greece)*
*BOARD MEMBER, EUFAMI (European Federation of Families of People with Mental Illness)*

Spyros Zorbas

Dear Members of WFMH,

First, I would like to take the opportunity to introduce myself. My name is Spyros Zorbas and I have been actively involved, since 2006, with the sensitive but challenging sector of mental health. That was the year that my sister became increasingly more seriously challenged by her illness, and neither my parents nor myself understood how to offer her the support that she needed. The situation became serious and we did not have the luxury of behaving and acting as if a problem did not exist.

I cannot explain why, but I had a positive attitude about finding information. My first steps in learning about schizophrenia came from an article in a Sunday newspaper and participation in a world conference in Athens in 2007. Exchanging views with people who had more experience than I did gave me hope that there is this magic word called recovery. I felt that if we were to follow best practices with patience and a sense of commitment both we and our loved one would lead better lives, lives with more stability and optimism.

I gained a deeper understanding of mental illness from books, the Internet, participation in conferences and by contacting professionals who had a human / friendly approach, but family and patient associations also contributed to my understanding. Small steps, specific goals, hope and collaboration with people who could provide support and useful ideas all proved valuable.

A crucial concept that encouraged me--and this is something that came from reading American psychiatrists--is the value of looking for answers not in a private, but in a wider, collective manner. Searching for answers and sharing the process with other people is what associations and self-help groups are all about. Sharing good practices and offering support to and receiving it from other
people who face the same challenges are valuable steps. Good ideas and knowledge do not seem good enough if a group of people, a human network, is not there to offer understanding and guidance. The burden of caregiving is too wide to be carried by a single person, no matter his or her financial or social status. On the contrary, being in a network, having a phone or mailing list with colleagues available at any point when we need feedback or emotional support, this we can have at no cost. My personal belief is that the notion of networking helps me feel less insecure and more confident because I am able to connect more easily.

The need for communication with like-minded individuals of a similar age, who also have a sibling with a mental illness like schizophrenia or bipolar disorder, helped a group of people to unite in Athens in 2007 to create a self-help group. This was later transformed into the KINAPSI association, an association directed by people who have a brother or sister with a mental disease (www.kinapsi.org).

Today KINAPSI, which has over 200 members, emphasizes social integration through leisure and arts, including regular meetings in cafés, cinemas, and sports arenas. A sibling might come alone to an event, or he might invite his relative with mental illness, offering a safe environment for entertainment and socialization with a friendly group of people.

An equally important aspect of KINAPSI is to offer education and support to siblings.

In Athens on 6 June 2014, under the auspices of the Greek Presidency in the European Union, EUFAMI and KINAPSI brought together representatives of associations of families of people with mental illness from across Europe. The goal is to share their experiences of current practices in the field of mental health, especially during the current financial crisis.

Regards,
Spyros Zorbas

MESSAGE FROM THE VICE PRESIDENT FOR CONSTITUENCY DEVELOPMENT

Dear Members of WFMH,

I think it is timely to make contact with you using this new medium of the Bulletin, followed by direct communication by email.

The strength of the WFMH is its global constituency and global reach, and what is global is also local. As agreed in our WFMH Action Plan we need to continue to build and strengthen our global constituency, increasing our membership and strengthening our collective efforts for the Plan’s delivery.

I propose to have an open communication channel with you, and I will be happy to receive your proposals on how this could be achieved. What could the WFMH do more of, and better, in delivering our mission?

As Chair of the Meetings Committee, I want to ask for your suggestions about venues for future Regional Congresses and our Biennial World Congress. If your organization would like to sponsor one of these meetings, please send me your proposals.
In these difficult times we should all demonstrate solidarity and strong commitment to our mission and values in promoting mental health and wellbeing for all. I wish to make particular reference to the implementation of the WHO Comprehensive Mental Health Action Plan 2013-2020. Whilst governments are expected to implement this plan, its delivery will also depend on action by the people and civil society.

An important contribution to this was the WFMH People’s Charter for Mental Health that embodied a civil society response on mental health priorities and what makes good mental health care. The Charter was circulated last year and included the results of a survey of organizations supporting our Great Push for Mental Health campaign. WFMH is currently conducting another survey of those organizations on the Charter’s call for action, which incorporated the following five key objectives:

- That the United Nations General Assembly convene a Special Session on Mental Health
- That mental disorders be accepted as the fifth major Non-Communicable Disease
- That mental health and well-being be recognized as essential components of the UN Post-2015 Sustainable Development Goals
- That mental health be represented on all disaster emergency committees
- That WHO’s Comprehensive Mental Health Action Plan 2013-2020 be implemented expeditiously by all countries

If you have received the survey, please return it as soon as possible (the deadline has been extended). Once the survey results have all been received, WFMH will update the Charter and circulate it again.

Lastly, I’d like to take this opportunity to tell you about developments at the 7th Geneva Conference on Person Centered Medicine held on 27-30 April 2014. WFMH consolidated its alliance with the host organization, the International College for Person-Centered Medicine (ICPCM). As part of its program the meeting prepared a 2014 Geneva Declaration on Person- and People-Centered Integrated Care (the theme of this year’s event). While there I took the opportunity to propose the establishment of a WFMH-ICPCM program to advance person- and people-centered mental health care.

The conference ended with a meeting with the World Health Organization at which WHO presented its draft Strategy on People-Centered and Integrated Health Services, a major development towards integrated care that includes mental health care.

Regards,
Mohammed Abou Saleh
The Argentine Association for Mental Health (AASM) will host WFMH’s first Latin American Regional Congress on 27-29 August 2014. The WFMH Congress program will be held in conjunction with the 8th Argentine Congress on Mental Health, a large annual conference organized by the AASM in Buenos Aires.

The theme of the WFMH Regional Congress will be “Body and Subjectivity,” covering diverse mental health topics which are listed on the website. The programming for the WFMH Regional Congress focuses on “Living with Schizophrenia,” the theme for this year’s World Mental Health Day. The languages for the two conferences will be Spanish and Portuguese. A substantial number of participants from Brazil are expected.

The AASM brings exceptional management skill to this dual event. Last year it hosted the WFMH Biennial World Congress and drew some 5,500 participants representing over 60 countries, with programming spread over 4 days, three hotels, and 22 simultaneous tracks. For 2015 it expects about 4,000 participants. The conference headquarters will be at the Hotel Panamericano and Resort in the center of Buenos Aires, and the Hotel Colón next door will provide extra meeting rooms.

There are different registration fees for people living in Argentina and for people coming from abroad. Registration fees for those coming from abroad range from US$430 to US$250 according to country group, with a standard rate of US$250 offered to WFMH members for the combined AASM and WFMH congresses. More details are available on the conference website.

An International Congress on “Living with Schizophrenia” will be held on 9-11 October 2014 at the Aegli Zappeiou in Athens, Greece. The organizers are WFMH and the Hellenic Psychiatric Association; the Congress President is Professor George Christodoulou and the Chair of the Executive Committee is Professor John Giouzepas. The program is intended to contribute to a better understanding of this difficult illness. It will present what is known scientifically about schizophrenia, together with perspectives from person-centered medicine, and from resilience and recovery approaches.

The need for better care through holistic and integrated physical and mental health services will be put forward, as will the importance of adequate social support. Confronting the stigma attached to the disorder will be addressed. Technical equipment will be available to simulate the experience of schizophrenia, which may be useful in helping relatives and others to understand aspects of the illness.

Distinguished international speakers include Wolfgang Gaebel (Germany), Roy-Abraham Kallivayalil (President Elect, World Association for Social Psychiatry, India), George Ikkos (UK), Dinesh Bughra.
The general abstract deadline is 25 August for oral presentations and e-posters (the deadline for break-out symposia is 31 July). Abstracts must be accompanied by a registration form and fee from at least one presenter; all presenters and chairs for a break-out symposium must send in registration forms and fees by 31 July. The date for notification of acceptance is 5 September.

While the conference theme is “Living with Schizophrenia,” allowing for a variety of topics within the theme, there will also be a “miscellaneous” track to allow for some abstracts on wider topics.

The Congress will be accredited by the European Accreditation Council for Continuing Medical Education with CME-CPD credits.

World Mental Health Day

The Athens Congress theme is identical to that selected by the World Federation for Mental Health for this year’s World Mental Health Day. A special event, incorporated into the program, will be held at the aula (main hall) of the University of Athens on the evening of World Mental Health Day (10 October).

France

28-30 April 2015
(http://www.imhclille2015.com)

The organizers invite you to an innovative international Congress on “Mental Health for All: Connecting People and Sharing Experience” at the Grand Palais Lille on 28-30 April 2015. The conference program will provide an opportunity for sharing best practice in delivering the WHO Comprehensive Mental Health Action Plan.

This Congress is organized by WFMH and its French psychiatrist partners—the Congrès de Psychiatrie et de Neurologie de Langue Française (CPNLF), the Société de l’Information Psychiatrique (SIP), the Association Française de Psychiatrie Biologique et de Neuropsychopharmacologie (AFPBN), the Société Française de Psychiatrie de l’Enfant et de l’Adolescent et des Disciplines Associées (SFPEADA), and the Regional Federation of Research in Mental Health, Nord-Pas-de-Calais. The conference is also supported by Wonca (the World Organisation of Family Doctors). The languages of the conference are English and French.

Abstract submission is now open and full details are available on the website. The deadline for submission is 1 November 2014, and the main presenter for an abstract must register by 15 January 2015.

The Early Bird registration fee ends on the 15 January 2015. It is €360 for members of the sponsoring organizations and €385 for non-members, with special rates of €100 for undergraduates and €175 for graduate students. There will also be a one-day pass for €155.
The main Congress objectives are:

- To support an integrated approach to mental health globally
- To support joint working across primary, secondary, tertiary and social care
- To support the upskilling of the primary care workforce
- To support dialogue and training between primary care and secondary care teams
- To promote public awareness of mental health including anti-stigma interventions that promote social inclusion
- To support and advocate for mental and physical health parity of care for mental health service users
- To engage policy makers and support them in understanding their roles in mental health delivery
- To support and promote mental health innovations and service re-design
- To promote holistic care and the management of co-morbidity
- To support the implementation of the Global Mental Health Action Plan

A list of additional thematic areas is presented on the website.

Lille has frequent rail service from Brussels, Paris and London. The time by train is 35 minutes from Brussels, 60 minutes from Paris, and 80 minutes from London by the Eurostar service.

Preparations are well underway for the WFMH Biennial World Congress to be held in Cairo from 16-19 October 2015. The Congress will be hosted by the Behman Hospital, the Egyptian Society for the Rights of People with Mental Illness, and the Middle East Division of the Royal College of Psychiatrists, London. The theme is “Building comprehensive integrated strategies for mental health through innovation, people and practice.”

The Planning Committee has settled on the venue, the InterContinental Citystars Cairo Hotel, and Emeco Travel has been chosen as the conference organizing company and travel agent. The hotel has exceptional facilities for meetings, including the largest conference hall in Cairo seating up to 2,200 people, and many breakout rooms.

The hotel is conveniently located only 7 km (4.25 miles) from the airport, outside the center of Cairo but relatively close to the Pyramids of Giza and the historic 12th century Citadel. It has an attractive setting and offers full guest services. In addition there are ample food and shopping options in the City Stars mall immediately beside the hotel.
NEWS FROM WFMH’S VOTING MEMBER ORGANIZATIONS

In the last Newsletter, WFMH invited Voting Member Organizations to send news of their recent activities and programs. A selection is presented here, and more will be included in the next Bulletin in the second half of the year.

ADVOCACY GROUP FOR THE MENTALLY ILL, CYPRUS

The Advocacy Group for the Mentally Ill (A.G.M.I.), based in Larnaca, Cyprus, focuses on collective advocacy with other organizations to influence mental health policies in Cyprus and in Europe. It works on behalf of people with mental illness or psychosocial/psychiatric disability, and their families and caregivers, to secure improvements in quality of treatment and quality of life.

A.G.M.I. directs its advocacy toward local and European Commission officials and politicians who work in particular issues of concern. Depending on the issue, it might target local politicians or parliamentary committees; leading civil servants in particular government departments in Cyprus (Health; Labor; Justice and Public Order; Education and Culture; Social Welfare Services; Social Inclusion and Disability); European Commission representatives; members of the European Parliament from Cyprus; or the Cyprus Police Department office dealing with domestic violence and child abuse.

It works with a network of other advocacy organizations on matters such as institutionalization; the Convention of the Rights of People with Disabilities; services and benefits for people with disabilities; family violence; barriers to integration and inclusion; and support for families and caregivers.

In order to direct its advocacy work appropriately, A.G.M.I. has to gather information and assess it in order to develop its advocacy positions. This in itself requires a considerable investment of time and effort.

Each year the organization arranges an event well in advance of World Mental Health Day to publicize the year’s theme in the community. For 2014 the community event on 11 May included the Choir “Angelic Voices” and featured the winners of popular television talent shows in Greece. The program also included the Papamoiseos Music Group, the Voroklini New Generation Cultural Association, and the Digeni Voroklini Dance Group. The event was held under the auspices of the Minister of Health and was attended by representatives from various government departments and political offices as well as people from NGOs, parents and other family members.

Several thousand people were reached through the broad distribution of the invitation, which was accompanied by material describing aspects of the World Mental Health Day theme. The leaflet covered the needs of people affected by schizophrenia, caregivers, support required for transition from institutional to community care, stigma, prejudice and social exclusion. It also included mental health priorities for the 2014 elections to the European Parliament.

A.G.M.I. PRESIDENT

Elise Torossian
The American Psychological Association (APA) is the world’s largest association of psychologists. Its 130,000 members, associates and students span the entire field of psychology’s areas of expertise. This report describes four highlights of APA activities in the last year.

1) APA founded a Center for Psychology and Health at its central office in Washington D.C. The new Center is dedicated to highlighting and advancing the contributions of psychology to the overall improvement of health status — both mental and physical — and health care in the nation. The Center engages in a variety of cross-association and organizational collaborations to apply psychology’s expertise to increase access to quality health care at a reduced cost. Please see [http://www.apa.org/health/index.aspx](http://www.apa.org/health/index.aspx) to learn more about the Center’s activities.

2) During 2013, APA hosted its second professional visit to Cuba. The purpose of the trip was to study the Cuban health care system – where mental health is integrated into overall health care, and mental health service providers work alongside physicians in integrated primary care teams. The APA visitors learned that Cubans have health check-ups every year, including a mental health screening, and that psychologists and other mental health workers train and teach in medical settings. They also learned of the strong emphasis on prevention and public education in all aspects of health. See [http://www.apa.org/international/outreach/learning-partner.aspx](http://www.apa.org/international/outreach/learning-partner.aspx) for more details.

3) APA’s Committee on International Relations in Psychology (CIRP) held its first 2014 meeting in March. During that meeting the committee began to act on its 2014 priorities of infusing an international perspective throughout APA and facilitating international perspectives in graduate education by exploring the development of guidelines for international competencies. The committee developed a broad outline of the competencies needed in research, education, service and policy for those working outside the United States and for those working with immigrant populations within the United States. They will be engaging in conversation across many groups at APA to develop the ideas and structures for international competencies in psychology.

4) APA continues to provide financial support for an initiative of the International Union of Psychological Science (IUPsyS) to provide a psychologist as a senior program officer at the World Health Organization. This initiative supports activities surrounding the completion by WHO of Chapter 5, Mental and Behavioural Disorders, in the revision of the International Classification of Disease (ICD-11). Currently the Clinical Descriptions and Diagnostic Guidelines for ICD-11 Mental and Behavioural Disorders are largely developed. They are now being refined through field trials, including input from the new 10,000 strong Clinical Network, and input from internet-based field trials. One of the major goals of this work is to ensure that ICD11 classifications are functionally based, and matched to clinicians’ experiences. See [http://www.apa.org/international/outreach/who-icd-revision.aspx](http://www.apa.org/international/outreach/who-icd-revision.aspx).

The next APA Annual Convention will be held in Washington, DC, in August 2014. All are invited to attend! See [http://www.apa.org/convention](http://www.apa.org/convention) for information.
She was desperate. Nothing very earthshaking had happened, but she felt like the camel whose back was breaking with the last straw. For years she had suffered inwardly. Neglect by parents, ridicule by her mother, bad relations with her siblings, and instances of emotionally traumatic child sexual abuse. All these had contributed to making her feel isolated and lonely. The world seemed one happy circus to which she did not belong. She was under the glare of the arc lamps, but in the darkness of her heart, she was weeping bitterly.

She hoped that there would be an escape some day. She dreamt that her knight in shining armour would come and take her away from her own misery. She dreamt of romance, freedom and adventure. Her dreams were shattered bitterly when a much older man, highly placed and rich, sought out her hand only for her beauty, the external beauty that she had come to hate. He gave her all material comforts, and sought to buy her love. She could not sell it. She now knew that she was doomed into a life of utter misery, solitude and sadness.

Years rolled by and the pain became numb. At times she would wonder whether she had any feelings left. Try as she might, there appeared to be no hope. No light was shining at the end of the tunnel. In fact she gave up hope that the tunnel would ever have an end.

For weeks she had carried with her a pamphlet from the counselling centre. She did not think that anyone could help her, she did not even dare to hope. Yet one day on an impulse she walked in, not knowing what to expect. She found an elderly person, kind and soft. What made the greatest impact on her were his eyes – they shone with love and concern, with understanding and care. Could she dare to hope once more?

The counselling sessions went on, hesitatingly at first, then picking up speed. There were times when she despaired that anything would come out of it. Many a time she would feel like breaking off. There were even occasions when she stood outside the door and hesitated for long minutes, wondering whether to turn back. But she resolutely kept on with the counselling.

Nothing changed in her life. Her circumstances did not improve, the world did not treat her any more kindly. But she learnt how to start loving herself. Her counsellor’s eyes were like mirrors that would help her to straighten herself out. His empathy taught her for the first time in her life what it meant to be understood and accepted, even by a stranger.

Many a time she asked him for solutions. She came to him with so many problems, and spoke for hours. She badgered him for answers and guidance. He did not give any. He would always listen, a shadow of a smile on his face, a genuine and deep concern in his eyes. That is all that she got from him. And that is all that she needed. She began a struggle to cope with her situation in life. She built up her inner strength and developed a resoluteness to face whatever she had to face. And slowly, imperceptibly at first, she started succeeding.

The time came to bid good-bye to her counsellor. It broke her heart to think of severing the tie. But she knew she had to do it. The time had come to spread out her wings and take flight. She stood awkwardly looking at him, her eyes brimming over. No words of adieu were required. She forced herself to turn around and walk away into the milling crowds, with the warm feeling that if she ever needed him again, she knew that he would always be available for her.

This case study shows the significance of “being there” for a person in emotional need, a basic philosophy of all of us at Banjara Academy. We encourage individuals to come in person, talk on the phone, or write to us through our website, and we ensure that we respond to every person who reaches out to us.
It has been a very fulfilling journey for the past 30 years, particularly as all our counselling is free, and every counsellor gives his or her time without expecting any remuneration or even appreciation.

ENOSH, ISRAEL

“The Other Me” project, carried out for the 5th straight year by Enosh in collaboration with the Rimon School of Jazz and Contemporary Music, culminated in a moving performance on 1 May at Tel Aviv’s Einav Center. Twenty poems written by members of Enosh, all of whom cope with mental illness, were set to original music and performed by the students of the Rimon School.

Ariel Horowitz, a leading music performer in Israel, worked with a select group of outstanding Rimon students on this special project. The students worked for six months on their compositions and on the production of the musical performances. The Enosh contributors attended rehearsals and developed personal relationships with the students.

“The Other Me” has earned a reputation as a high-quality artistic performance; the project is considered very prestigious and many students aspire to take part in it. It has gained wide coverage in the Israeli media, and also received the “Best Practice of the Year” award at the 2012 GAMIAN Europe Convention. There are now plans to replicate the project in countries throughout Europe.

The poems written by the Enosh members served as an artistic outlet for coping with mental illnesses such as depression, schizophrenia and bipolar disorder. Contemplating the meaning of the poems enabled the music students to become acquainted with the human psyche in a deep and unique way and to build a personal relationship with people coping with mental illness. This direct artistic and emotional connection is a novel way to change stereotypes and support integration in the community.

The “Other Me” Project: You Tube video clip to the song “The Lieutenant”
(Lyrics: Galia Even Chen; Melody: Oded Schechter; Director: Galia Malatesta)
http://www.youtube.com/watch?v=3ynzEU2qpyg

Here are links to some of the songs from the 2013 performance:
http://www.youtube.com/watch?v=mN4NAQ-aPmo
http://www.youtube.com/watch?v=kg_znP6mHhi&list=PL59cDVGryccnFUzqvhz7Jlr9BjYlLFB4

ENOSH, THE ISRAELI ASSOCIATION FOR MENTAL HEALTH
Chairman, Yoram Cohen
Executive Director, Hilla Hadas
www.enosh.org.il
The Hellenic Psychiatric Association, established in 1986 as a continuation of the Hellenic Society of Neurology and Psychiatry that was founded in the 1930s, represents the Greek Psychiatric community to international organizations like the World Psychiatric Association and the European Psychiatric Association. It is a voting member of the World Federation for Mental Health. The Association organized the World Mental Health Congress of the WFMH in Athens in 2009 and the WFMH International Congress on Crises and Disasters, also in Athens, in March 2013. Both congresses were very successful scientifically, socially and financially. During the Congress on Crises and Disasters a special Declaration was produced, co-signed by a great number of collaborating organizations, that underlined the need for mental health care of the survivors of crises and disasters.

The Association organizes Panhellenic congresses in Greece every three years and a thematic congress every year. It produces a journal called “Psychiatriki” in Greek and English that is included in international data bases (Medline/Pubmed, Index Copernicus, EMBASE/Excerpta Medica etc) and it is very active in educational activities for Greek psychiatrists and for mental health workers in the area of the Balkans and Eastern Europe. It has taken the initiative to establish a psychiatric society for the area, the Psychiatric Association for Eastern Europe and the Balkans (www.paeeb.com). It has close links with organizations of patients and families in Greece that are always invited to take part in the celebration of the World Mental Health Day every 10 October.

Psychiatric trainees are active members of the Hellenic Psychiatric Association. They have independent scientific activities under the auspices of the Association in which trainees from other European countries are invited to participate.

The Hellenic Psychiatric Association will again collaborate with the WFMH to organize the International Congress of the WFMH in Athens on 9-11 October 2014 (www.wfmh2014.gr). The theme will be “Living with Schizophrenia,” the same theme as World Mental Health Day, and there will be a special event within the Congress at the Aula of Athens University on 10 October to celebrate World Mental Health Day.

The Hellenic Psychiatric Association is very happy to collaborate with the WFMH and will continue to work to promote mental health internationally.
The HKADCP was established in 2011 in Hong Kong. Its aim is to develop a community of clinical psychologists with high professional standards to better serve societal needs, particularly those of the underserved. It is establishing local and international alliances with relevant authorities and organizations, providing professional training to mental health practitioners and promoting evidence-based practice.

The HKADCP is delighted to announce that a Memorandum of Understanding with the Society of Clinical Psychology of the American Psychological Association was signed on 14 February 2014. This new alliance confirms a shared vision and commitment to the professionalism of clinical psychology and the community. It is hoped that such collaborative efforts will further strengthen cooperation among members within the network of the World Federation of Mental Health.

Besides international alliances, the HKADCP also organizes professional training activities that enhance clinical skills and competence. Recently the HKADCP held sessions on clinical interviewing with mentally disturbed patients and workshops on non-verbal intelligence testing. It arranges regular meetings among its registered members to share cases.

The HKADCP welcomes opportunities for professional exchanges and other local and international collaborations to enhance work in mental health.

Paul Gionfriddo, an experienced nonprofit leader and former state legislator, was named the new President and CEO of Mental Health America by its Board of Directors in March after an extensive national search. He has held key health and public health-related leadership positions during a career spanning more than 30 years. In addition to leading nonprofit organizations in three states, he ran his own consulting business, specializing in public health, children’s health, primary care and mental health.

From 1978 through 1991 he served as a full-time elected official, with eleven years in the Connecticut State Legislature and two years as Mayor of Middletown, Connecticut. In 2013 he was appointed by Health and Human Services Secretary Kathleen Sebelius to a four-year term on the 12-member National Advisory Council to the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services.

At the national level, Gionfriddo has worked extensively with the Agency for Healthcare Research and Quality on health services research dissemination to state and local policy leaders, helping to develop workshops and programs on long term care, prevention and public health, child health, minority health,
From a movement of small grassroots organisations that began 35 years ago, Mental Health Carers Arafmi Australia (MHCAA) has grown into a national body with a united voice for mental health carers. Arafmi was originally an acronym for Association of Relatives and Friends of the Mentally Ill.

Mental Health Carers Arafmi Australia’s mission is to represent at national level the interests of Arafmi groups throughout Australia and the needs and concerns of their constituency – families and others voluntarily caring for people with mental illness.

MHCAA member agencies are the leading mental health carer support agencies across Australia. MHCAA services provide specialist mental health support to families, carers and their friends. Support includes: linking people to other carers who can offer face to face peer support, education services with other carers, and advocacy services which assist individuals to identify and find solutions to their challenges.

One in four Australians will experience a mental illness over the period of their lives. When you think about it, it is therefore true that many more Australians will provide care and support during the critical times of this illness.

Carers need to also look after their own mental health and wellbeing. MHCAA member organisations have expertise in supporting mental health carers. If you would like to find out more about our members’ carer services, please visit our website at: http://www.arafmiaustralia.asn.au/

Policy and Advocacy

MHCAA advocates for mental health carers at a national level. One of our key focuses for this year is ensuring family sensitive practice is implemented within the National Disability Insurance Scheme (NDIS).

The NDIS raises the hopes of many people with chronic mental illnesses and their families that there will be financial support for improved services over a person’s lifetime. The NDIS (now called Disability Care Australia) is ‘a social insurance model, for funding and delivering long-term disability care and support for people with severe or profound disabilities however they are acquired.’ The scheme aims for nationally improved care and support for people with a lifelong disability, including those with chronic mental illness. It is based on the premise that all citizens have a right to health care regardless of their economic circumstances.

There is a wide range of information, policy documents and legislation available on the NDIS.
In 2011 the Productivity Commission conducted an inquiry into a Disability and Long-term Care and Support Scheme. This inquiry reviewed the current system, and the feasibility of a national disability scheme. The inquiry found current disability support arrangements are inequitable, underfunded, fragmented, and inefficient and give people with a disability little choice… A coherent and certain system for people with a disability is required — with much more and better-directed resourcing, a national approach, and a shift in decision-making to people with a disability and their carers.\textsuperscript{v}

In May 2013 an increase of 0.5\% in the Medicare levy to fund the scheme was passed into law with bi-partisan support.\textsuperscript{vi} Then, the National Disability Insurance Scheme Act 2013 (The Act) became fully operational on 1 July 2013 at the launch of the NDIS.\textsuperscript{vii}

The scheme is now being piloted in the Hunter and Barwon regions of NSW and Victoria respectively as well as South Australia and Tasmania. A roll out at other pilot sites is planned over the next three years. For information on our advocacy initiatives related to the NDIS please go to:

References

MENTAL HEALTH ASSOCIATION
IN TAIWAN

The Mental Health Association in Taiwan (MHAT) participated in the non-governmental section of the 58\textsuperscript{th} session of the United Nations Commission on the Status of Women (CSW) from 10-21 March in New York.

In recognition of the approaching end of the 2000-2015 timeline for the United Nations Millennium Development Goals (MDGs), the priority theme of the CSW session addressed “Challenges and Achievements in the Implementation of the Millennium Development Goals for Women and Girls.” The MHAT sponsored parallel events with the overarching theme of “Meet Taiwan – Implementing the MDGs for Women and Girls.”

The first parallel event was “Decent Work and Gender Equality—The Informal Economy.” Despite progress on the first MDG, which aimed to achieve decent work for all, the gender gap in employment still persists. Panelists discussed various aspects of unpaid female labor: elders in rural areas, the aging population without retirement income,
women with mental and physical disabilities, indigents, family care-givers and female immigrant spouses. The panelists emphasized the need to develop effective global policies in the forthcoming UN Post-2015 Development Agenda to provide decent work for the marginalized populations who are faced with geographic, socioeconomic and gender disparities.

The second parallel event was titled “MDG 5: Innovation and Collaborative Efforts for Girls and Women’s Health.” The target of achieving universal access for reproductive health services is the second component of the fifth MDG. However, access to reproductive health services showed limited progress compared with the progress in reducing maternal mortality. The event focused on perspectives on the challenges faced by girls and women with regard to reproductive health services and justice. Panelists represented different non-profit organizations and offered both international and domestic viewpoints in terms of access to services, local advocacy, legal challenges, and government accountability and commitment. Furthermore, the conversations centered on the importance of recognizing women’s health as a human right, setting effective targets to achieve progress for various demographics, and including gender equality in all aspects of the UN Post-2015 agenda.

During this event the MHAT highlighted its “Boy Engagement: Teen Pregnancy Prevention Campaign” which began in 2012. Unlike traditional teen pregnancy prevention campaigns, the MHAT campaign targeted 10th grade male students. The campaign recognized the importance of including male participation to help improve women’s health. It incorporated comprehensive sexuality education, which emphasizes psychosocial wellbeing and gender equality in addition to knowledge of reproductive health. MHAT’s campaign serves as an example of innovative and collaborative efforts to improve both maternal and reproductive health for girls and women as countries move toward the UN Post-2015 Development Agenda.

NEW LIFE PSYCHIATRIC REHABILITATION ASSOCIATION, HONG KONG

Over a number of years the New Life Psychiatric Rehabilitation Association has re-oriented its entire service structure towards a recovery perspective. This article discusses the process.

Milestones of a recovery-oriented system transformation in Hong Kong – the experience of the New Life Psychiatric Rehabilitation Association

Definition of recovery

Recovery-oriented services focus on people’s strengths and abilities to fully participate in the community, with the aim of empowering them to strive for personally meaningful goals that are beyond the limitations of mental illness. Using the U.S. Substance Abuse and Mental Health Service Administration’s recovery model (SAMHSA 2005), coupled with input from staff, persons-in-recovery (PIR) and carers, we have contextualized the recovery model at three levels of support in the Association: (1) individual level (choice & self-direction, participation, individualized service & responsibility), (2) support level (family participation, respect & anti-stigma, strengths-based & peer support) and (3) global level (non-linearity, holistic & hope). In the development of recovery-oriented practice since 2009, we have achieved the following milestones:
(1) Enhancement of service users' participation

The expertise of lived experience from PIR is crucial to facilitate the recovery movement. Early in 2009, focus groups were conducted where PIR discussed the concept of recovery. The Alliance for Recovery and Care was formed with PIR, carers and professionals within the organization to develop and implement recovery-oriented services. In 2010, we invited PIR to share their experiences of recovery in staff training. We also launched various programs to prepare PIR for full participation, including Recovery Basic Training, the Wellness Recovery Action Plan (WRAP), Cognitive-behavioral Therapy for Anti-self-stigma and Community Navigator. We gradually replaced the Individualized Rehabilitation Plan with Person-centered Care Planning (PCP) in case management. In 2013, we piloted with three other non-government organizations to organize Peer Support Worker Training and an Employment Program. Currently, we have PIR participating in different platforms.

(2) Staff training in recovery knowledge, attitude and skills

To ensure the delivery of effective recovery-oriented practice, the knowledge, attitude and skills of staff are vital to system transformation. As most of the recovery-related knowledge and tools are developed in the Western world, language and culture are two important issues that we have to face. Much effort was needed in facilitating this development. We kicked off the foundation training with a dialectic and experiential mode of learning through the train-the-trainers approach in 2010. Later, we provided staff-specific skills workshops, including WRAP in 2010, WRAP advanced facilitator training in 2012, PCP foundation training in 2011, PCP implementation training in 2013, as well as motivational interviewing training in 2011 and 2012. We invited local and overseas experts to provide staff training. In addition, international training materials were localized and used to improve recovery knowledge and skills among our frontline staff. We also published leaflets, a Recovery Glossary, and newsletters, manuals and booklets to promote recovery values. In 2012 and 2013 managerial and service-based recovery day retreats were also held to consolidate recovery knowledge, to support the realization of recovery-oriented practice, and to discuss the barriers encountered.

(3) Development of recovery-oriented assessment

Collaborating with the Department of Psychology of the Chinese University of Hong Kong, we developed and validated local or translated recovery assessment tools, namely the Recovery Knowledge Inventory, Recovery Assessment Scale, Test Life Satisfaction Scale and Attitude towards Recovery Questionnaire. These recovery-oriented measurements became our regular outcome measures.

(4) Evidence-based practice

Various research projects on recovery-oriented services were conducted in collaboration with the Chinese University of Hong Kong, including (1) organizational assessment and evaluation of different recovery programs, ranging from staff PIR and carer training; therapeutic groups; a case work approach to public education programs; and (2) staff, PIR and carer focus groups on their opinions of recovery-oriented practice. The findings provided input for future evidence-informed service development. Some of the research results were presented at local and international conferences.

(5) Knowledge and experience-sharing platform

In order to promote the mental health recovery model to other service providers, we organized three symposia on Pathways to Mental Health Recovery—Person-centered Care and Beyond in 2011, Peer Support Development and Beyond in 2012, and User Involvement and Peer-led Services in 2014. These symposia gathered groups of local and overseas mental health professionals, PIR and family members to share their opinions and experience in recovery development. We also launched the first Chinese recovery website (http://www.recovery.nlpra.hk) to reach out to more members of the Chinese population in need of this information. Lately, we have published Unlimited Potential of Life: 15 Recovery Stories, to feature the collaboration between PIR and service providers in walking through their recovery journeys.
Way forward

We hope to promote participation and empowerment by PIRs in the community, and to create partnerships with different parties to further advocate for evidence-based recovery-oriented services in Hong Kong.

Reference


NGO FORUM FOR HEALTH, GENEVA

The March 2014 issue of *Psychology International* has just been published online by the Office of International Affairs at the American Psychological Association. It has brief and interesting articles related to global mental health (GMH) and international psychology. One of the articles, **GMH: Strategies for Staying Updated** (Kelly O’Donnell) identifies seven “GMH flows” that are important for getting updated and staying updated in GMH. It also includes relevant updates from other sectors – health, humanitarian, development, economic (*Psychology International, March 2014, Vol. 25, No. 1*).

You can also access the full version of the article on the GMH-Map website or on the MGMH website.

**GMH and NGOs: Working Together Well!** is a short version of a PowerPoint plenary session given at the HimalPartner Global Mental Health Seminar in Oslo, 7 March 2014, by Kelly O’Donnell representing the NGO Forum for Health. Several of the other presentations will be available shortly on the HimalPartner website. The presentations are an excellent example of the learning and challenges of implementing GMH in low- and middle-income countries.

ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRY

2014 is shaping up as another busy and exciting year for the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

The RANZCP is committed to growing and strengthening our international partnerships with other psychiatric organisations. To achieve this, the RANZCP CEO and I are visiting and contributing to several conferences throughout the year. In May, prior to our RANZCP Congress in Perth, we travelled to the American Psychiatric Association Annual Meeting. At the end of May we attended the inaugural Asian Federation of Psychiatric Associations Regional Meeting that was held in conjunction with the Malaysian Psychiatric Association.
During this event, the RANZCP arranged a Workshop, which was held over two days, to discuss the challenges facing the delivery of mental health services within the Asia Pacific region. The RANZCP invited a number of leaders in mental health from both the Asian and Pacific regions to participate, so that delegates could identify key actions to be implemented following the Workshop as part of a broader program of work that can be carried forward in conferences and regional meetings.

I was also pleased to attend the Royal College of Psychiatrists Annual Meeting and the Japanese Society of Psychiatry and Neurology Annual Meeting, both of which were held in June.

In September I will attend the World Psychiatric Association World Congress in Madrid. A number of RANZCP Fellows are candidates for the elections that will be held as part of this meeting, and the College is pleased to be supporting their candidacy.

Closer to home for the RANZCP the College has commenced the process of developing a new Strategic Plan, as our current plan expires at the end of 2014. Our Strategic Plan is a framework document for the College that will clearly set out our priorities and objectives for the years ahead.

In May this year the College officially launched the RANZCP Reconciliation Action Plan, a formal statement in which we set out our guiding vision for further work to reduce the inequality in mental health outcomes between indigenous and non-indigenous Australians. The disparities are compelling – rates of suicide, hospitalisation, imprisonment and occurrence of a wide range of psychiatric disorders, to name just a few.

The Australian Indigenous Doctors Association (AIDA) recently released a position paper entitled Cultural Safety for Aboriginal and Torres Strait Islander Doctors, Medical Students and Patients. As the position statement explains, “Cultural safety refers to the accumulation and application of knowledge of Aboriginal and Torres Strait Islander values, principles and norms ... Cultural safety is about overcoming the cultural power imbalances of places, people and policies to contribute to improvements in Aboriginal and Torres Strait Islander health.”

This applies to New Zealand and to Maori and Pacific people too, where we also see significant differences in health status.

If you are interested in learning more about the RANZCP I invite you to visit our website which can be found at www.ranzcp.org. I also welcome hearing from colleagues around the world, so if you would like to contact me I invite you to do so via president@ranzcp.org.

---

Nomsa is the young mother of a toddler who has severe Intellectual Disability. She lives in a township where she alone takes care of her son who requires 24-hour care. Since she has no support from the father or her family, she is shackled to her poverty-stricken environment and circumstances, unable to leave her son in order to find work. Nomsa also has to deal with the shame and condemnation she faces in her community on a regular basis due to the stigma attached to Intellectual Disability. Black women and youth in rural areas remain marginalised and women largely take responsibility in caring for the disabled.
This March (Intellectual Disability Awareness Month) the National Office of the South African Federation for Mental Health (SAFMH) began campaigning for the upscaling of services for persons with Intellectual Disabilities. Mrs Bharti Patel, National Director of SAFMH, said: “The S.A Federation for Mental Health is passionate about reaching out to persons with Mental Health Disabilities – especially those in rural areas, who do not have access to the support and care that they need and so deserve. Many people still do not even know that there is help and support out there, let alone where to find it. We rely heavily on funding from Government and donors to continue spreading awareness in communities across South Africa.”

Persons (children and adults) with Intellectual Disability in South Africa are among the poorest, most vulnerable and marginalised in the country. Education, therapy and stimulation for children with Intellectual Disability are critical to their hopes of achieving greater independence and community participation. However, in Africa less than 10% of disabled children attend school.

The health conditions and support needs of persons with Intellectual Disability – especially in their adult years - is a neglected topic, despite international evidence that these individuals are at greater risk of poor physical and mental health than the general population. Stigma, isolation and limited access to services contribute to poor health and wellbeing in general.

In spite of commendable progress in policy and legislation development and the designation of numerous governmental and non-governmental good practices, failures in policy implementation and service delivery continue to result in unmet social, health and educational needs. This is a serious cause for concern and a call for action to government and civil society.

SAFMH will be conducting research in order to gain a better understanding of some of the micro issues at the grassroots level as well as the holistic picture. This will lead to the formulation of a comprehensive advocacy document on the upscaling of services for persons with Intellectual Disability and Mental Illness.

The March campaign formed part of a three-year drive initiated by SAFMH to advocate for adequate service delivery for persons with Intellectual Disability and Mental Illness. In July 2013 SAFMH kicked off this drive by creating public awareness around the lack of beds for psychiatric patients in South Africa.

South Africa is by no means the only country characterized by inadequate services for people with Intellectual Disability. However, South Africa is a nation that has publicly declared its commitment to upholding the rights of the mentally ill and disabled by becoming a signatory to the United Nations Convention of the Rights of Persons with Disabilities. We therefore have a responsibility to take action and protect the rights of persons with Intellectual Disability by ensuring that service delivery is on par with policies and legislation.

To contribute toward helping to improve mental health services or to find the South African Mental Health Society closest to you, contact us for more information.

References

ACKNOWLEDGEMENT:
The design of this online publication has been kindly sponsored by Lundbeck and Otsuka. The World Federation for Mental Health is solely responsible for the contents.