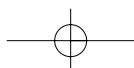
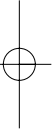
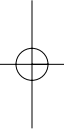


PLENARY LECTURES

PL I- PL XV



PL I
**IS THE WORLD FEDERATION FOR MENTAL HEALTH
RELEVANT TO THE MODERN WORLD?**

John Copeland

The important achievements of the World Federation for Mental Health over the past two decades are reviewed briefly, including World Mental Health Day, the Biennial World Congress, the World Bank Project and more recently the Centre for Culture and Mental Health, the setting up of the Disaster Support and Response Initiative and the African Initiative.

What should be the World Federation's primary role in the new century?

It should continue to strengthen its grass roots leadership and its support for education but should use its position to identify World Mental Health problems, convened experts and encourage them to seek solutions.

What are the problems currently facing world mental health?

The failure of governments to respond to successive World Mental Health reports; the perceived failure of the mental health community to establish a unified voice for change; lack of visibility compared to other areas of health; poor human rights record in most countries and the failure to provide recovery-based therapies for the larger proportion of the world's population

Could the Federation tackle these problems?

The Federation could raise a CAMPAIGN TO MOVE MENTAL HEALTH UP THE AGENDA OF GOVERNMENTS by demonstrating UNITY by its Great Global Consensus (initial results will be presented) , establishing VISIBILITY on World Mental Health Day by rallies and marches worldwide (already encouraged), establishing a Centre for Human RIGHTS and Mental Health to hold governments accountable and by encouraging RECOVERY-based treatments now that computer assisted methods are available.

PL II
MENTAL AND PHYSICAL HEALTH – THE ROLE OF STRESS

Dusica Lecic-Tosevski, Olivera Vukovic, Jelena Stepanovic,
Saveta Draganic-Gajic

School of Medicine, University of Belgrade

Numerous psychoneuroimmunological studies have shown that stress-related biopsychosocial reaction can be the cause or precipitating factor of numerous mental or physical disorders. It is believed that stress-related disorders, or the so-called life style diseases are the cause of death in 70-80% of cases in developed countries while this rate is somewhat lower in developing countries. The studies point out to the deteriorated functions of the immune system within a complex influence of stressors on the individual's health. The influence of chronic stress on functioning of the central nervous system is of also of a great importance, as well as the correlation between stress, disease and personality type. Our studies have shown that the spiral of stress reaction may cause mental disorders such as posttraumatic stress disorder and depression, but also coronary disease. The results of contemporary research and clinical experience have indicated and accentuated the need for a multidimensional, psychosomatic approach both to mental and

physical health as well as in prevention and treatment of mental and physical disorders, which are frequently comorbid.

References:

1. Lecic Tosevski D, Pejovic Milovancevic M. (2006). Stress and physical health. *Current Opinion in Psychiatry* 19, 2, 184-190.
2. Stepanovic J, Ostojic M, Lecic-Tosevski D, et al. (2002). Mental stress test and myocardial ischemia. *Balneoklimatologia*, 27, 1, 307-315.

PL III
MENTAL HEALTH ADVOCACY THROUGH A NATIONAL NGO

Anthony Fowke

World Federation for Mental Health

This presentation considers the role that national non government organizations can play in achieving systemic change in mental health policies and services.

The paper particularly focuses on the national achievements of the Mental Health Council of Australia including:-

- Publications on particular issues
- A nationwide consultation followed by a detailed report
- Direct advocacy and presentations to politicians
- Representation on governmental committees and working groups
- An annual World Mental Health Day event
- The support of mental health consumer and carer representatives
- Media statements and articles

PL IV
**INNATE KNOWLEDGE, AWARENESS, UNCONSCIOUS AND
FUNCTIONAL IMAGING TECHNIQUES**

Athanasios Fokas

Academy of Athens

To the Platonic position of a priori knowledge, Aristotle and later Locke juxtaposed the position that knowledge is the result of experience. In the first part of this lecture, the above positions will be placed in the context of neuroscience. Then, the value of functional imaging techniques for elucidating the interaction of unconscious functions and awareness will be discussed.

PL V
**A CALL FOR ACTION TO STRENGTHENED COLLABORATION
BETWEEN MENTAL HEALTH AND HIV/AIDS PROGRAMS IN
AFRICA: THE WFMH AFRICA INITIATIVE"**

Preston J. Garrison

World Federation for Mental Health

Poor access to mental health care for people infected and affected by HIV combined with poor access to HIV prevention, care and treatment for people with mental health needs were

key themes discussed at a World Federation for Mental Health expert forum of 23 leaders in mental health and HIV/AIDS convened in Cape Town, South Africa in January 2008. The meeting documented how service gaps can lead to undue suffering, a loss of quality of life, and poor uptake of, and adherence to, HIV prevention, treatment and AIDS care programs.

People living with HIV/AIDS, their families, and their caregivers need additional mental health support. This includes education about the mental health needs, development and disorders of children, adolescents, adults, and families, and about the circular relationship between mental health and HIV/AIDS. They also need information about stress management, social support, building self-esteem and coping skills, as well as help in accessing medical and financial assistance, stress management, attention to physical health problems, and safe opportunities to talk openly about their fears and concerns.

This presentation will describe the rationale for the World Federation for Mental Health's Africa Initiative addressing the mental health consequences of HIV/AIDS and outline the planned Initiative's goals, objectives, and initial activities to address these major issues and to develop a formal network of organizations and individuals working in the areas of mental health and HIV/AIDS in Africa.

PL VI ETHICS IN MEDICINE AND PSYCHIATRY

George N. Christodoulou
*World Federation for Mental Health
Hellenic Psychiatric Association
Hellenic Center for Mental Health and Research*

In this plenary lecture the moral theories pertaining to the practice of Medicine and Psychiatry are discussed and the importance of Virtue Ethics is highlighted. It is emphasized that these theories (virtue ethics, casuistry, deontological theory, utilitarianism, principlism and ethics of care) should be regarded as complementary rather than antithetical.

Furthermore, the most important Ethics Codes, starting from Hippocratic Ethics are discussed and brief reference is made to Corpus Hippocraticum, the Declaration of Geneva of the WMA, the Principles of Medical Ethics of the AMA, the Declaration of Helsinki of the WMA, the physician's oath of the Soviet Union, the Oath of the Russian Physician, the Declaration of Hawaii and the Declaration of Madrid of the WPA.

Lastly, it is emphatically stressed that protection of the human rights of patients and therapists alike is guaranteed by observing professional ethical values, principles and rules.

References

Green S and Bloch S: *An Anthology of Psychiatric Ethics*, Oxford, 2006
Marketos S and Karpathios S. *Hippocratic ethics in Modern Medicine In: Stanciu C and Ladas S. Medical Ethics*, Beta, Athens, 2002

PL VII ETHICAL ISSUES RELATED TO PSYCHIATRIC TREATMENT IN DEVELOPING COUNTRIES

J.K. Trivedi, M. Dhyani, Himanshu Sareen
*C.S.M. Medical University (Formerly K. G. Medical University)
Lucknow, India*

Ethics is derived from the Greek word "*ethicos*" which means "Rules of conduct that govern natural disposition in human beings". It is the body of moral principles or values governing a particular culture or group. Ethics in psychiatry is always in a state of flux adapting to changes in the specialty & its place in the world at large. The ethical issues that are relevant to the developing or low resource countries are in contrast to the industrialized countries. The issues such as euthanasia, surrogate motherhood, organ transplantation and gene therapy, which are on the forefront in the industrialized countries, are, for the moment, irrelevant in most developing countries. Ethical dilemmas associated with scarcity and the allocations of limited resources are more important in the developing countries. The issues such as scarcity, oppression, and corruption along with cross cultural research and activities of multinational companies are relevant in developing countries. The majority population in these areas is illiterate and unaware of their rights and is vulnerable to all sorts of allurements and or mistreatments. There is lack of consensus on the ethical issues and well defined ethical guidelines are needed. These ethical issues related to treatment in psychiatry in the developing countries will be discussed.

PL VIII PERSON-CENTERED INTEGRATIVE DIAGNOSIS AND GLOBAL HEALTH

Juan E. Mezzich
Mount Sinai School of Medicine, New York University,

The development of a Person-centered Integrative Diagnostic (PID) model is a key component of the efforts being undertaken to build a person-centered psychiatry, medicine and general health care. One of the crucial features of the PID model is that it attempts to cover the whole of health, including its ill and positive aspects.

The evolving domains of the PID include three levels (each ranging from ill health to positive health), as follows:

1. Health Status
2. Experience of Health Status
3. Contributing Factors

These domains will be evaluated using both standardized (categories and dimensions) and narrative/idiographic descriptive approaches. As diagnosis is fundamentally not only a formulation but a process or activity, the description and understanding of the above domains will be undertaken interactively by clinicians, family and the patient.

PL IX**STIGMA RELATED TO MENTAL DISORDERS**

Miguel R. Jorge

World Psychiatric Association

The Brazilian site of the WPA Global Program against Stigma and Discrimination Because of Schizophrenia was launched in 2001. Among its activities, several research projects were carried to investigate aspects of stigma in different settings. One project studied representative adult sample of Sao Paulo city and dealt with the public perception of 4 major psychiatric disorders including schizophrenia. All 4 disorders were perceived by them as causing negative reactions in the social environment and related to high risk of violence, particularly alcohol dependence (80%), followed by schizophrenia (60%). Another research was conducted with family health professionals working at Primary Care Centers to whom a vignette depicting a person with schizophrenia was presented. Just 3% of all professionals identified schizophrenia as the main diagnosis and another 5.4% considered the diagnosis of psychosis (the most frequent diagnosis was depression, considered by 29% of the professionals). 70.5% of the professionals considered that the patient would be discriminated by the community if people knew about his/her problem. Adolescents from lower and higher socio-economic level (SEL) and were also studied regarding attitudes and beliefs related to schizophrenia. Female students presented less stigmatized beliefs and attitudes, and less social distance from people with schizophrenia than male students. Students from higher SEL presented less stigmatized beliefs and attitudes, and less stereotypes towards people with schizophrenia than students from lower SEL. Previous knowledge about schizophrenia was related to less stigma and previous contact with a patient was related to less social distance. Additional data will be presented for discussion.

PL X**MAUDSLEY INTERNATIONAL**

Nick Bouras

Institute of Psychiatry - King's College London, David Goldberg Centre, HSRP Department, London, U.K.

Maudsley International was launched in 2008 and is a new joint initiative of the Institute of Psychiatry and the South London and Maudsley Foundation NHS Trust. The aim is to undertake teaching, training and consultancy related to research, clinical practice and policy in the field of mental health worldwide. Maudsley International promotes best practice in the following: clinical training, research and development, clinical governance and ethics, evidence-based policy and practice.

Some of our current projects of the Maudsley International include:

- A. A partnership agreement with Voluntary Service Overseas offering South London and Maudsley Foundation NHS Trust staff an opportunity to undertake voluntary work in mental health projects in Sri Lanka.
- B. An on line pilot Support Professional Development Scheme for Psychiatrists working in NGOs or public sector in Low and Middle Income Countries.
- C. Organising educational visits of mental health professional

from various countries to our clinical services in London.

D. Organising state of the art intensive clinical courses on a variety of clinical mental health topics.

E. Encouraging the promotion of Memorandum of Understanding for training, research and development with the Academic Department of Psychiatry and clinical services overseas.

Maudsley International offers the knowledge, skills and support necessary to help, plan, develop, implement and evaluate cost-effective and locally appropriate training, services and policies, tailored to meet the specific mental health needs of neighbourhoods, regions and countries anywhere in the world. We collaborate with research institutions, professionals, policy makers of governmental and non-governmental organisations to help promote mental health, prevent illness, and treat and support individuals and their families.

PL XI**COLLABORATIVE CARE FOR HOMELESS PEOPLE WITH MENTAL ILLNESS**

Julian Freidin

The Alfred Hospital, Melbourne, Australia

On the night of the 2006 census approximately 106,000 Australians were homeless, a situation associated with poorer health, employment and relationship outcomes. Mental illness is a significant factor in causing or maintaining homelessness, with symptoms of mental illness often resulting in conflict with family, co-tenants or landlords. Mental illness can also be caused or exacerbated by living homeless, with the constant social instability and potential for victimisation, potentially triggering the onset or relapse of mood or psychotic disorders, particularly when coupled with substance abuse.

People living homeless with a mental illness are in general transient, often unwell due to long periods without treatment, and reluctant to engage in mental health care so are poorly served by traditional mental health systems that rely on people attending a clinic to access support. A new initiative established co-location and partnership of mental health staff alongside accommodation and support staff at drop-in and crisis accommodation services to ensure improved identification of mental illness, rapid responsiveness and joint assessment and intervention supported by formal and informal education and consultation.

People who were homeless that accessed this model of collaborative care for at least one month obtained markedly more stable and permanent accommodation. The initiative resulted in significantly fewer referrals to mental health crisis services and a 50% reduction in admissions of these people to hospital. This demonstrated the significant benefit to service users of a system where clinical and non-clinical services work in partnership.

PL XII**UPCOMING CHANGES IN CONTEMPORARY PSYCHOTHERAPY**

N. Tzavaras

Hellenic Psychiatric Association

During the last decades a continuous attempt toward a more

systematic collaboration between different psychotherapeutic orientations, dictated by clinical needs, has been observed. The realization that this attempted dialogue can contribute to more successful clinical treatment required a long period of time in order to overcome ideological immobilization maintained by the lack of comparative studies. Nonetheless, characteristic of the change noted in the attitude of representatives of different schools, is the search for new methods of comparing their results as well as ways to discuss clinical cases together. At the same time, there is a proliferation of publications whereby different orientations are explored, which in addition reflect the possibility of refinement of selection criteria regarding the most appropriate form of psychotherapeutic intervention for each particular psychopathological syndrome. It seems too that the sought -after dialogue enhances not only recognition of the limits of each specific technique, but in addition, leads to further growth and elaboration of each theoretical orientation. This effort will perhaps prove to be one of the most interesting developments in the domain of psychotherapy.

PL XIV
DIFFERENTIAL DIAGNOSIS BETWEEN DEPRESSION AND
“NORMAL SADNESS”: A CLINICAL, SCIENTIFIC AND
ETHICAL ISSUE TO BE ADDRESSED BY DSM-V AND ICD-11

Mario Maj

Department of Psychiatry, University of Naples, Italy
World Psychiatric Association

The issue of the differentiation between depression and “understandable” intense sadness (representing a “normal” response to an adverse life event) has significant clinical, scientific, political and ethical implications, which have become particularly visible in the past few decades, in parallel with the escalation of the prevalence rates of depression in the community, of the estimated social costs of depression, of the number of people on treatment for depression, and of the prescriptions of antidepressant medications (1). According to the DSM-IV, periods of sadness are inherent aspects of the human experience, which should not be diagnosed as a major depressive episode unless criteria are met for severity, duration and clinically significant distress or impairment. The implication of this statement is that “understandable” intense sadness following an adverse life event does qualify for the diagnosis of major depression if the severity, duration and impairment criteria are fulfilled. The proposal has been recently put forward to exclude loss-triggered uncomplicated intense sadness from the DSM-V diagnosis of major depression (i.e., to introduce a “contextual” criterion excluding intense sadness which appears “proportionate” to a loss). However, further research is needed to explore the applicability and reliability of this “contextual” criterion and its clinical utility for the prediction of treatment response and clinical outcome. The limited available research evidence suggests that “situational” major depression does not differ from “non-situational” major depression on many clinical and psychosocial variables, and that response to antidepressant medications is unrelated to whether or not major depression is preceded by a life event.

Reference

Maj M. Depression, bereavement, and “understandable” intense sadness: should the DSM-IV approach be revised? (Editorial). *Am J Psychiatry* 2008;165:1373-1375.

PL XV
THE POLITICAL ECONOMY OF PSYCHIATRIC
DEINSTITUTIONALIZATION

Michael Madianos

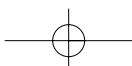
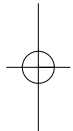
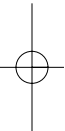
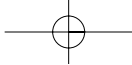
School of Health Sciences, University of Athens
World Association for Psychosocial Rehabilitation

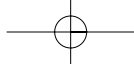
Deinstitutionalization of chronically mentally ill persons in many western countries was initiated in the late sixties and early seventies of the last century, of course after the massive introduction of neuroleptics.

However in many countries the discharges of the inmates were made before community and local support network had organized satisfactory number of alternatives to host the discharged patients resulting to the negative phenomena of revolving door and homelessness.

On the other hand, Deinstitutionalization is directly linked with the welfare state and the adequate financial support of the programme. In several countries the shift from the welfare state to the market economy caused dramatic negative impact in the organization of the delivery of adequate mental health care for the vulnerable low socioeconomic class mentally ill individuals.

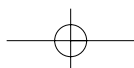
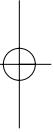
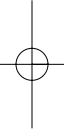
Deinstitutionalization was proven to be successful, when there where strong ideological or humanitarian motives and when psychiatric reform was a priority and was completed with a comprehensive system of community based alternatives and sufficient welfare support.





WFMH LECTURE SERIES

WFMH LSI - WFMH LSIV



WFMH LS I**MARGARET MEAD LECTURE****CULTURE AND MENTAL HEALTH: ARAB AND ISLAMIC PERSPECTIVES**

Mohammed Abou-Saleh

*Professor of Psychiatry, Division of Mental Health,
St. Georges, University of London, Cranmer Terrace,
London SW17 0RE, UK*

Culture in relation to mental health refers to beliefs, values, norms, and myths shared by a community that are transmitted from one generation to another. Mental illness as a human condition is essentially a subjective experience with strong socio-cultural determinants and implications for their assessment, diagnosis, treatment and prevention. It is therefore imperative to consider the experience and the suffering of the mentally ill in their socio-cultural context. There is evidence that cultural factors influence the presentation, perception, symptom patterns, symptom content, diagnostic concepts, prevalence, risk factors, and outcome with implications for their prevention, treatment and care.

Traditional Arab-Islamic perspectives on culture and mental health are deeply rooted in the humane values, traditions and the practice of Arab-Islamic physicians and healers since the dawn of Islam. There is great heritage exemplified in the establishment of the first mental hospitals since 700 AD. Whilst there is a residue for such a culture in modern times, the mentally ill in Arab and Islamic countries face the double jeopardy of stigma and poorly developed mental health services often confined to institutional care.

The presenter will review the literature in this area with reference to studies undertaken in Arab countries on the cultural aspects of mental illness, its prevalence, socio-cultural risk factors and impact on outcome, service utilisation, socio-cultural change and discuss the implications for prevention, treatment and care.

WFMH LS II**HOPE BEING FULFILLED? PROGRESS IN ADDRESSING RELIGION-RELATED INEQUALITIES IN MENTAL HEALTH SERVICES**

Catherine M. Loewenthal

*New York University in London, Royal Holloway University of
London, London, UK*

Pamela is a patient in a psychiatric ward. She and some of her fellow-patients want to have a bible-study group. The staff won't allow this. Pamela thinks this is because the staff believe that religion will make the patients more disturbed.

This talk will illustrate some ways in which religious and spiritual issues are associated with inequalities in mental health service provision. There is hope of reducing inequality if the factors leading to it are recognised.

There are many such factors. These include

- religion-related barriers to seeking help, such as stigma, shame, doubts about ones spiritual worth;
- religion-related attitudes and beliefs that users and service providers might have about each other, often involving fear of misunderstanding;
- religion-related attitudes and beliefs about different treatments,

such concerns that ones beliefs about causes may not be acknowledged, or about the religious acceptability of treatments;

- religion-related factors affecting service provision, including beliefs about the relations between mental health and spirituality.

Examples of attempts to deal with some of these factors will be described.

WFMH LS III**GEORGE ALBEE MEMORIAL LECTURE****MAKING THE CASE FOR PRIMARY PREVENTION: NEW DEVELOPMENTS. OPPORTUNITIES AND CHALLENGES**

Clemens M.H. Hosman

*Prevention Research Centre, Radboud University and
Maastricht University, The Netherlands*

It is exactly 100 years ago that the advocacy for prevention of mental disorders was launched by Clifford Beers and several well-known psychologists and psychiatrists at the inauguration of the Mental Hygiene Movement. This Movement and the later Mental Health Movement have grown into a worldwide enterprise to improve the mental health of populations in all regions of the world. In 1909 this was not more than a challenging idea and ideal. To date, in 2009, it has become a reality as an outcome of many investments in advocacy, research, experimental practices and policy-making. Especially, during the last three decades much progress has been made in science-based prevention. This progress has been earlier summarized in the WHO Reports on Prevention of Mental Disorders (Hosman, Jané-Llopis & Saxena, 2004) and Promoting Mental Health (Herrman, Saxena & Moodie, 2004, 2005). It has become evident that societies more and more are developing to prevention-oriented societies, and that mental health is becoming recognized as an essential element of societies and human capital.

In this lecture I will discuss some learning experiences from prevention efforts in the past and briefly summarize where we currently are in developing evidence-based primary prevention of mental disorders. The major part of this lecture will be devoted to new developments, current opportunities for further progress in practice and policy making, and an outline of the challenging agenda for the next decade.

One of the major learning experiences from the past is that significant progress in developing and practicing effective prevention is only possible when sufficient preconditions are simultaneously met (e.g. knowledge, evidence-based tools and strategies, political support, economic necessity or value, embeddedness in professional ideologies and organizations, and targeted capacity-building systems). Much has been learned about strategies to achieve these conditions. Secondly, the number of evidence-based practices and programmes to improve mental health and to prevent mental disorders is growing and needs further investments. Notwithstanding their availability still only a small part of our target populations is reached and benefit from them. A major challenge for the next decade is to improve their dissemination and implementation in societies, taking into account differences in cultures and needs across populations. Enlarging the impact of preventive efforts in societies also require the development of innovative strategies such as use of internet support to people at risk,

expanding use of mass media, changing long term risk trajectories early in life, systematically integrating prevention opportunities in primary health care, a better understanding of the relations between mental health, health and social problems, enlarging insight in social and economic benefits of prevention, making mental health a part of local health, social and economic policies and programs, developing culturally sensitive guidelines for developing prevention and mental health promotion in local communities, investing in capacity-building and empowerment for prevention and mental health promotion across disciplines and local organizations, and linking our field productively with human rights and educational movements. Some illustrations of successful innovations will be offered.

Looking back to the last two centuries we have witnessed the emergence of large scale health systems, primarily focused at cure and care of a wide range of diseases, with the involvement of a growing range of medical and many other disciplines and an impressive spectrum of evidence-based technology and treatments. I expect that the 21st century will show the growths of prevention and health promotion (including mental health) to a comparable, influential and multidisciplinary field balancing cure and care, and widely present across countries and local communities. During his life George Albee has offered a rich spectrum of analyses and ideas that could be used as a valuable source of inspiration for innovating research, practice and policy to make this happen.

developers in tertiary education and training

- services that are better informed and responsive to client need

The overall message will be a call to enact the motto of partnership for consumer / user / survivor movement, "Nothing about us without us".

WFMH LS IV PARTNERSHIP OR PRETENCE?

Janet Meagher, AM

In the presentation "Partnership or Pretence?" the theory and practices around consumer / user / survivor participation and integration in services, policy development, research and organizations will be discussed. The rationales for and against participation of service users and barriers to genuine participation will be fully addressed. Matters around personal coping, capacity, educational level, remuneration and ability are frequently raised as rationales for limiting consumer / user / survivor input and the presenter will illustrate the development of participation models by using options and examples from countries and research across the world.

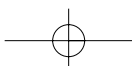
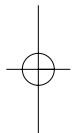
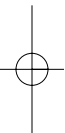
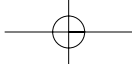
Outcomes of solid partnership arrangements between ...

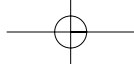
- governments and consumers / users / survivors
- service providers and consumers / users / survivors
- non-government organizations and consumers / users / survivors
- local communities and consumers / users / survivors

...will bring forward benefits that participants will learn of and will be encouraged to emulate.

Results of ongoing partnerships are well documented. They lead entities to develop...

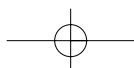
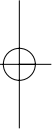
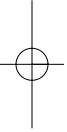
- recovery focussed services
- rights sensitive practices
- empowered participation of consumers / users / survivors in all aspects of services that affect their lives
- aware, responsive and sensitised staff
- peer led initiatives or peer run services
- consumer / user / survivor lecturers and curriculum





PLENARY SESSIONS

PL SI- PL SII



Saturday, September 5, 2009, 15.30-17.00
Hall Hesperides

PLENARY SESSION

PL S I

2009 World Mental Health Day. Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health

Welcome and Introduction: L. Patt Franciosi

PL S I

OVERALL ABSTRACT

The 2009 World Mental Health Day campaign addresses the theme "Mental Health in Primary Care: Enhancing Treatment and Promoting Mental Health". This campaign theme focuses international attention on one of the increasingly important trends in the way that mental illnesses are being treated worldwide. The campaign planning and background materials developed by WFMH to support the campaign summarize the growing body of information and knowledge focusing on the integration of mental health in primary healthcare, and to provide this information to grassroots patient/consumer, family member/caregiver, and advocacy and educational mental health associations around the world. This is a significant trend in shifting mental health diagnosis, treatment and care from the traditional separate, but unequal, mental health services delivery system into mainstream healthcare and one that will require grassroots mental health organizations to play a continuing advocacy role.

The engagement of the "end users" of mental health services, their families who often carry much of the responsibility for helping people living with mental illnesses to manage in the community, and the advocates who attempt to influence mental health policies is critical during this time of change and reform. Informing and equipping the grassroots mental health community to make certain that mental health and mental illnesses are considered integral to overall good health and appropriate services for those who require them are the principal goals for the 2009 World Mental Health Day global awareness campaign. One of the primary advocacy concerns to be addressed is the danger that adequate and effective diagnosis, treatment and recovery of people living with mental illnesses will not receive a parity level priority within the general and primary healthcare system. It is the job of the global mental health advocacy movement to assure that this is not an unintended result of healthcare reform.

Sunday, September 6, 2009, 11.30-13.00
Hall Hesperides

PLENARY SESSION

PL S II

«Trialog» Consumer/Service Users, Family/Carers, and Clinicians Issues Forum

Moderators: L. Patt Franciosi, S. Steffen

PLS II.1

THE ROLE OF THE FAMILIES AND PATIENTS IN PSYCHOSOCIAL REHABILITATION AND EFFECTIVE PSYCHIATRIC REFORM – THE DEVELOPMENT OF THE MOVEMENT IN GREECE.

Niki-Eleni Nomidou, Alexandra Stroumbou
Panhellenic Federation of Families for Mental Health

The family at the centre of caring: From silence to information and action

In 2003 the Associations of Families for Mental Health in Greece founded the "Panhellenic Federation of Families for Mental Health" with the aim of breaking the silence and allowing the voices of the families to be heard more dynamically and more collectively. Today the Federation has 8 associations of families as regular members and a further three as assistant members.

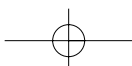
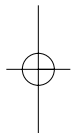
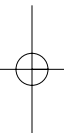
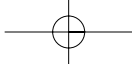
Since 1993 when the first Association was founded in Vyrion, Athens, both the Associations and the Federation have developed significant activities in the field of information, in sensitizing specialists and public opinion through day-long sessions in Athens and many other cities throughout the country, theatrical performances, concerts, interviews in the press, television, radio, as well as by publishing journals and information leaflets.

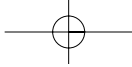
The focus of the Associations' activities is to strengthen the family through the psycho-educational programmes for families and patients, in which particular emphasis is given to the active participation of the family in the process of recovery from mental illness. In our opinion all of this activity has improved perceptions of mental illness and up to a point has reduced prejudice. We believe that the active participation and the direct contact with the common members of the family and patients contribute effectively to reducing ignorance and stigma.

The federation collaborates with almost all of the organisations for mental health in the country and representatives as a rule participate as speakers in their day-long sessions and conferences, as well as with Gamian and Eufami. The

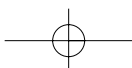
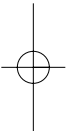
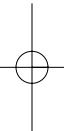
Federation is a member of the "National Federation of People with Handicaps" and a representative participates in the General Council and through this furthering various institutional demands which concern handicapped persons generally, including those with mental handicaps.

Our attempts will continue to focus on campaigning for the necessary actions on the part of the state to design and put into practice a "National Plan of Action" which will fulfill the needs of the families and patients through a network of services in the community which will be close to their needs.





WFMH SPECIAL SYMPOSIUM



Sunday, September 6, 2009, 10.00-11.30

Hall Hesperides

WFMH SPECIAL SYMPOSIUM

WFMH SS I

Diabetes and Depression: Current Knowledge and Future Challenges

Chair: Helen K. Millar

WFMH SS I

OVERALL PRESENTATION

The World Federation for Mental Health is a charter member organization of the Dialogue on Diabetes and Depression (DDD), an international collaborative effort addressing problems related to the co-morbidity of diabetes and depression. It aims to review the evidence and experience relevant to co-morbidity of diabetes and depression in order to define gaps in knowledge and formulate strategies for priority research and action in this field.

This symposium will bring together several active members of the DDD working group to provide information about the epidemiology, treatment, research and advocacy issues being addressed through the initiative. It will offer opportunities for interaction and discussion among presenters and symposium participants and open new avenues for dissemination of the DDD initiative's efforts.

This symposium will be one of the first major opportunities to disseminate information regarding the work of the Dialogue on Diabetes and Depression to an international and diverse segment of the global mental health constituency, and offers a unique opportunity to build interest in and support for this important public health initiative.

The learning objectives for this symposium are as follows :

- To provide information to attendees at the WFMH World Mental Health Congress about the health implications of co-occurring diabetes and depression by presenting up-to-date evidence-based know regarding the epidemiology of diabetes and depression and the effectiveness of treatment interventions
- To familiarize the attendees about the aims, goals and activities of the Dialogue on Diabetes and Depression (DDD) initiative and to gain their interest and involvement in means to share the work of the initiative with their grassroots constituencies through education and awareness activities
- To raise awareness of the general population about the physical and mental health consequences of co-morbid conditions of diabetes and depression and to encourage greater attention to this major public health issue by mental health and primary care professions, policymakers,

advocates, and the general public.

- To provide practical information and strategies to grassroots mental health organizations, including consumer/service user, family carer and mental health advocacy and education groups, that they can use to inform and educate their own communities and constituencies about the relationship and consequences of diabetes and depression.

WFMH SSI.4

THE PERSPECTIVE OF SERVICE USERS AND FAMILIES IN MANAGING DIABETES AND DEPRESSION

Yoram Cohen

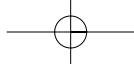
Enosh Israeli Mental Health Association, GAMIAN-Europe

The co-morbidity of diabetes and depression presents a special challenge to service providers, patients and their families.

Patients who suffer from both disorders are often unable to receive adequate treatment as a result of an existing lack of integrated and holistic care. Such patients often complain of a lack of options regarding psychological therapy for their depression. In addition, while patients being treated with psychiatric medication are at serious risk for developing diabetes, they are often unaware of the extent of this risk and do not have access to all relevant information concerning the side-effects of their medication.

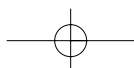
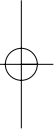
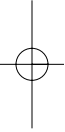
The path to improving this situation consists of several key steps:

First, there must be the development of integrated and holistic care addressed specifically to individuals with co-morbid depression and diabetes. Secondly, there is a need for greater awareness on the part of service providers, patients and their families concerning the special needs and risks of this condition. Third, there should be an increased flow of vital information from service providers to patients and their families. Finally, robust patient advocacy is required in order to ensure the upholding and preservation of patients' rights.



PANEL DISCUSSIONS

PDI - PDII



Saturday, September 5, 2009, 13.30-15.00
Hall Hesperides

PANEL DISCUSSION

PD I

Person-Centered Psychiatry and Mental Health Care

Chair: Juan E. Mezzich

PD I

OVERALL ABSTRACT

This 90-minute Panel will involve a series of brief (5-minute) presentations on the meanings of and specific activities on person-centered care from the perspectives of various groups across the constituencies of the World Federation for Mental Health. In line with Ortega y Gasset's dictum *I am I and my circumstance*, this collaborative initiative promotes the person in context as the center and goal of clinical care, prevention, and health promotion.

More specifically, the initiative aims to promote a psychiatry and health care of the person (of the totality of the person's health including its ill and positive aspects), for the person (to contribute to the fulfillment of the person's life project), by the person (with clinicians extending themselves as professionals well grounded in science and committed to exemplary care and high ethical aspirations), and with the person (in respectful and empowering collaboration with the person who presents for care).

Saturday, September 5, 2009, 17.00-18.30

Hall Hesperides**PANEL DISCUSSION****PD II****Advances and Perspectives of Mental Health***Chair: George N. Christodoulou***PDII.2**

Tsuyoshi Akiyama

Kanto Medical Center, Japanese Society of Psychiatry and Neurology, Japan

East Asia plays a unique role in Asia, the largest continent in the world. This region is based on a common cultural background, which was originated in China, and has hardly received direct influence of western culture through colonization.

Korea, Japan and Taiwan share many features, including advanced economy, high education and aging. The knowledge of psychiatry developed in the west has been imported rigorously.

The important issues for these countries include

- Shift to community based care
- Development of better advocacy and awareness
- Wider psychological consultation service
- More participation of families and communities on treatments
- Age focused services

China has been attaining co-existence of communism in politics and vast development in economy. In developed areas like Shanghai, advanced community mental health system is available. For the whole country, there still exist fundamental issues like insurance. Mongolia was previously communist, and is economically not developed yet and has to deal with primary issues like establishing epidemiological data or mental health policy. Historically Hong Kong alone received a direct European influence.

The important issues for these countries include

- Shift to community based care
- Outpatient treatment, rehabilitation
- Increase of human capacity and funds
- Health care reform, health policy
- 10 years plan by the ministry of health in China

The fundamental challenge in this region is how to assimilate the imported knowledge with the indigenous cultures, when the indigenous culture itself has been shifting rapidly.

Reference

Inoue S, Okada K, Motoki Y, et al: Current situation of psychiatric rehabilitation in East Asia. *Jap J Psychiatric Rehabilitation* 1997 1 (2): 114 - 121

Shinfuku N: Mental health services in Asia: International perspective and challenge for coming years. *Psychiatry Clin Neurosci* 1998 Jun 52 (3): 269-74

PDII.3

George N. Christodoulou

*World Federation for Mental Health**Hellenic Psychiatric Association**Hellenic Center for Mental Health and Research, Greece*

Mental Health has advanced in recent decades in all components of its holistic entity – Biological, Psychological and Psychosocial. Biological progress has mainly derived from interaction of mental health sciences with basic sciences and non-psychiatric medical disciplines (e.g. neuroimaging and genetics). In the clinical field, adoption of a common language as a result of adoption of the international classification systems represents a significant advancement.

Recognition of the importance of psychological and psychosocial factors in the production and perpetuation of mental disorder is also positive and in line with recent evidence on brain plasticity.

Community Psychiatry and General Hospital Psychiatry represent positive directions as well as positive mental health, primary care, prevention, empowerment, personified medicine and psychiatry and other concepts and practices aiming at a more humanistic but also more evidence-based direction.

Lastly, alliance of mental health professionals with patients-consumers-service users and their families-carers is a most promising development and represents the moto and the leading direction of this meeting.

**PDII.4
PATIENTS AS PARTNERS: EMPOWERING PATIENTS AS A
MEANS OF BRIDGING THE DIVIDE BETWEEN PATIENTS,
THEIR FAMILIES AND THE MENTAL-HEALTH
ESTABLISHMENT**

Yoram Cohen

Israeli Mental Health Association, GAMIAN-Europe

At present, a degree of separation exists between the mental-health establishment and patients being treated for mental illnesses, an estrangement which has limited the influence of patients' perspectives in taking important decisions. Major decisions, with broad-ranging repercussions, taken without regard to patients' perspectives, have all too often been to patients' detriment. The negative effects of such decisions, which are never intentional, have hampered in many cases the recovery of patients, the maximization of patient well-being, and the empowerment of patients and their families.

What is desperately needed, therefore, is the development and maintenance of an ongoing partnership between patients, their families and the mental-health establishment. Such a partnership will serve to empower patients, speed up their recovery and maximize patient well-being, and, most importantly ensure that patients' perspectives are always taken into account in taking major decisions with broad repercussions for patients and their families.

**PDII.6
REDUCTION AND ELIMINATION OF SECLUSION AND
RESTRAINT**

Anthony Fowke

World Federation for Mental Health

There is a need for a global movement for the reduction and potential elimination of the practices of seclusion and restraint in mental health services as neither of these can be regarded as having any therapeutic value. The use of these practices is still however very common in some parts of the world and can be considered as an abuse of human rights. They are adopted for varying reasons none of which can be accepted as being for good treating practice even though sometimes are used out of necessity. Work has been done in some parts of the world i.e. the National Association of State Mental Health Program Directors [USA] and the Safety and Quality Partnership Committee [Australia] to prevent violence and conflict and create recovery orientated systems of care.

**PDII.8
THE UNFINISHED AGENDA OF MAKING MENTAL HEALTH
A GLOBAL PRIORITY**

Preston J. Garrison

World Federation for Mental Health

During the past 30 years, major changes have occurred in the way in which the general public's voice has been heard on issues relating to mental health and mental illnesses. Until the late 1970s and early 1980s, advocacy and public awareness

efforts on behalf of these issues came primarily from a very few "umbrella" citizen advocacy organizations – primarily represented by national mental health associations that were historically characterized as "speaking for the mentally ill," and were made up of a variety of constituencies including mental health professionals, citizen volunteers and, to a lesser extent, family members of those with a mental illness. In most instances, people with mental illnesses and their family members constituted a minority – and usually a silent one – of MHA memberships.

During the late 1970s and early 1980s, there began a period of significant change and fracturing of the citizens' mental health movement. During this time, parents of adult children with severe and persistent mental illnesses began to become more vocal about their frustration with the public policies of "deinstitutionalization" and "community-based care," as they voiced concerns about the burden of care placed on families, and the fear for their children's future when parents died or were unable to provide care, leading to the development of a number of national family support and advocacy organizations in Western countries that have continued to spread more slowly to other countries in succeeding years.

At around the same time, other organizations began to evolve – some driven by people with mental illnesses who were no longer institutionalized – some representing individuals with specific disorders (depression, schizophrenia, anxiety disorder). A third group of service user/survivor/ex-patient organizations also developed in the 1970s and 1980s and brought a decidedly negative view of psychiatry, medication use and effect, and the "mainstream" mental health advocacy movement to the forefront.

Among the results of this evolution of "diagnosis-specific" and patient – family support and advocacy organizations have been sometimes significant "disconnects" in the key advocacy messages directed to policy makers, professional associations, the general public, and the funding community. As more organizations have developed, the degree of competition for funding, strategic position, and miscommunication has also increased.

The more recent active engagement of the pharmaceutical industry, the national and global psychiatric associations, the WHO Department of Mental Health and Substance Abuse, and the European Union in influencing and sometimes directing the efforts of the mental health advocacy community has also enhanced the competition for status and support among the consumer, family, and citizen advocacy organizations (and at all levels – local, state/provincial, national, and international). Even as the global mental health advocacy community is being greatly challenged by the current global economic and funding climate, and as services worldwide continue to shrink in availability and access, there remains an overall absence of unity of purpose, common message, and collaborative effort among this important constituency. Without greater effort, and support, to form a more unified force for advocacy among these crucial organizations, the opportunity to make mental health a global priority anytime within the near future is not a likely reality.

PDII.9
**THE NEED FOR MENTAL HEALTH PROMOTION IN LOW
INCOME COUNTRIES**

Helen Herrman

University of Melbourne, Australia

Mental health is promoted through population-based public health measures, as well as health system change. The links between mental health, general health, family function and productivity make population-based mental health promotion in countries at all income levels a necessity, rather than a luxury as sometimes portrayed. Poor mental health is associated in high- and low-income countries with social disadvantage, human rights abuses, and poor health and productivity, as well as heightened risk of mental disorders.

The health promotion strategies of advocacy, communication, policy and legislative changes, community participation, and research and evaluation can promote mental health together with physical health and productivity. Mental health promotion activities take place at several levels. Some are distal from the individual, such as policies to improve housing; others closer to the individual, such as combining psychosocial interventions with childhood nutrition programs, and activity programs for older adults. Effective interventions are possible across the lifespan. Social and health priorities such as HIV prevention, maternal and child health, violence, substance abuse, and gender equity require interventions focusing on appropriate participation, in turn related to mental health. We need wider research and evaluation of public mental health interventions.

Reference: Herrman H, Swartz L. Promotion of mental health in poorly resourced countries. *Lancet* 370:1195-97, 2007

PDII.11

Miguel Jorge

*Federal University of Sao Paulo, Brazilian Association of
Psychiatry, Brasil*

Mental health has many faces in a Latin American country like Brazil and its situation has changed in the last two decades since the "Caracas Declaration" launched a movement to close psychiatric hospitals in the region. Nevertheless, a real construction of community care alternatives to hospitalization is far behind the needs of population and the wish of psychiatrists. The author will discuss some challenges still present for the near and distant future of mental health in Brazil and similar countries.

PDII.14

Juan Mezzich

*International Center for Mental Health, Mount Sinai School of
Medicine, New York University, USA*

Over the past several years an initiative emerged within the World Psychiatric Association, in collaboration with the World Federation for Mental Health, to develop scientifically and humanistically concepts and procedures for a psychiatry of the person, for the person, by the person and with the person (1). It includes diagnostic, clinical care, and public health projects.

More recently, this initiative has been extended to medicine and health care at large, through the organization of a First and Second Geneva Conferences on Person-centered Medicine in collaboration with the World Medical Association, the World Organization of Family Doctors, the World Federation for Mental Health, the International Alliance of Patients Organizations, the International Council of Nurses, the International Federation of Social Workers, and ten other international health institutions (2). An International Network for Person-centered Medicine www.personcenteredmedicine.org has emerged to coordinate future steps towards advancing the whole person of the patient, the clinician and the career as the fundamental focus of health care.

References

1. Mezzich JE: Psychiatry for the Person: Articulating Medicine's Science and Humanism. *World Psychiatry* 6: 1-3, 2007
2. Mezzich JE, Snaedal J, van Weel C, Heath I (eds): Conceptual Explorations on Person-centered Medicine. *International Journal of Integrated Care*, Supplement, in press.

PDII.18

J.K.Trivedi & Himanshu Sareen

*Department of Psychiatry, C.S.M. Medical University, U.P.,
Lucknow, India*

Medicine is a dynamic branch and very few specialties can rival the advance that the field of psychiatry has seen in the last 4-5 decades. India too, has been a witness to these strides and has reaped the benefits of being in a 'global' world. The introduction of the National Mental Health Program, 1982, introduction of the Mental Health Act, 1987 and the recent report of the law commission regarding decriminalization of suicide attempt deserve special mention.

Concept of Community Psychiatry has made it possible for even the poorest and those residing in remote areas to enjoy some of the advances in this field. The psycho-pharmaceutical industry too has come on its own and by introducing cheaper and newer drugs in the market has aided in lowering the stigma associated with mentally ill patients. Greater availability of training facilities for medical as well as paramedical staff right to the primary health care level and robust increase in the number of post graduate training opportunities too merit a mention.

However one should not rest on his/her laurels and always strive to achieve higher. A lot more work needs to be done to make psychiatry a part of mainstream medicine rather than its current status of peripheral discipline. Introduction of psychiatry as a separate subject at under graduate level would be a step in that direction. There also needs to be an insistence on developing of indigenous models for treatment and diagnosis rather than following the European concepts which arise from a different cultural milieu than ours.

Efforts need also to be made to ensure that psychiatry remains a holistic discipline with a bio-psychosocial approach. Ultimately the goal should be to make certain that the benefits of modern scientific psychiatry be made available to all sections of society without discriminating on the basis of caste, creed, economic status and sex.

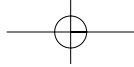
PDII.19**COMMENTS ON THE CONCEPT OF MENTAL HEALTH**

Nikolaos Tzavaras

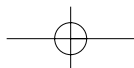
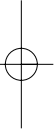
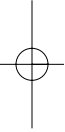
Hellenic Psychiatric Association

The restoration and maintenance of each individual's mental health comprises the most essential goal of contemporary Psychiatry, whose progress is evaluated in all of its domains- within the framework of its scientific aspirations, the variety of therapeutic methods, the social penetration of reformative demands. Nonetheless the concept of Mental Health can lead to its ideological distortion when for example in historical periods of totalitarian regimes it is used to limit and to threateningly minimize its citizens tolerance of regarding psychopathological behavior or behavior that differs from the norm. The reduction of sensitivity toward the mentally ill, and the opposite, that is, the predominance of rejection of the mentally ill from certain groups of the population may be accompanied by the abusive application of the criteria of mental health. When a Psychiatry defined by an essentially humanistic orientation considers the opposition to stigmatization and the isolation of patients as inalienable aspects of its work, it thus advocates the fundamental understanding of psychopathological syndromes. And perhaps something more: the essential enhancement of subjective empathy which helps the reconciliation and acceptance of psychopathology while simultaneously acting against prejudice.

For these reasons psychiatric thought and action must insist on the critical complementary contribution of its two perspectives: the fight against psychic pain as well as the simultaneous social inclusion of patients.



ROUND TABLE



Thursday, September 3, 2009, 13.30-15.00

Hall Galaxy**ROUND TABLE****RT I****The Role of Organizations and Professionals
in Post-Conflict Communities***Chairs: John Copeland, Mohammed Abou-Saleh***RTI.1****THE ROLE OF PROFESSIONAL ORGANIZATIONS IN
DISASTERS: THE WPA EXPERIENCE (2005-2008)**

G.N. Christodoulou

*World Federation for Mental Health**Hellenic Psychiatric Association, Hellenic Center for Mental
Health and Research, Greece*

The role of Mental Health professionals in disasters is basically to provide assistance and advice to the health authorities of countries hit by disasters through the local professional organizations and to offer advice and support to the public (mental health promotion).

The World Psychiatric Association has responded to the challenge of worldwide disasters in the following ways:

- Establishment of an Institutional Program on Disaster and Mental Health (chairs: Prof. George Christodoulou and Prof. J.J. Lopez-Ibor).
- Production of a consensus statement of the WPA on Mental Health implications of Disasters (Dec. 2002).
- Production of a volume on "Disasters and Mental Health", 2005.
- Implementation of educational programs for mental health professionals in collaboration with the WPA Section on Disasters and Mental Health.
- Contact, encouragement and collaboration with the psychiatric associations of the areas hit by disasters.
- Establishment of Task Forces for the following disasters situations:
 - South Asian Tsunami
 - Katrina and North American Hurricanes
 - Honduras and Guatemala Disasters
 - Kashmir Earthquake
 - Central Java Disaster
 - Peruvian Earthquake
 - Bangladesh Cyclone Sidr
 - China Earthquake
 - Myanmar Disaster
- Presidential Messages on Disasters presenting the

philosophy and recommended actions of the WPA ("A new call for actions on Disasters", WPA Electronic Bulletin, Nov. 2006, Editorial "World Psychiatry", Febr. 2006.)

- Mediation for the production of anti-war statements by the Psychiatric Associations of Lebanon and Israel (following local visits and special conferences on Dec. 2006 and Jan. 2007).

Reference

Lopez-Ibor J.J., Christodoulou G., Maj M., Sartorius N., Okasha A. Disasters and Mental Health, Wiley, Chichester, 2005

RTI.3**THE MENTAL HEALTH EFFECTS OF MASS VIOLENCE**

Dusica Lecic Tosevski

*Institute of Mental Health, School of Medicine, University of
Belgrade, Serbia*

Organised violence, such as wars, oppression by dictatorships and massive terrorist attacks are extreme cases in which hundreds or thousands of people are exposed to trauma in a short period of time. Many studies have documented that mass violence can have a devastating effect on mental health of the affected population as a whole, especially in the vulnerable groups such as children, adolescents, single mothers, elderly, refugees and detained people. Psychosocial consequences are frequent and many and manifest as stress disorders, including posttraumatic stress disorder, depression, psychosomatic disorders, aggression and violence among the young, somatization, substance abuse, suicide and burnout syndrome of medical staff dealing with traumatized persons, and in those giving psychological aid. Mass violence prevents the normal development of children threatening their childhood, causing development of personality disorders as well as predisposition to adult mental disorders. Moreover, cumulated trauma, or severe and prolonged stress, if unresolved might

lead to lasting scars of the psyche such as personality changes, malignant, pernicious memories as well as somatic, brain changes. In addition to that, unresolved hostilities lead to a spiral of violence which might be repeated in future generations through a mechanism of transgenerational transmission of trauma and a compulsive repetition of violence and aggression. Acting against mass violence might prevent this spiral which is endangering mankind as a whole. Mental health professionals should raise their voice against mass violence and put their effort to prevent the causes of mass violence instead of only dealing with prevention of their psychosocial consequences.

References:

1. Lecic-Tosevski D, Draganic-Gajic S. The Serbian experience, in *Disasters and Mental Health*. Edited by Lopez-Ibor JJ, Christodoulou G, Maj M, Sartorius N, Okasha A. John Wiley & Sons, 2004.
2. Murthy RS. Mass violence and mental health – recent epidemiological findings. *Int J Psychiatry* 2007; 9(3):183-192.

RTI.4 DISASTERS IN ASIA

J. K. Trivedi & Adarsh Tripathi
Department of Psychiatry, C.S.M. Medical University, U.P., Lucknow, India

Disaster is severe disruption of ecological and psycho-social situation which greatly exceeds the coping capacity of the affected community (WHO, 1992). A variety of psychological, physiological, behavioral, and community responses encountered in the aftermath of a disaster. Survivors of the disaster have psychological manifestations in the form of different psychiatric disorders eg. acute stress disorder, PTSD, bereavement and grief, anxiety disorders, depression and somatoform disorder, alcohol and drug abuse or dependence, and exacerbation of preexisting psychiatric disorder. The growing numbers of refugees increase in the manmade disasters and the natural disasters make planned interventions for survivors and sufferers an urgent need.

Asia is a highly susceptible area and frequent victim of disasters. Almost half of the world's population lives in this geographical region. It has a vast population vulnerable to risk in terms of sudden fluctuations in markets and natural shocks in terms of weather. It also has high disparity in income, health, education and includes developing countries like India, Bangladesh and Srilanka to developed countries like Japan. Poor infrastructure, adverse economic conditions and tough geographical terrain in most regions add on to the existing problems. The level of preparedness and availability of the resources might vary from country to country. Therefore, we have a multi-hazard risk profile. Fewer numbers of mental health professionals, poor availability of the auxiliary staff and meager support from governmental organization in most of the areas adds to the misery. In this talk special issue regarding disasters in Asia will be discussed.

Reference:

- World Health Organization. (1992) *Psychosocial Consequences of Disasters*

RTI.5

TIME TO TAKE A STANCE: THE GAZA EXPERIENCE

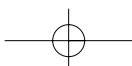
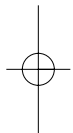
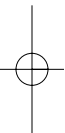
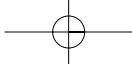
Mohammed T Abou-Saleh
St George's, University of London, UK.

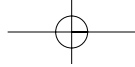
In recent decades, the Middle East has witnessed numerous armed conflicts including recent ones in Iraq, Lebanon, the Sudan and Gaza. However the Gaza disaster stands out for the scale of its excesses and its context such that it may be a turning point in history for mobilizing civil society including professional organizations to take a stance.

The Gaza Strip, the most densely populated area in the world with 1.5 million people living in an area 41km long and between 6 and 12 km wide, with a total area of 360 sq.km was subjected to 22 days of constant air, sea and ground attacks by the Israeli army (IDF) resulting in the death of 1400 Palestinians, a third of whom were children and 5600 injured and widespread destruction of the Strip's infrastructure including hospitals, schools and other civilian facilities. This disaster has occurred against the background of the blockade of Gaza since June 2007 causing severe food, energy and health insecurity and shortages. Jimmy Carter in a Comment in the *Lancet* (March 7, 2009) wrote "The Gazan health-care system is severely damaged, overstretched, demoralised, and short on essential supplies. Skilled health personnel are scarce, and those that are available often are encumbered by inefficiencies and danger from military attack. 1 500 000 people are imprisoned in Gaza, with no access to the air or sea and extremely limited – mostly non-existent – opportunities to enter or leave through land portals". Moreover, evidence from the UN, human rights organizations, medical charities and the international media indicates Israeli breaches of international humanitarian law and the Geneva Conventions on Human Rights suggesting war crimes against the unarmed civilian population of Gaza.

The recent *Lancet* Series on Palestinian health (March 7, 2009) was launched " to change the way health professionals, politicians, policy makers, media, and the public view, think about, and discuss the predicament facing this region of the Middle East.... Our ultimate hope is that this Series could contribute to a mass international social movement for peace and justice through health in, and with the people of, the occupied Palestinian land. Justice in this context is about fashioning a fair and sustainable future for the people of Palestine. Health can be a magnetic nucleus to draw together the necessary critical mass of agreement to make this idea more than simply an aspiration".

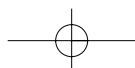
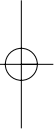
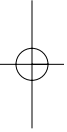
It is time that health professionals, health professional organizations and NGOs concerned with health to take a stance and responsible action as expressed in WFMH Statement on the Mental Health Consequences of War and Civil Conflict, to call " On all nations involved in conflict, and to those contributing aid to support such conflict, to respond specifically to these issues and to consider the serious immediate and long term mental health consequences of continuing armed conflict; and to intervene with respective governments to insist on upholding the Geneva conventions concerned with the health consequences of war".





SYMPOSIA

SI - SX



Friday, September 4, 2009, 08.30-10.00
Hall Galaxy

SYMPOSIUM

S I

Combating Stigma on a Low Budget

S I

OVERALL ABSTRACT

It is now widely accepted that people suffering from mental disorders experience stigma and discrimination, which can seriously hamper their recovery process, including having access to important life opportunities, and social integration.

In recent years, psychiatric stigma became recognised as a global health concern, and several initiatives worldwide have been designed to address some of the issues it involves, such as: conceptualizing stigma and its processes [1, 2]; understanding the factors that produce and sustain such processes [3, 4, 5]; developing instruments to measure the different aspects of mental illness stigma [6,7], and developing and evaluating programmes capable of changing levels of stigma and discrimination [8, 9, 10]. Although many advances were made in the field, there are still many research questions to be answered, and ultimately the great challenge of improving health outcomes and social inclusion by reducing stigma.

However, there is a great disparity between countries in the efforts and investment given to this issue. For example, while in the UK the recently launched 4 year campaign "time to change" involves an investment of £ 18 million, countries like Portugal have only had one nationwide campaign implemented in 2008 by a NGO, with no support from any governmental institution.

In this way, it is important to acknowledge and learn from the many "low budget", "less-known" initiatives to combat stigma, that can also be found worldwide.

This symposium aims to present four successful initiatives developed by NGOs in Brasil, Greece, Malta and Portugal, as they can contribute to the broader discussion about ways of combating psychiatric stigma.

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SI.1 EMPOWERMENT STRATEGIES AGAINST STIGMA OF MENTAL DISORDERS FROM A BRAZILIAN PERSPECTIVE

Cecilia Villares
ABRE, Brasil

The Brazilian Schizophrenia Association (ABRE), established in 2002 in Sao Paulo, Brazil, originated from an anti-stigma project which was part of WPA Global Programme against Stigma and Discrimination Because of Schizophrenia. ABRE was constituted as a nonprofit civil organization co-led by consumers and family members, with the participation of mental health professionals on its Board of Directors. Our goal is to work with the state-of-the-art psychiatric knowledge and practices in actions that bridge science and promotion of human dignity of people affected by schizophrenia, proposing dialogue and empowerment as main strategies for social change.

Brazil is a country marked by important social inequalities, and many people with schizophrenia have their condition greatly aggravated by poverty, poor education, and social exclusion. Changing this reality requires a complex and sustained set of networking strategies. In such context, what would be the meaning of "empowerment" for those engaged in our anti-stigma actions? We envision this change as a result of developing less constrained discourses, practices and perspectives for people with mental disorders and their relatives, empowering and legitimating them in social positions other than marginal places and roles.

This presentation will address some key cultural aspects of the empowerment strategies employed in such a context of action, to discuss the meanings and possibilities of including people with mental illness and their family members as stakeholders to design and deliver messages of hope to their peers and support them to overcome stigma and reach out for help, treatment and involvement in community. The presentation will describe two lines of action - Information and Communication Strategies and Educational Initiatives - in which the Brazilian project devised successful creative low-budget actions that can act as case examples to inspire similar initiatives in other countries.

SI.2 THE PORTUGUESE "UNITED TO HELP" MOVEMENT TO COMBAT STIGMA AND DISCRIMINATION AGAINST MENTAL ILLNESS

Filipa Palha, Luisa Campos
ENCONTRARSE, Portugal

With this presentation we aim to present the "United to Help" Movement developed by "ENCONTRAR+SE", a Portuguese NGO which aims to advocate for better mental health services in Portugal, and is committed to develop initiatives to fight stigma and discrimination of people with mental disorders, an area never considered in a proper and continuous way.

The United to help movement is the 2nd phase of an anti-stigma campaign ENCONTRAR+SE has launched on 10th October 2007, which had the main purpose of exposing the general public to a theme that is not talked about (mental illnesses); to highlight some of the stereotypes and myths that result in stigma and

discrimination in order to help people start questioning them. This campaign used music to convey the messages, and ENCONTRAR+SE was granted the generous and magnificent support of some of the most famous musicians of Portugal that associated themselves to the campaign against discrimination in the field of mental disease. These musicians have translated the causes we defend into poetic lyrics and sounds: the causes of a society that protects and cares for the more fragile individuals. Each song represents a thematic polarity and it is important to turn it into an action: to pass from negative to positive, growing together within a community. The campaign lasted for 12 months, and was developed in two different phases. By the end of the campaign, 68,5% % of the Portuguese population + 15 years of age had been exposed to the campaign at least once; 90435 visits to the website; participation in 12 radio programmes and 6 TV programmes; the campaign was the theme of several magazine editorials and was used in schools and other initiative involved different populations.

SI.3 COMBATING STIGMA ON A LOW BUDGET

Saliba Holger
Richmond Foundation, Malta

Stigma is a pervasive reality around mental health and illness. It affects, service users, related services, professionals and organizations working in the field.

In spite of the stringent resources, financial and human, Richmond Foundation, an NGO, has been a catalyst and a leading organization which has effectively combated stigma on a very low budget.

Believing and adopting an approach that is more open towards the service users does not cost money. Though the Foundation's activities are planned and coordinated, it has worked in the absence of a national strategic plan in combating stigma. The interventive aspects and the preventive aspects in dealing with stigma on a low budget took form on four levels, namely (1) Microlevel, (2) Mesolevel, (3) Exolevel, and (4) Macrolevel.

- Microlevel – empowering and training various service users to share their experiences in public through media and encourage others to do the same.
- Mesolevel – working with family members and encouraging carers to share their experiences with other families and the general public as well. Schools and employing organisations should be addressed as well.
- Exolevel – Mainstreaming of mental health and illness in all social, economic and cultural fields to enhance an integrated and a holistic approach in policy making and service delivery.
- Macrolevel – The general public has been targeted through the media though as research has shown, campaigns targeting specific groups can be more effective.

Stigma is an abstract concept and cannot be determined and measured unless through properly and scientific research, which though desirable is very costly. Nevertheless, generally it is noted that the Maltese society, nowadays, is more likely to include and accept persons with mental health difficulties than it used to a decade ago.

SI.4**OPEN-MINDNESS CAN OPEN THE DOORS: LOW BUDGET
ANTI-STIGMA INITIATIVES IN GREECE**

Marina Economou
EPIPSI, Athens, Greece

The Greek "anti-stigma" Programme run by the University Mental Health Research Institute has been participating in the "Open the Doors" global endeavour of the World Psychiatric Association to fight stigma and discrimination because of schizophrenia since 2000. Throughout these years, the primary aim of the project has been twofold, to raise community awareness about mental illness and to improve the attitudes towards the people who suffer from it. A multitude of activities have been undertaken, which were all driven by research experience. As the programme faced certain financial difficulties, it had to rely on team spirit, fresh ideas and networking to secure resources. Specifically, two were the courses of action: one was centred on volunteers and the other one on establishing good relationships with important stakeholders and media professionals. Concerning the volunteering aspect, psychology postgraduate students were educated and trained with regard to stigma theories and anti-stigma initiatives and interventions. In their turn, these volunteers were the ones who delivered educational anti-stigma interventions at schools. As far as networking is concerned, the program tried to come at the forefront of attention. It organized cultural events which aimed at fundraising as well as at raising public awareness about the stigma surrounding mental illness and the role of the anti-stigma programme. Concomitantly, many media workers were approached to get acquainted with and present the programme's initiatives. Gradually the relationships were cemented to the extent that media professionals are often using the anti-stigma programme as a reference point when they need to cover stories pertinent to mental illness.

This presentation will delineate the activities and strategies employed with emphasis on volunteering and networking. It will argue that often the best strategy to break resistances is to be open-minded. By being comprised of open-minded people, the programme relayed its open-mindedness and managed to empower volunteers, media workers and stakeholders.

Friday, September 4, 2009, 10.30-12.00

Hall Hesperides**SYMPOSIUM****S II****Ethical Issues in Medicine and Psychiatry***Organized by the European division of the Royal College of Psychiatrists**Chairs: George N. Christodoulou, George Ikkos***SII.1****ETHICS OF MEDICAL AND PSYCHIATRIC RESEARCH: THE HELSINKI DECLARATION**

G.N. Christodoulou

*World Federation for Mental Health**Hellenic Psychiatric Association**Hellenic Center for Mental Health and Research*

The statement of ethical principles for guidance of physicians in research involving human beings (Declaration of Helsinki, revised 2008) is discussed.

The 2008 revision was carried out following broad consultation and consensus and, for the first time, the Ethics Committee of the World Psychiatric Association was asked to contribute.

The most important principle of the Declaration is probably the statement that the well-being of the individual must take precedence over all other interests. Protection of vulnerable potential research "subjects", care for privacy and confidentiality and approval of every research project by an ethics committee are also important points as well as obligation of the research team to publish (or make public) not only the positive but also the negative findings of their research.

Reference

The Declaration of Helsinki of the World Medical Association (2008 revision) WMA website (www.wma.net/e/)

discourse and legitimation. It is supported by legislation, professional standards, material and human resources and enforced through professional governance, professional regulation and the courts. Politicians have an important role in negotiating and supporting professionalism.

The professional principles of medicine have been defined as giving primacy to patients' welfare, patients' autonomy and social justice. The professional responsibilities in medicine have been defined as commitments which include professional competence, patients' confidentiality, maintaining appropriate relationships with patients and maintaining trust by managing conflicts of interest: integrity, compassion and excellence, wider team partnership, improving quality of care, improving access to care, just distribution of finite resources, scientific knowledge and training the next generation, leadership, facilitating multidisciplinary work and taking ultimate responsibility for patient care.

The professional roots of psychiatry lie in the 19th century in Europe. Communities and politicians have played a fundamental role in the establishment of the profession. Since the latter part of the 19th century service users and carers have had a voice in influencing professionalism and this has become particularly strong in recent years. Sister professions have also been gaining a stronger voice, some times, like service users and carers, challenging psychiatry. With increasing use of multidisciplinary teams in psychiatry clarity about issues raised and commitment to goals, supported by mutually shared ethics is becoming increasingly important"

SII.2**PROFESSIONALISM AND ETHICS IN PSYCHIATRY**

George Ikkos

Royal College of Psychiatrists

"Professionalism implies a contract between the medical profession and society. Public trust is the cornerstone of professionalism in medicine. This is particularly so in psychiatry where concerns about patient welfare are complimented by concerns about public safety. The contract is underpinned by private ethics and public morality and is arrived at through public

SII.3**ETHICS AND COMPULSORY ADMISSIONS**

A. Douzenis

*Athens University Medical School, 2nd Psychiatry Department
Attikon Hospital*

Compulsory admission and treatment against the wishes of a patient are central issues in the care of mentally ill patients. Psychiatry is the only medical discipline that can treat patients

against their will. Restriction of liberty in order to protect the health of the suffering individual, or the lives of others, raises important ethical dilemmas for the psychiatrist.

Aim: To describe the ethical dilemmas and everyday difficulties faced by clinicians and what is considered to be the best practice in this area.

Results: Compulsory admission is central in general psychiatry practice. Deciding on the need to restrict one person's liberty should be done after considering all the alternative non restrictive options and respecting the liberties. Case examples of best practice are described.

SII.4

ETHICAL ISSUES IN TELECOMMUNICATIONS

M. Margariti

First Psychiatric Department of Athens University, Eginition Hospital, Athens, Greece

In Medical practice, the principles that have been developed to protect sensitive patient data, apply regardless of the medium used - paper, video, computers or other media. New technologies, through the advantages they bring, have vastly and rapidly invaded everyday medical practice, promising convenience, flexibility, new opportunities in communication and sharing of knowledge. However, as they expanded, they caused major concerns about patient privacy and confidentiality.

Unlike traditional practices, new technologies usually involve technicians, computer programmers, and personnel not familiar with sensitive issues like medical confidentiality. Therefore, establishing guidelines and securing the ethical use of electronic media in medical practice has become a major issue, while establishing secure organizational frameworks for access and use of patient information such as electronic records is a vital priority for the medical community. In this discussion, we will comment on doctors' responsibility to educate the community on confidentiality and ensuring the security of patient information.

with poor infrastructure and funding for mental health services and few professional human resources.

Regrettably the national psychiatric associations in countries where unmodified ECT is still in use have not provided guidance on its use. The WPA as a global professional association and following a recent WPA international congress in Istanbul has requested a position statement on the use, safety and ethics of unmodified ECT. This position statement was prepared by the WPA Section on Biological Psychiatry and approved by the WPA Standing Committee on Ethics. The statement makes recommendations including the following guidance: In settings where the current choice in the field is unmodified ECT or no ECT, to make decisions on the basis of the clinical condition of the patient, current evidence - based information, the informed consent of patient and relatives and the consideration of possible equally effective alternative treatments.

SII.5

THE WPA POSITION STATEMENT ON THE ETHICS OF THE USE OF UNMODIFIED ELECTROCONVULSIVE THERAPY

Mohammed T Abou-Saleh¹, George Christodoulou²

1. St George's, University of London, UK.

2. World Federation for Mental Health

Hellenic Psychiatric Association

Hellenic Center for Mental Health and Research

Whilst unmodified ECT is as effective as modified ECT (administered with an anaesthetic and a muscle relaxant), it is associated with significant risk and adverse effects (fractures and dislocation), which do not occur with modified ECT. This has rendered the use of unmodified ECT more controversial than modified ECT and raised ethical concerns over its continued use. Recent reviews of the practice of ECT has indicated that unmodified ECT is still in use in countries like Japan, the Russian Federation, India, Thailand, Turkey and most probably in many developing and low income countries

Friday, September 4, 2009, 10.30-12.00

Hall Galaxy**SYMPOSIUM****S III****WPA Section Symposium****Literature, a Link Between Mental Health and Psychiatry***Chair: Yves Thoret***S III****OVERALL ABSTRACT**

Bibliotherapy is a new approach of psychic suffering. The therapist uses the mediation of chosen texts of literature ; Pierluigi DIOTAIUTI and Rosella TOMASSONI (Univ. of Cassino, Italy) will analyze how the client may find a metaphorical image of his inner conflicts in reading texts, chosen by the therapist in accordance with his most personal pattern of anxieties, fears, aspirations and joys.

As an homage to Greek Tragedy, Antonio FUSCO and Eugenia TREGLIA will analyze the character of Medea in the Euripides' play. They will dismiss the hypothesis of a psychotic state when she commits infanticide. They will propose a psychopathological analysis of her negative narcissism in a traumatic context of acute jealousy, leading her to privilege shizoid revenge to motherhood.

If we can consider the madness of King Lear in Shakespeare's play as a typical case of psychosis, Yves THORET (L'Evolution psychiatrique, France) will examine this play with the brilliant interpretation of Stanley Cavell as « the disowning knowledge » of love relationship by Lear and the other characters of this play.

Concluding the symposium, Ahmad MOHIT, chair of the section, (Cairo, Egypt), will explain how looking at the attitudes towards mental patients through the mirror of literature may be quite relevant in psychiatry as in the field of mental health.

We suggest to ask Vanlentine ANASTASIA-RIGAS (Univ. of Crete) , psychodramatist, to be discussant of the symposium.

SIII.1**SELECTING LITERATURE FOR A BIBLIOTHERAPY INTERVENTION**

Pierluigi Diotaiuti, Rosella Tomassoni

Human and Social Sciences Department, University of Cassino, Italy

Books may offer solutions to certain problems or even present the solution that could lessen a person's inner turmoil and thus break many attitudinal barriers to learning. Reading about a situation has the potential to sharpen perception while deepening understanding. Any intervention using bibliotherapy couldn't overcome the work of select reading material according to the reading level of the client. It should be noted that this does not always correlate with age. The language and vocabulary of the text must be easily understood by the reader in order to be effective. If the reading level is too low, the client may get bored or lose focus. If it is too difficult, the client may become discouraged and be more likely to give up in the early stages of bibliotherapy. Since the reading of the book should be of a voluntary nature, taking the idea of reading level and age into consideration is imperative. In selecting literature, it is also critical to look for books that would be considered quality-reading material. In many cases, however, different therapists may define quality in a number of different ways. Most of the literature in regards to book selection focus on a few similar threads in this regard. The way the problem is dealt with in the book must not be overly simple or easily solved. Such simple solutions could lead to disappointment in the client if their problems are not solved as easily as the characters in the novel. The other side of this issue is that the books should not have characters dealing with a number of problems. This could prove to be overpowering to the client emotionally and make solutions to his or her problems seem unreachable. In summary, books need to be believable in terms of characters, plot, and the particular issue or disorder being represented in the book. Though there are many resources in regards to the selection of books, it is imperative that the therapist or counselor be familiar with the book, its themes, and other central ideas when deciding if a text would be beneficial to use in a bibliotherapy setting. The therapist would want to develop his or her own criteria for the selection of texts. Clearly,

the therapist should also be comfortable with the text, and have read it numerous times before sharing it with a client. The ultimate goal in regards to book selection is fitting the right book to the individual child or adult's anxieties, fears, aspirations and joys. The present contribution discuss critically a few examples of application schemas.

SIII.2

NARCISSISM, JEALOUSY IN A STATE OF MENTAL HEALTH OR PSYCHOSIS IN "MEDEA" BY EURIPIDES?

Antonio Fusco, Eugenia Treglia
*Human and Social Sciences Department, University of
Cassino, Italy*

This study aims to investigate whether Medea when she kill her children is in a state of extreme aggression excluding her Ego when she kills her children or whether she has lost all mental faculties and acts in a state of transient psychosis. In the Greek tragedy, the Baccantes, for example, Agave kills her son in a state of serious psychotic state, but the psychological dynamics of Medea in the acting of committing the infanticide seems to be really different. The character isn't a Greek magician and therefore we believe that the narcissistic dimension is an essential factor increasing her jealousy, in the sense that the sun god's nephew can not bear the insult provoked by the wedding between Jason and Glauche. In our opinion the most interesting psychological theme of the tragedy is the question whether there is a momentary absence of the Ego or if the Ego itself, being a slave itself of the aggressive impulse, is also able to handle the tragic moment of infanticide. We have to remember as Leskj correctly states that the mental dimension of Medea changes four times and only after a lacerating struggle between the maternal Eros and the narcissistic one, the latter manages to triumph. From a psychopathological point of view we could not recognize a real psychotic state of mind in the psychiatric sense of the term. But if there is a moment where we can find a still conflicting mental antithesis, a destructive dialectic of a specific psychic energy, the schizoid, this is the particular state of mind of the dying mother and the triumphing woman. Medea is in control of her mind after the time of the tragedy; this is proved by the fact that instead of choosing suicide, she prefers self punishment lucidly as resolutely as a titan could choose for himself, and that is a life in exile in an unfamiliar city where she will always be scourged by the memory of the aspect and the smile of her children, in a painful darkness that even the sun, her relative, can't penetrate. But this is the proof that the Ego is in control of the mind, the mental dimension of which can be considered traumatic and painful, but not psychotic.

SIII.3

AVOIDANCE OF RECOGNITION IN SHAKESPEARE'S KING LEAR

Yves Thoret
*French Society L'Evolution psychiatrique, WPA Section
Literature and Mental Health*

Between the abdication scene of King Lear and the final recognition of his love for his daughter Cordelia, during the acts III and IV, Lear is wandering out of social life, with other outcast

characters, all victims of ingratitude and cruelty of their family and court. We shall try to interpret this dramatic situation with a main reference to the analysis proposed by Stanley Cavell, «The Avoidance of Love : a reading of *King Lear* »(1966-7). For this philosopher and critic, Shakespeare shows how the characters of this play do not accept to express and assume their love relationship with other human beings, especially Lear himself. Their resistance against strong affects, leads them to a collective madness and self destruction. In this tragedy, the process of recognition (*Anagnorisis*) described by Aristotle in *the Poetics*, is refused, repressed, bannished, deferred, disowned. The characters of this play do not accept the reciprocity of their affective links and they miss all opportunities of happiness. We may take this example to explore clinical manifestations of such a defensive annihilation of affects by a person.

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Friday, September 4, 2009, 10.30-12.00
Hall Santorini 4+5+6

SYMPOSIUM

S IV

The Global Mental Health Assessment Tool- GMHAT/PC and its applications in primary care, general health and other settings

Chairs: Vimal Kumar Sharma (U.K), John Copeland (U.K)

S IV.1

THE GMHAT/PC DEVELOPMENT, RELIABILITY AND VALIDITY

Vimal Kumar Sharma

The GMHAT/PC A, computer assisted interview has been developed to assist general practitioners and other health professionals to make a quick, convenient, and comprehensive, standardised mental health assessment. A health professional by using GMHAT/PC, in about fifteen minutes, covers worries; anxiety and panic attacks; concentration; depressed mood, including suicidal risk; sleep; appetite; eating disorders; hypochondriasis; obsessions and compulsions; phobia; mania/hypomania; psychotic symptoms; disorientation; memory impairment; alcohol misuse; drug misuse; personality problems and stressors. It has proved to be a reliable and valid tool in various studies (sensitivity 0.84, specificity 0.92; Sharma et al 2004, 2008). Its use by other health professionals may help in detecting and managing mental disorders in primary care and general health settings more effectively. So far, this has been translated in to Spanish, Netherlands, German, Chinese, Arabic and Hindi. The results of cross cultural studies are very encouraging and will be presented in the symposium. The GMHAT/PC has also been used in the general health setting including in elderly population with promising findings.

S IV.2

CAN GMHAT/PC ASSIST IN MEETING CHALLENGES OF PROVIDING MENTAL HEALTH CARE IN LOW TO MIDDLE INCOME COUNTRIES?

John Copeland

U.K.

Mental health problems are one of the leading causes of disability in the world .It takes about six years to train a doctor and further three years to train as a psychiatrist. The low and middle income countries therefore have few doctors and fewer psychiatrists, because of the high cost of medical education. A high proportion of them emigrate to high income countries. In

a number of African countries there are no psychiatrists and in some only one or two. There is no foreseeable answer to this problem. As a result many thousands of mentally ill people remain untreated, unable to work and in poverty or in mental institutions. Early and accurate detection of mental health problems followed by an appropriate treatment and management plan would help to reduce the global burden on health and social care systems caused by mental disorders. We have developed with primary care workers and those from low and middle income countries a computer assisted package the Global Mental health Assessment Tool (GMHAT/PC) already translated in to a number of basic languages of low and middle income countries. The package is an innovative way to address this problem. This method aims to improve the recognition of mental illness in primary care and initiation of appropriate treatments by skilling primary care workers. A version for secondary care is now being tested which provides a differential diagnosis and more detailed assessment suitable for nurses where there is no psychiatrist.

S IV.3

USE OF GMHAT/PC IN GENERAL HEALTH SETTINGS

Peter Lepping

U.K.

The prevalence of depression in cardiac diseases has been estimated at around 15% (Ginzburg, 2006; Faller 2007). The twelve month prevalence and odds of major depression are high in individuals with chronic medical conditions such as coronary artery disease, congestive heart failure and CVA, and major depression is associated with significant increases in utilisation, lost productivity and functional disability (Egede, 2007). We used GMHAT/PC in assessing mental health morbidity in the cardiac rehabilitation patients in North Wales. Patients were primarily post-myocardial infarction but also post-angioplasty or valve replacement surgery. They also include a small number of patients with heart failure. Of 106 patients interviewed, nearly a quarter of them had significant mental health morbidity. The distribution of mental illness in

this group of patients will be presented.

S IV.5

USE OF GMHAT/PC IN ELDERLY POPULATION

Murali Krishna

Objectives: A computer assisted interview, the GMHAT/PC has been developed to assist health professionals to make a quick, convenient and comprehensive standardised mental health assessment followed by management guidelines. It has been proved as a reliable and valid tool in our previous study in the working age population. Little is known about its use in older people. The main aim of this study was to assess the validity and feasibility of Global Mental Health Assessment Tool – Primary care version (GMHAT/PC) in this age group.

Methods: Design: cross sectional validation and feasibility study. A total of 169 patients aged 60 years and above were assessed by nurses and psychiatrists in various settings: cardiac rehabilitation centre (n = 73), and community mental health clinic (n = 67) and Psychiatric day hospital for older people, (n = 29). The kappa coefficient (κ), sensitivity, and specificity of the GMHAT/PC diagnosis were measures of validity and the time taken for the interview, and feedback from patients and interviewers were indicators of feasibility.

Results: Mean duration of interview was under 14 minutes. The agreement between GMHAT/PC interview-based diagnosis and consultant psychiatrists' International Classification of Diseases (ICD)-10 criteria-based clinical diagnosis was good ($\kappa = 0.69$, sensitivity = 0.74, specificity = 0.97). Feedback from patients and interviewers indicated good practical feasibility.

Conclusions: The GMHAT/PC can help make accurate mental health assessment and diagnosis in older people in various healthcare settings and it is acceptable to patients and clinicians.

Friday, September 4, 2009, 13.30-15.00

Hall Thalia 2**SYMPOSIUM****S V****Hellenic Center for Mental Health & Research (HCMHR): Activities related to Educational and Socioeconomic Integration of Professionals and Users of the Mental Health Services***Chair: Maria Kokkossi***S V****OVERALL ABSTRACT**

HCMHR is the largest non-hospital-affiliated agency in Greece which is active in the community with regard to clinical, educational, and research matters. It has a long tradition of educating professionals in the mental health sector, as well as special population groups. Its output includes the establishment of one of the oldest schools for mentally retarded children in Greece and the oldest Specialized Therapeutic Unit offering education to children with autistic problems. In the last 25 years *HCMHR* operates Services of Professional Education and Rehabilitation for persons with mental health problems who live in the community and from 2000 operates a certified Vocational Training Center.

The purpose of the present round table is:

- to describe the educational actions that were realized in the bosom of the certified Vocational Training Center (VTC) and the Specialized Vocational Training Center (SVTC) of *HCMHR* for professionals of mental health throughout Greece, as well as for the users of the mental health services
- to present the expected results such actions had on the trainees
- to emphasize the necessity for education, and in fact for lifelong learning

SV.1**DESCRIPTION AND PRIMARY EVALUATION REGARDING EDUCATIONAL AND SOCIOECONOMIC INTEGRATION ACTIONS FOR PERSONS WITH MENTAL HEALTH PROBLEMS****Timoleon Gonis***Vocational Training Coordinator, HCMHR*

Presentation of the business and organizational framework within which the actions regarding the education and social integration of vulnerable population groups is undertaken, with

particular emphasis on the persons with mental health problems. Analysis of the framework of the realization of said actions with the assistance of the European Social Fund of the EU and presentation of qualitative and quantitative data for the actions realized in the course of the previous years. Additionally, description of the planning of actions for the next programmed period as well as examples of best practices.

SV.2**COMPLETE INTERVENTIONS FOR PERSONS WITH MENTAL HEALTH PROBLEMS WHO LIVE IN THE COMMUNITY**

M. Potamianou, K. Athanasopoulou

Vocational Training Center Patras, HCMHR

Six educational programs with parallel psychosocial support (hence "complete") of persons with mental health problems who live in the community will be presented. 89 persons with mental health problems have participated in these programs. The above mentioned programs were realized in Athens and Patras (the Peloponese) in the years 2007 and 2008.

SV.3**TRAINING OF MENTAL HEALTH PROFESSIONALS DURING THE YEARS 2002-2008**

Janis Keramaris

Vocational Training Center, Patras, HCMHR

Extensive references will be made to the scope, type, and content of the programs of training adult professionals in mental health carried out by VTC from 2002 to 2008. These programs regarded:

- the training of existing social welfare carriers for the operation of modern structures and programs of social care

- the training of unemployed social scientists
- the training of the recently employed staff to positions related to the "Psychargos" Program
- the training of those already working in the above mentioned carriers, who were trained in the operation of new, contemporary structures and the new techniques of intervention in the domain of mental health

SV.4
EUROPEAN PROGRAMS OF LIFELONG LEARNING: THE
PARTICIPATION OF HCMHR IN THE GRUNDTVIG PROGRAM
FOR THE ELDERLY

S. Portinou

Vocational Training Center Patras, HCMHR

For the first time HCMHR participated in a life long learning program, the Socrates-Grundtvig lifelong learning program, and it collaborated with 4 University agents from 3 European countries. This joint effort aimed at preparing a program for training the elderly in matters of new technologies as well as other matters which the elderly themselves had chosen as being of interest to them. The presentation will include the methodology of this joint effort as well as the final program set forth.

Friday, September 4, 2009, 15.30-17.00

Hall Thalia 1**SYMPOSIUM****S VI****The Kaleidoscopic Image of Schizophrenia***Chair: Konstantinos N. Fountoulakis***SVI.1****THE NEUROCOGNITIVE DEFICIT IN SCHIZOPHRENIA:
PRACTICAL WAYS OF ASSESSMENT**

Konstantinos N. Fountoulakis

*3rd Dept of Psychiatry, School of Medicine, Aristotle University
of Thessaloniki*

Neurocognitive impairment has always been regarded as an important characteristic of schizophrenia, however it's only recently that neurocognitive dysfunction has been recognized as a primary and enduring core deficit in schizophrenia in contrast to the previous focus on positive and negative symptoms. Many domains of cognition are disrupted with varying degrees of deficit including attention, executive functions, verbal and visuospatial working memory, learning and memory. The greater obstacle in the study of this deficit is the need to apply complex, expensive and sophisticated neuropsychological methods which are not always available in all settings. Thus, the need for a simple paper and pencil test is great.

In this frame, use of simple tests like the graphic version of the Alternating Sequence Test (introduced by Luria), the copy of the pentagon task (part of the Bender-Gestalt test and Mini Mental State Examination (MMSE), the copy of the a Necker Cube Task and the clock drawing test could be of significant help, providing their scoring is sufficiently reliable, valid and allows a sensitive assessment of fine neurocognitive function. We describe the development of a new short easy to administer paper and pencil neuropsychological battery, tailored to the need of the neurocognitive assessment of psychotic patients on the basis of normative data from healthy volunteers. This battery, based on novel scoring methods of classical and well known tests is reliable, valid and sensitive to change in response to treatment. Further research is needed in order to test its usefulness as neuropsychological tests in psychiatric population.

SVI.2**IS THERE AN INCREASED RATE OF CARDIOVASCULAR RISK
FACTORS AND ESPECIALLY OF THE METABOLIC
SYNDROME AND SMOKING IN SCHIZOPHRENIA?**

Stavros Samolis

Dept of Psychiatry, Ippokration Hospital, Thessaloniki, Greece

The improvement of antipsychotic therapy over the last fifty years led to a revolution in the outcome of psychosis by reducing the desperate outcome to a tiny proportion of that the natural course of the illness would have had caused. However, the life expectancy of psychotic patients is at least 20 years shorter in comparison to the general population, and this is mainly due to a failure to follow the increase of the general population life expectancy. This failure is generally attributed to suicide and cardiovascular disease and second generation antipsychotics are considered to somewhat contribute to this increased morbidity. Research data indicate that the metabolic syndrome and some other cardiovascular risk factors including smoking are more prevalent in patients with schizophrenia, compared to the general population. The etiology of the development of the metabolic syndrome, although poorly understood, seems to be multifactorial. Second generation antipsychotics, unhealthy lifestyle with poor dietary choices, smoking and physical inactivity as well as a possible genetic vulnerability are considered as contributing causes. Recently several researchers support the idea that schizophrenic patients may be at greater baseline risk for developing the metabolic syndrome; however this remains to be proved. The risk is higher for females. We present the first data concerning Greece from a case-control study, which suggest that the overall picture in Greece is similar to what seen internationally. Treatment decisions should incorporate information about the medical risk factors, while routine monitoring and lifestyle education can be very useful in minimizing the risk.

SVI.3
**QUALITY OF LIFE AND DISABILITY IN PATIENTS WITH
SCHIZOPHRENIA**

Katerina Moutou
Aristotle University of Thessaloniki, Greece

After the important advances in the treatment of people with schizophrenia and the control of positive symptoms, during the past decade there has been an increased interest in the overall disability and its causes, the quality of life (QoL) but also in the subjective wellbeing (SWB) of patients suffering from schizophrenia, which represents a conceptual extension of therapeutic outcome criteria. Disability seems to relate to residual symptoms and especially negative ones, as well as to a sustained neurocognitive deficit. The QoL seems to be correlated with a number of factors, including the illness itself and medication. Although schizophrenia usually leads to impairments in many aspects of life, including physical, neurocognitive, and role functioning, until recently, treatments for schizophrenia have focused mainly on reducing positive symptoms, often neglecting the patients' numerous residual difficulties, including negative symptoms and impairment in cognition, everyday living skills, and social/occupational functioning. The atypical antipsychotics are reported to cause significant improvement in QoL and subjective wellbeing, since they seem to have a positive impact on factors most associated with QoL, however this has not been solidly proven. Both QoL and SWB are strongly related to the patient's willingness to be or stay engaged in psychosocial and pharmacological treatment, and therefore to the symptomatic and functional outcome. QoL is an important parameter in estimating the social and interpersonal impact of psychopathology, clinical course and response to treatment in patients suffering from schizophrenia. Therefore, more integrated treatment strategies, prioritizing the patient's QoL are needed.

SVI.4
**INSIGHT AND ATTITUDES TOWARDS PHARMACEUTICAL
TREATMENT IN PATIENTS WITH SCHIZOPHRENIA**

Eleonora Pantoula
Aristotle University of Thessaloniki, Greece

While the traditional approach to treatment considers the patient to adhere in a more or less passive way to the doctor's instructions, we know today that non-adherence is a prime cause of poor outcome. Usually non-adherence relates to poor insight, that is lack or suboptimal awareness of the disease and its consequences, and the ability of the patient to understand his/her psychopathology. Unfortunately lack of insight is maybe a core symptom of schizophrenia. One way to assess the level of insight in schizophrenia is with the Scale to assess Unawareness of Mental Disorders (SUMD) while the view of the patient towards therapy could be assessed with the use of the Drug Attitude Inventory (DAI). Except from the poor insight, lack of adherence is also attributed to other reasons including the stigma related to schizophrenia, the cultural background of the patient concerning psychotic experiences and mental health, the patient's tolerability towards drugs and a problematic therapeutic alliance between the patient and the therapist. Psychoeducational approaches could play a crucial role in improving this spectrum of problems at least in a group of patients.

Friday, September 4, 2009, 17.00-18.30

Hall Hesperides**SYMPOSIUM****S VII****Supporting Traumatized Population: What, When and How?***Chair: Numan S. Ali***S VII****OVERALL ABSTRACT**

In a war or other disaster situation basic needs such as survival, shelter, medical treatment food and adequate security are priority one for traumatized population , mental health support can be provided after meeting these important needs and may go hand in hand with that.

In this symposium we shall discuss mental health interventions that could be offered to traumatized people, especially the ones that are evidence based, cost effective and can be delivered to groups there will be discussion of the psychodynamic relationship between trauma, attachment and personality development.

The relationship between resilience and trauma, and how could resilience be as protective factor against trauma experiences are going to be discussed.

There will be a systematic review of the effectiveness of written emotional disclosure for post-traumatic stress disorder, depression and anxiety with special reference to its usefulness for adolescent population.

SVII.1**SUPPORTING TRAUMATIZED POPULATIONS: AN OVERVIEW**

Numan S. Ali

Iraqi Psychiatric Association

In a war or other disaster situation basic needs such as survival, shelter, medical treatment, food and adequate security are priority one for traumatized population, mental health support can be provided after meeting these important needs and may go hand in hand with that.

It may well happen that public health services collapse or get disrupted during or immediately after war or during periods of continued violence . this is exactly what happened in Iraq with collapse of health services soon after the war in April 2003 and

the loss of law and order that followed that led to looting of most hospitals including both psychiatric hospitals in Baghdad, where patients were forced to leave the premises to the streets.

Learning from other's experiences we think that the support is offered the better are the results on the long run in terms of reduction of symptoms and social adjustment . we think that it is unethical to just wait for healing to occur by time and not offering any kind of help.

A brief review of the evidence based mental health interventions that could be offered to traumatized population will be discussed.

SVII.2**PSYCHODYNAMIC RELATIONSHIP BETWEEN TRAUMA, ATTACHMENT AND PERSONALITY DEVELOPMENT**

Maria Ammon

*WPA Section "Psychoanalysis in Psychiatry".**German Academy for Psychoanalysis, Berlin*

The paper gives an overview about classic psychoanalytic formulations of psychic trauma and contrasts them with recent contributions from trauma therapy, attachment research, and neurobiology. It focuses especially on Günter Ammon's understanding of early relationship trauma and its consequences for personality development. After reviewing relevant trauma-therapeutic approaches in contemporary psychoanalysis, Ammon's therapeutic concept for patients with early traumatizations is outlined. Finally the realization of this concept in Dynamic Psychiatry is described.

**SVII.3
EVALUATING THE EFFECTIVENESS OF WRITTEN
EMOTIONAL DISCLOSURE FOR POSTTRAUMATIC STRESS
DISORDER, DEPRESSION AND ANXIETY. WILL IT WORK
FOR ADOLESCENTS?**

Tori Schnell
School of Psychology, University of Leicester, UK

A systematic literature review examined whether written emotional disclosure significantly reduced PTSD, depression and anxiety symptoms in experimental conditions when compared to controls. The review summarised existing research on adults with a secondary aim to determine whether studies for adolescents could offer theoretical background for an unpublished intervention designed for war and disaster affected adolescents.

Method: Main electronic databases were systematically searched for articles published using the key words: written emotional disclosure; written narratives and PTSD; expressive writing; Pennebaker paradigm. Articles were examined for inclusion criteria, data extraction and coding procedures identifying 11 studies suitable to the review aims.

Results: Five studies examined all three psychological conditions; two investigated PTSD and Five studies examined all three psychological conditions; two investigated PTSD and depression; a further three were on child/adolescent populations. Three of the five studies on PTSD, depression and anxiety produced significant results though results for all others were mixed and confounded by methodological weaknesses.

Conclusion

Few studies have been conducted on psychological outcomes of the written paradigm, which must be carefully considered since even fewer studies exist on adolescent populations. It is difficult to provide insight for the unpublished intervention though early findings suggest future research is worth pursuing.

long-term effects. For trauma victims' recovery an integrative intervention is indicated: treating the person with a highly individualized, culturally sensitive and contextualized treatment concept including the strengthening of her/his capacity for coping and her/his resilience within the family, social network and community. Interdisciplinary network interventions are necessary.

References:

Harvey MR, Tummala-Nara P (eds.)(2007): Sources and Expressions of Resiliency in Trauma Survivors. Ecological Theory, Multicultural Practice. Haworth, Birmingham, NY.
Amering M, Schmolke M (in press): Recovery and resilience. In: Mezzich JE & Salloum IM (eds.): Psychiatric Diagnosis: Patterns and Prospects. Wiley, Chichester.

**SVII.4
RESILIENCE AS PROTECTIVE FACTOR AGAINST TRAUMA
EXPERIENCES**

Margit Schmolke
German Academy for Psychoanalysis, Munich, Germany

In clinical psychology and psychotherapy, the term "resilience" has been used only in recent years. Here it implies mental and emotional elasticity, the power to resist, and regaining the former mental stability following a stressful period or event. It is the process in which children, adolescents and adults resist against challenges and are able to bounce back or to recover from those stressful conditions.

In this paper, the author discusses some results of international projects on the study of the relationship between resilience and trauma, dealing with clinical and community interventions with the aim of capacity building and strengthening on an individual, family, and social level. A major positive result is that resilience can be promoted, and programs for children in disasters are feasible. Such programs can be adapted to children, adults, service providers, students, and those working with children in disasters. From a psychotherapeutic point of view, we can say that psychological interventions are effective in preventing many

Saturday, September 5, 2009, 08.30-10.00

Hall Hesperides**SYMPOSIUM****S VIII****Person-Centered Sexual Health***Chairs: Juan E. Mezzich, Said Abdel Azim***SVIII.1
CONCEPTUAL BASES OF PERSON-CENTERED SEXUAL
HEALTH**Juan E. Mezzich
New York

Over the past four years a programmatic effort on person-centered psychiatry started within the World Psychiatric Association which more recently has been extended to cover medicine and health care in general in collaboration with the World Medical Association, the World Organization of Family Doctors, the World Association for Sexual Health, the World Federation for Mental Health and several other international medical and health institutions. This programmatic effort seeks to extend the focus of medicine from disease to patient to person. Its key principles include a comprehensive biopsychosocial concept of health, including its ill and positive aspects, as well as promoting the dignity and engaging the protagonic involvement of the person of patients, carers and clinicians. Consistent with these principles a WPA Educational Program on Sexual Health promoted in recent years an integrative person-centered approach to the understanding, diagnosis, and treatment of sexual problems and the enhancement of positive sexual health.

Reference

Mezzich JE, Hernandez-Serrano R (Eds): Psychiatry and Sexual Health: An Integrative Approach. Rowman & Littlewood, New York, 2006.

**SVIII.3
CULTURAL INFLUENCE ON HUMAN SEXUALITY**Said Abdel Azim
WPA Human Sexuality Section

Historical studies proved that sexual activities constituted an important aspect of the lives of our ancestors. From old Egypt,

China, India there were different contribution to the development of our knowledge about human sexuality. Anthropological studies of other nations showed as well other variations in sexual behavior and traditions.

Cultural factors have a potential role regarding epidemiology, nosology, diagnosis and treatment of sexual disorders. These include gender identity disorders, paraphilias, sexual dysfunctions and other related sexual problems.

Going from DSM-IV, ICD-10 towards DSM -V and ICD-11, needs the clarification of the input of the cultural factors on various mental disorders including those of human sexuality and its disorders.

**SVIII.5
PERSON-CENTERED SEXUAL HEALTH PROMOTION**Felipe Navarro-Cremades¹, Jesus Rodriguez-Marin²,
Ruben Hernandez-Serrano³, Juan E. Mezzich⁴,
Jose M. De La Fuentes⁵*1. Dpt. de Medicina Clinica, Facultad de medicina UMH,
Carretera de Valencia, San Juan (Alicante) Spain**2. Universidad Miguel Hernandez. ELCHE, Spain**3. Universidad Central, Caracas**4.. University of New York**5. Hopitaux de Iannemezan, France*

1. As introduction is presented the institutional and legal context, and also the international policy and human rights considerations. In this way we can describe the main declarations of international agencies and organizations, and the related the human and citizens rights

2. Regarding the general sexual health promotion and sexual and reproductive rights, we discuss the next topics: national policies in educational fields (e.g., professional training, primary and secondary school education, sexuality and sexual education in special situations and family and community education)

We present some epidemiologic and public health considerations (: specially risk behaviors associated with stis and aids, and social general problems as violence, poverty and abortion) also focussing the life cycle and sexual health promotion, comunication and sexual health in work place and mass media. moreover are described the general social, cultural and spiritual perspectives principles, and values, as well the cultural and ethnic issues in sexual expression and the topics of gender and diversity.

3. Finally, is presented the promotion of personal sexual health in the clinical setting, specially the significance of the person positive factors, regarding the ethical perspectives within patient-doctor relationship, and the need to be respectful with the principles of patient: (mainly autonomy, beneficence, non maleficence and justice).

As relevant general principles are considered the next:

positive attitudes toward human sexuality, basic sexual information and education, sexual enrichment and health promotion whit special focus on the important of active lisening and relaxation training, the personal responsibility for self and the mutual cooperation with the partner with special emphasis on the essential role of relationship intimacy, realistic sexual expectations (e.g.,: correcting sexual "myths") and enhancing personal and couple competences in communication and cooperation

Are described the next specific personal factors in different fields : lyfestyle, socioeconomic status, well-adapting behavior and sexual adjustment history, to be able to care for his own needs/ requieres support services, lyfe cicle (e.g.,: developmental issues for children, adults and aging), legal and social status, communication style (eucommunicational and dysfunctional patterns in the interpersonal communication), general interaction style, possitive affects and roles

As relevant positive personal areas and issues are included fight managemant, resources, problem solving. sexual, attitudes, principles and values, priorities, self-efficiency management, and the personal way to prevent and resolve crisis, coping ability and stress tolerance. and religion and spiritual concerns.

Saturday, September 5, 2009, 10.30-12.00
Hall Santorini 4+5+6

SYMPOSIUM

S IX

Suicide Prevention Strategies

Chairs: L. Lykouras, V. Kontaxakis

Organization: Section on Preventive Psychiatry, WPA & Section on Preventive Psychiatry, HPA

S IX

OVERALL ABSTRACT

Recent increases in suicide rates in many countries have focused attention on suicide prevention as an important area of public health. According to WHO data around the world, every year, more people die from suicide than from traffic accidents, homicides and wars, together. The recommended strategies for suicide prevention include persons with mental or physical illnesses as well as suicide attempters. It is well documented that psychiatric patients have a much higher suicide risk than the general population. Most people who commit suicide have a psychiatric diagnosis which is the strongest risk factor for suicide behavior. Physical illness that are painful, chronic, incurable or terminal, present also, a high risk for suicide. Patients suffering from cancer and cardiovascular diseases have the greater suicide risk. Among the factors found to predict suicide, a previous suicide attempt is one of the strongest. Hopelessness and suicidal intent of the attempters have been found to predict completed suicide in most studies.

SIX.1

SUICIDE PREVENTION: FOCUS ON PHYSICAL ILLNESSES

V.P Kontaxakis

Athens University, Department of Psychiatry

The presense of painful and incurable physical disorders, usually concurrently with depression, are important risk factors for suicide. Patients suffering from cancer, cardiovascular diseases, multiple sclerosis, epilepsy, cerebrovascular diseases, head injuries, dementia, parkinsonism, AIDS, Cushing's disease, thyreotoxicosis, porphyria have a greater risk for suicide. Risk factors for suicide among physically ill patients include being of an older age, experiencing a chronic, painful or terminal illness, suffering from pro-existing or current depression, having a history of alcohol abuse. It is important, for all physicians, to recognize risk factors for suicide in patients with physical illnesses and to lead early interventions and effective suicide prevention programs.

SIX.2

PREVENTION OF SUICIDE: FOCUS ON MENTAL ILLNESSES

A. Douzenis

Athens University, Department of Psychiatry

Suicide is a major cause of mortality in all countries. Reducing death by suicide is a common and acceptable target for mental health services. Most of the people that commit suicide suffer from a serious mental illness (SMI). The aim of this presentation is to review the existing scientific literature on suicide prevention strategies applied to people with mental illness. Depression is diagnosed in most suicide victims. However, psychotic disorders, addictions and personality disorders also carry an increased risk for suicide. Effective treatment, early detection and support are considered to be the most effective means in the prevention of suicide in mentally ill individuals. There is a great need for innovative methods of psychiatric services delivery in order to achieve the best results.

SIX.3

SUICIDE PREVENTION STRATEGIES: FOCUS ON SUICIDE ATTEMPTS

Paplos K.

«Sotiria» R.G. Hospital, Department of Psychiatry, Athens

Suicide is a leading cause of death worldwide. Despite improvements in mental health care provision, the rates of both completed and attempted suicides have remained largely unchanged. Although individuals with a history of suicide attempt form a high-risk group for suicide, suicide completers have a profile that differs in important ways from that of suicide attempters, making prediction and prevention of suicide, hard. The prevalence and risk factors for the suicide attempts are not well known, especially in developing countries, and moreover, the causative pathways and

relationships, between suicide ideation, suicide attempt and suicide completion are unknown. Although, recent studies suggest that there are marked differences in suicidal behaviour between developed and developing countries, yet, among multiple factors for suicide attempt, the most consistent include age, sex, marital status, mental disorders and previous attempt. In the field of suicide prevention, both high-risk and population-based strategies, provide doubtful evidence for their efficacy mainly due to methodological problems. Monitoring both attempted and completed suicides is essential to the identification of more accurate predictors of suicide, and to the implementation and effectiveness assessment of prevention programs. Optimal prevention programmes should incorporate a broad variety of strategies in a multi-level approach.

Saturday, September 5, 2009, 10.30-12.00 & 13.30-15.00
Hall Thalia 4

SYMPOSIUM

S X

Emilia - Empowerment of Mental Illness Service Users: Lifelong Learning, Integration and Empowerment

Chair: James Ogunleye

S X

OVERALL ABSTRACT

The EMILIA project is a Framework 6 European Union project, funded at €3.4 million over a four and a half year period; it is the European Union largest ever funded research and intervention project on lifelong learning and mental health – with 16 partners in 13 European countries. A central aim of the project is to explore the use of lifelong learning as a means of achieving improved social inclusion of mental health service users with enduring, long-term mental health difficulties. A major innovation – and a unique feature of the EMILIA project – is the use a lifelong learning process to facilitate the social inclusion of mental health service users (which EMILIA work has found to be therapeutically beneficial to, or have aided the recovery process). In EMILIA demonstration sites across Europe, the *EMILIA intervention activity* – lifelong learning training modules – has resulted in increased mental health service user self-confidence in their abilities and capacity to train and to get work and a noticeable and significant shift in learning culture: lifelong learning is valued and accredited; newly acquired skills are recognised and implemented, and the outcomes are evaluated for all participants. The EMILIA project on the whole has succeeded in integrating European policy in the areas of lifelong learning, social inclusion, employment, and information technology. The following presentations highlight some of the significant findings from the project.

SX.1

CULTURAL CONTEXTS OF LIFELONG LEARNING: FACTORS FACILITATING AND IMPEDING THE TAKE-UP OF LIFELONG LEARNING AMONG PEOPLE WITH SEVERE AND ENDURING MENTAL ILLNESS ACROSS EUROPE

James Ogunleye

Middlesex University, UK

Across the European Union region, lifelong learning, continuing

education, and vocational education and training are intertwined and the use of lifelong learning as a tool for achieving social inclusion or widening participation in education, training and employment is emerging (Ogunleye, 2007; Stenfors-Hayes, Griffiths and Ogunleye, 2008). Similarly, work in the EMILIA project has shown that lifelong learning is key to making social inclusion a reality for people with mental health problems – especially those suffering from severe and enduring mental illness. At present, very little empirical work exists nor is emerging at European level on the specific uses of lifelong learning among people suffering from severe and enduring mental illness or the extent to which national/regional culture impact/affect their take-up of lifelong learning courses/training programmes. This presentation highlights key findings from EMILIA research project in eight demonstration sites or case study countries – namely the United Kingdom, France, Norway, Bosnia and Herzegovina, Denmark, Poland, Greece and Spain. The presentation provides new insights into major factors facilitating and impeding the take-up of lifelong learning among people with severe and enduring mental illness across Europe.

SX.2

OBSTACLES AND FACILITATORS IN IMPLEMENTING TRAINING AND EMPLOYMENT PROGRAMMES FOR PEOPLE WITH SERIOUS AND ENDURING MENTAL ILLNESS ACROSS EUROPE: EXAMPLES FROM THE EMILIA PROJECT

T. Greacen, E. Jouet

*Laboratoire de Recherche, Etablissement public de santé
Maison Blanche, Paris, France*

At six key points in implementing lifelong learning projects for people with severe and enduring mental illness (SMI) at 8 European sites, qualitative questionnaires, interviews and user pathway analysis reveal progressively deeper layers of obstacles to accessing and completing training for this

population. On an institutional level, the lack of integrated rehabilitation schemes and the barriers between social and health care systems create multiple problems for users, ranging from contradictory counselling through to difficulties accessing financing to do training. Disabilities allocations, sheltered workshops and other social benefits, including social support and housing, create a sense of security and stability that works against training on the open market or in competitive contexts. Users – and indeed families, carers and often healthcare professionals – fear the economic and psychological consequences of losing current security. Psychosocial obstacles appear at all sites, with discrimination, stigma and internalised stigma playing major roles in accessing real-world training. Finally, on an individual psychological level, the nature and severity of the psychiatric disability can constitute an obstacle in themselves. The paper concludes with a presentation of the *Pathways Readiness Evaluation Tool* (PRET), a checklist instrument designed to assist programme designers in taking into account obstacles and facilitators to accessing lifelong learning and employment and to identify possible pathway strategies, both for the institutions running the programmes and for participants.

SX.3 THE IMPACT OF THE EMILIA PROJECT'S FORMAL LEARNING AND EMPLOYMENT OPPORTUNITIES ON THE SENSE OF COHERENCE AND RECOVERY OF MENTAL HEALTH SERVICE USERS: EXAMINING THE UNDERLYING MECHANISMS

C. Griffiths
Middlesex University, UK

This research is based in the context of the EU's EMILIA project which seeks to increase the social inclusion and empowerment of mental health service users (MHSU) through providing formal learning and employment opportunities. A review of research literature showed that psychosocial educational interventions specifically for mental health service users can bring significant benefits to those experiencing mental health disorders. A combined quantitative and qualitative study was conducted using the SOC-13 sense of coherence measure and interviews/self reports to assess the impact of EMILIA on its participants. Antonovsky's sense of coherence theory relates to the adaptive capacity of humans. Antonovsky (1979; 1987) stated that an individual's sense of coherence strength determines an individual's subjective experience of both physical and mental health. Sense of coherence strength is itself determined by internal and external resources available, ability to deploy these resources in coping with life experiences and the belief that the demands of life are challenges worthy of investment and engagement. Antonovsky's sense of coherence theory was investigated and it was found to be relevant in understanding, coping with and the existence, development and treatment of mental disorder. The quantitative results showed that involvement in the EMILIA project training increased sense of coherence of the participants. This result is a positive indicator of recovery and it provides support for efforts to increase the social inclusion and empowerment of mental health service users through providing formal learning and employment opportunities. The qualitative results highlight the potential mechanisms and processes

involved in strengthening of SOC through the EMILIA experience. The results help demonstrate that EMILIA strengthened MHSUs ability to effectively respond to the needs and demands of their lives. The results reflect EMILIA training participants increased ability to be flexible, to generate alternative solutions and to be self-directed (Antonovsky, 1979).

SX.4 EMPOWERMENT OF MENTAL HEALTH SERVICE USERS – EXPERIENCES FROM EMILIA TRAINING

M. Kaunonen, I. Nieminen
*University of Tampere, Department of Nursing
Science/Pirkanmaa Hospital District, Science Center, Finland*

One conception of lifelong learning is that everyone should have equal and open access to high quality learning opportunities. Learning is not just confined to the classroom, but can be delivered through different means, including the training packages that have been developed by the EMILIA project, and later piloted in eight European demonstration sites. According to the hypotheses, lifelong learning for people with serious and enduring mental illness will: 1) Increase the number of days that people are in employment, 2) Increase the number of days that people are in education or training, and 3) Improve their quality of life. The research design involves the use of semi-structured interviews and self-report questionnaires to explore service user participation in lifelong learning. The service user outcome component evaluates the impact of the EMILIA training in terms of the increase in numbers of employment and measure any increase in quality of life. Data for the study comprises of self-reporting, key users' interviews, SF-36 and CSSR-I instruments, which were collected at baseline and at 10 month follow-up. The findings from baseline indicated that overall mental health service users were positive about their experiences on the EMILIA training. The findings also showed that learning, social integration and being employed were the main expectations of training and being in work or gaining a work experience was seen as an essential part of life or regarded as key to improving mental health. The findings from the 10 months follow-up explain the 'motivating and supportive' impact of the EMILIA training resulting, for example, in the participants gaining new skills and knowledge, and experiencing noticeable improvement in their social life. However, the findings also indicate that overall the participants' employment and financial situation have not significantly improved.

SX.5 EMILIA INTERVENTION AND ITS CREATION OF A USER INVOLVED TRAINING PROGRAMME: INTRODUCING THE NEW ROLE OF EXPERTS BY EXPERIENCE AS A CONTINUATION OF BARCELONA EMILIA DEMONSTRATION SITE

Flores P., Leahy, E., Palomer, E., Domingez, T., Izquierdo, R., Masferrer, C.
Centre Forum, Psychiatric Hospital, Barcelona, Spain

This presentation provides insights into the on-going work in

Barcelona Demonstration Site that seeks to give the EMILIA project continuity and to ensure its legacy. EMILIA intervention has created the empowerment of mental health service users, the recognition of their expertise in the field of mental health and the use of this knowledge to help mental health institutions learn and develop. The Psychiatric Hospital, the case study institution, for example, is now no longer seen as a service provider but as a Learning Organization where all of its members, staff and service users alike, are involved in a process of lifelong learning. 25 mental health service users completed 40 hours of EMILIA training and feel that they now have a lot to offer. These EMILIA trained mental health service users are now inciting the next step of change, creating the role of *Experts by Experience* (EbE), a new professionally recognised working profile within the Psychiatric Hospital. These *Experts by Experience* service users will begin a new phase of training in March 2009 which will consist of 20 hours of theory and 4 hour of work practice within the hospital. The content will focus on three main areas: public relations and people skills, learning more about the workings of the mental health institutions and finally how to help others to work towards empowerment. Having learned how to learn from personal experience during the EMILIA training, the EbE will now learn how to share this experience with other mental health users. On the whole the EbE aims to help other mental health service users to understand better the mental health institution, informing them about hospital layout and procedures; to strengthen the relationship between service users and professionals; and to stimulate relationships between the service user and their social network friends and family.

SX.6

CONCEPTIONS OF EMILIA TRAINING

Bëck Moller¹, K. Nybjerg¹, A. Denmark², I. Dawson²

1. *Department of Education, Psychiatry in Midtjylland Region*

2. *Nordland Hospital, Bodo, Norway*

The EMILIA project training aims to assist the development of new employment opportunities for mental health service users. Eleven EMILIA training programmes have been developed and delivered in various forms in the demonstration sites over the last two years by mental health service users and practitioners in different national and international social, economic and cultural settings. Potential students/trainers may choose between 3 alternatives training pathways: the first is 'EMILIA Education', where students take modules within the areas of life related skills, work related skills and job related skills; the second allows the students/trainers to tailor their own training packages after their own particular needs; the third gives students/trainers access to the original training packages as they were produced. The target group for the EMILIA Training is mental health service users, other social disadvantaged groups and mental health practitioners/psychiatric staff. Our aim has been to create a truly European approach to service user and employer training by offering free access to internet based training packages which trainers can tailor to the service user's particular needs. This presentation presents the final versions of the EMILIA Training pathways following a rigorous evaluation.

SX.7

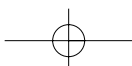
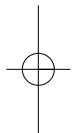
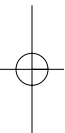
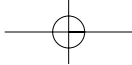
ATTEMPTING TO MAINSTREAM ETHNICITY AND GENDER IN A MULTI COUNTRY EU MENTAL HEALTH AND SOCIAL INCLUSION PROJECT

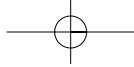
Shulamit R.¹, Urek, M.²

1. *Faculty of Health and Social Care, Anglia Ruskin University, Cambridge, UK*

2. *Faculty of Social Work, University of Ljubljana, Slovenia*

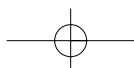
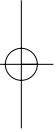
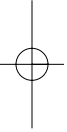
The EMILIA project has a focus on mental health and social inclusion. Eight EMILIA project demonstration sites undertook a baseline audit for staff members and for mental health service users, the findings of which led to specific action plans. This presentation examines the logic, parameters, and methodology of an attempt at mainstreaming ethnicity and gender within EMILIA project demonstration sites. It examines the process of, and outcomes for mainstreaming as well as highlights the impact of country-specific policies on disclosure of information pertaining to ethnicity and gender, practices of recognising inequality and ways of tackling it. This presentation also provides insights into the shared obstacles and opportunities for mainstreaming, issues underlying relevant training, and the role that different service providers can play within a multidisciplinary group and mental health service users in enhancing mainstreaming of ethnicity and gender in the European context.





WORKSHOPS

W I - W VI



Thursday, September 3, 2009, 10.30-11.30

Hall Galaxy

WORKSHOP

W I

Achieving Recovery through a Focus Theory Model

Presenter: Anna Gray

W I

Recovery is the desired outcome of mental health services, yet most find it elusive. By utilizing our Focus Theory Model, people have found recovery and the ability to effectively deal with the stressors of life. This model focuses on that which empowers and is whole; wellness as opposed to illness. There are three areas that contribute towards achieving wellness and reaching full potential:

1. Control - A person's belief that he or she is able to influence the course of events.
2. Purpose - Embracing a focus that incorporates curiosity and sense of meaningfulness for life.
3. Challenge - The individual's expectation that it is normal and beneficial for life to change, and as human beings we have a choice in how we respond to that change.

Recovery begins with a new focus on living powerfully with symptoms and a diagnosis. We will discuss the practical aspects of Focus Theory as demonstrated by the effective results produced by the Prosumer Empowerment Group, and peer provider programs using the theory such as Peer Crisis Navigators and Recovery Navigators. By learning and teaching this model, people develop resiliency in their life as they choose powerfully what to focus on, thus making this intervention both preventative in nature as well as providing recovery tools for those who are still actively showing symptoms. You will learn how to implement this model from the creators, as well as from people who utilize it in their own recovery.

Thursday, September 3, 2009, 13.30-15.00
Hall Santorini 4+5+6

WORKSHOP

W II

Paving the Way: Hiring Consumers and Family Members into the Mental Health Workforce

W II

OVERALL ABSTRACT

How do you achieve transformation of a mental health system? In 2004, California passed the Mental Health Services Act, intended to transform the mental health system to support a recovery-oriented, hope-filled environment that would offer opportunities for consumers to achieve their individual life-long dreams and goals. Hiring consumers to be role-models of recovery and hope is a core strategy in this system transformation. Not only are consumer's lives changed through employment, but their presence on the team transforms the system as well. This workshop will outline the process taken by a public mental health system to hire consumers and family members into the mental health workforce in San Mateo County, California, USA. The workshop highlights the strategies that promoted success in this endeavor, including targeted recruitment, preparation of the workforce, creating a welcoming environment, the development of training materials and post-employment supports. Research providing evidence of the importance of these strategies for success will also be presented. Recent research evaluated employment outcomes of 1200 students with psychiatric disabilities over a seventeen year period. These students participated in a nationally recognized, best practice supported education program at local community colleges.

Participants will have the opportunity to view a twenty-two minute DVD, documenting the process and highlighting the hopeful and inspiring changes that have been made. Featured in this film are consumer and family member employees describing their experience, the impact of this new role on their lives and the impact they have had on the people with whom they are working. Participants will also be given access to the Basic Skills Curriculum Manual used to train entry-level consumer and family employees. The teaching manual covers important topics such as confidentiality, the role of the consumer and family employee, using supervision, boundaries, cultural competence and worldview.

WII.1

Debra Brasher

Ms. Brasher will briefly introduce the Mental Health Services Act and the context in which it emerged. She will review key components important in preparation of the existing workforce: core values, staff concerns, training/supervision needs and general administrative issues. She will introduce the documentary, which chronicles the process that San Mateo underwent to hire consumers and family members on the team. In addition, Ms. Brasher will review the key components of the curriculum developed for the initial training of consumers and family members and highlight key training needs.

WII.2

Chris Coppola

Ms. Coppola will present the change strategy developed by San Mateo County Behavioral Health and Recovery Services. She will outline the core values that supported the initiative. She will identify the barriers and opportunities that existed within the system itself and other governmental bodies. These issues include employment and hiring practices as well as managerial and supervisor buy-in. In addition, she will identify the key elements that furthered implementation, including the committee established to oversee this process: Paving the Way.

WII.3

Terri Byrne

Ms. Byrne will outline the strategies used to successfully recruit consumers and family members. She will discuss specific strategies for recruitment in ethnically diverse communities, building

bridges to unserved and underserved communities. Ms. Byrne will present techniques used to engage and prepare potential new employees. She will outline the training provided to ensure that applicant's had all the tools necessary to successfully apply for and obtain government employment. She will also discuss the importance of partnering with Human Resources/Personnel.

W11.4

Lucinda Dei Rossi

Ms. Dei Rossi is the primary researcher for a study on educational and vocational outcomes for students with psychiatric disabilities participating in a supported education program. The study evaluates the correlation between educational success and employment in the mental health sector. She will also review findings related to barriers to successful employment that clearly indicate the need for a well-thought out hiring plan that includes vital supports for a positive experience.

Friday, September 4, 2009, 08.30-10.00
Hall Santorini 4+5+6

WORKSHOP

W III

Mental Health Care Reform in Central and Eastern Europe: Perception, Finance and Practice

Chair: Neal Adams

W III

OVERALL ABSTRACT

In his forward to *Mental Health Care Reform in the Czech and Slovak Republics: 1989 to the Present* (Scheffler, R.M. and Potucek, M., Karolinum Press, Prague, 2008), Matthijs Muijen of the World Health Organization states: "There is no doubt that mental health care across Europe is in transition...but there is a big gap between intentions and strategies on the one hand and implementation of community based mental health services on the other." Muijen goes on to note that "we are desperately in need of national health services research capacities across the whole of Europe".

This is especially true of the countries of Eastern and Central Europe who are still creating new post-Soviet democracies and looking to the West for full membership and participation in the European Union. These countries face unique and special challenges given the legacy of Soviet psychiatry and the lack of community based infrastructure as well as services research capacity.

Through funding by the National Institutes of Health and the Fogarty International Center, the University of California, Berkeley School of Public Health Program in Health Policy and Management, the Institute of Sociological Studies, the Prague Psychiatric Center, and the Institute of Health Policy and Economics at Charles University in Prague offer advanced multidisciplinary training and education to outstanding clinicians, economists, sociologists, public policy and mental health professionals from Czech and Slovak Republics, Romani, Bulgaria and Croatia interested in developing finance and service delivery research training in mental health issues. The sponsoring Universities are fully committed to producing a new generation of health policy analysts, researchers and faculty who can gain an international perspective through didactic training and collaborative research.

This workshop will provide an overview of the Mental Health and Policy Research Training program and will present three papers describing multinational research projects and initiatives that are part of this overall effort. These selected projects begin to give a picture of the challenges faced in mental health reform in

Eastern/Central Europe as well as the opportunities for success that regional/multinational collaboration and sharing can yield. Not only is the Fogarty program a unique and perhaps model initiative, the findings and experiences of the faculty and trainees may serve as a model for other like efforts around the world.

WIII.1

THE PICTURE OF MENTAL ILLNESS IN THE CZECH, SLOVAK AND CROATIAN PRINTED MEDIA

Nawka, A.¹, Vukusic Rukavina, T.², Andrija Stampar³, Klus, M.⁴

1. Department of Psychiatry, General Teaching Hospital, Prague, Czech Republic

2. School of Medicine, University of Zagreb

School of Public Health,

4. Department of Economical Science, Faculty of Political Sciences and International Affairs, and Designation for Vice Dean for Science, Research and International Affairs, University of Matej Bel in Banska Bystrica

Background: The media are the public's primary sources of information on those with mental illness. Many studies describing print media representations of mental illnesses have showed that these depictions are frequently negative and contribute to consequent stigmatization of people with mental illness. These public perceptions significantly impact the development and implementation of mental health reforms in post-Soviet countries.

Objectives: 1) to develop a coding manual for the analysis of media messages featuring the topic of mental illness, and 2) analyze the content of the media messages about mental illness in terms of stigma in Czech Republic, Slovakia and Croatia.

Methods: Articles containing key words pertaining to the topic of mental illness from 6 most widely read printed daily periodicals and 6 most widely read printed weekly periodicals in each country occurring during 5 separate weeks in 2007

were randomly selected for study. The keywords were chosen to obtain the sample of the articles. Four hundred and fifty (450) articles with mental illness as the main topic and were identified and coded using a coding manual developed by the research team. The coding manual includes both quantitative and qualitative information for the analysis of media messages featuring the topic of mental illness.

Results: Negative global impressions from the text were found in the 37,4% articles from Czech Republic, 38,4% articles from Slovakia and 40,0% articles from Croatia. Statistically significant differences were found among 3 countries in the distribution of articles associated with media type, the position of articles (covers), style (number of words, sensational seeking style), source of information, aggressive acts associated with psychiatric patients, stigmatizing headline and psychiatric diagnoses. This data should serve us to formulate practical recommendations for media in order to meet anti-stigmatizing objectives and thus improve media coverage.

WIII.2 MENTAL HEALTH FINANCING AND PURCHASING IN FOUR EASTERN EUROPEAN COUNTRIES

Cosoveanu, G.¹, Dlouhy M.², Cizmarik, P.³, Hinkov H.⁴

1. Department of the Planning, Development and Health Services Providers Relations, Health Insurance House of the Transports, Constructions, and Tourism Ministry (CAS MTCT)

2. School of Informatics and Statistics, The University of Economics, Prague

Dept. of Public Health, The Institute of Postgraduate Medical Education, Prague

3. Department of Finance and Accounting, Faculty of Economics, Matej Bel University, Banská Bystrica, Slovakia

4. Department Global Mental Health in National, Center for Health Protection, The Ministry of Health

Background: Understanding financing of mental health services in post-Soviet Eastern/Central Europe may be key to promoting system reform.

Objectives: 1) to describe and analyze the current status of mental health financing and purchasing in Romania, the Czech Republic, Slovakia and Bulgaria; 2) to identify common trends as well as country specific policies, and 3) to find opportunities for transfer of knowledge and experience among the countries. This information can be used to advance development of mental policy and access to services in countries Eastern European countries.

Methods: Country-specific information was obtained with a questionnaire developed as part of the overall project, *Finance and Mental Health Services in Central and Eastern Europe*, sponsored by the U.S. National Institutes of Health/John E. Fogarty International Center. The questionnaire included both quantitative and qualitative information about mental health policy, health services, financing and purchasing.

Results: All of the study countries have tax-financed social health insurance to assure universal access to mental health services. The Czech Republic and Slovakia have multiple health insurance funds; Romania has a unique social health insurance fund administrated by the National Health Insurance House; Bulgaria operates one national health insurance fund. In the Czech and Slovakian programs mental health care is

financially integrated with other services. In Romania there is a separate Mental Health National Program developed by the Health Ministry through the social health insurance fund. Bulgaria is the only country in which inpatient care for the mentally ill is financed from the state budget and outpatient care is financed from health insurance. These various funding streams create both opportunities as well as barriers to improving mental health services for these four countries, but as these systems develop and evolve, it is not yet clear if one strategy is more effective or equitable than another.

WIII.3 DEPRESSION AMONG DIABETES PATIENTS IN CLUJ- NAPOCA, ROMANIA AND TRNAVA, SLOVAKIA

Chereches R.¹, Majdan M.²

1. Center for Health Policy and Public Health, Institute for Social Research; Faculty of Political, Administrative and Communication Sciences, Babes-Bolyai University, Cluj, Romania

2. Trnava University Faculty of Health and Social Work Department of Public Health

Background: Despite the potential benefits of treating depression in patients with diabetes, major depression is not often recognized in primary care or specialty care settings. Screening for depression is not a standard part of the medical care protocols for the treatment of diabetes in Romania or Slovakia. Depression in the diabetes patients may go unrecognized because diabetologists in these countries generally lack formal training and/or sufficient time to conduct diagnostic interviews. Increasing the detection and treatment of depression has the potential to improve overall health outcomes, but baseline information about incidence and prevalence is needed to plan for further system/practice change. International comparisons have the potential to advance effective policy in each country.

Objectives: 1) validate translated versions of the PHQ9 as a screening tool for depression amongst diabetes patients in Slovakia and Romania, and 2) determine the prevalence of depression among diabetes patients in these two countries.

Methods: In a cross-sectional study in two major diabetes clinics in Cluj Napoca, Romania and Trnava, Slovakia, the PHQ9 (Patient Health Questionnaire) was used on a randomized sample of treated diabetes patients from both clinics. The scores of PHQ9 were compared against Beck Depression Inventory for validation.

Results: The collected data is in the process of being analyzed. The results from the final data analysis will be available by the time of the conference and will describe the utility of PHQ 9 as a screening tool for depression in diabetes patients both in Romania and Slovakia as well as the prevalence of depression in diabetes patients. The implications of significant differences as well as similarities will be considered.

Saturday, September 5, 2009, 08.30-10.00

Hall Thalia 3**WORKSHOP****W IV****Multiplicity in Group Interventions for Alcohol Abuse/Dependence
Patients: Implications for Quality of Life Improvement***Chair: Maria Ginieri-Coccosis***W IV****OVERALL ABSTRACT**

Purpose: This workshop has an educational purpose with respect to the addictive disorder of alcohol abuse/dependence focusing on group psychotherapeutic processes and related issues. An overview of group methods will be presented with emphasis to the special aspects regarding their application in alcohol dependence. Next, qualitative analysis outcomes of group therapy sessions will be presented revealing the presence of childhood traumatic experiences, the type of such experiences, their connection to alcohol abuse and the need for early detection and promotion of mental health. In the following presentation, acting out behaviors during therapy sessions will be connected to the patients' projective drawings and their narratives to projective testing, revealing important aspects of the therapeutic relationship. Finally, the application of creative arts in group psychotherapy with alcohol abuse patients will be presented offering techniques that may support quality of life changes and improvement.

focus on the interactions among group members. Five models are common in alcohol abuse treatment: a) psychoeducational groups, which aim at providing information relevant to substance abuse, b) skills development groups with the aim to help members develop skills in order to achieve abstinence, such as the control over powerful emotions, c) cognitive – behavioral groups, which aim at altering thoughts and actions that lead to substance abuse, d) support groups that help maintenance of abstinence and e) interpersonal process groups that deal with fundamental developmental issues which have played a significant role to addiction. In substance abuse treatment the use of specialized groups is also common: a) relapse prevention, b) communal and culturally specific groups and c) expressive groups. The latter groups make use of art, music, drama, psychodrama, gestalt, bioenergetics, psychomotor, dance, free movement and poetry. There are also groups focused on specific problems. These groups enable people to learn problem solving skills. Finally, Alcoholics Anonymous (AA) and other 12 – Step programs are not group therapy, but can have a complementary role to psychotherapy or regular group therapy.

WIV.1**GROUP PSYCHOTHERAPEUTIC INTERVENTIONS IN
ALCOHOL ABUSE**

Anna Trova, Maria Ginieri-Coccosis, Thomas Paparigopoulos,
Ioannis A. Liappas

Group therapy is a form of psychotherapy in which a small group of people meet regularly, are guided by a trained group therapist and interact in order to promote psychological growth and personality change. This kind of therapy is cost-efficient and available to many patients at the same time. Addiction is usually connected to depression, anxiety, denial, feelings of isolation and shame, temporary cognitive impairment and character pathology. Psychopathological symptoms may decline in response to group therapy. Group therapeutic interventions

WIV.2**CONNECTING CHILDHOOD TRAUMA TO ALCOHOL ABUSE:
QUALITATIVE OUTCOMES AND IMPLICATIONS FOR MENTAL
HEALTH INTERVENTIONS**

Olga Theodoropoulou, Maria Ginieri-Coccosis,
Elias Tzavellas, Ioannis A. Liappas

Adverse childhood experiences (ACE) are the most basic cause of several health risk behaviors, including alcohol abuse. Research results demonstrate that approximately 2/3rds of all alcohol abusers can be attributed to ACE. According to relevant studies, there is a significant and graded relationship between a history of multiple childhood traumas and alcohol dependence. In other words, the presence of traumatic

experience at an early age increases the risk of substance abuse in adult life. Specifically, adult alcohol misuse has been linked to child abuse and family dysfunction. In most cases this involves self-medicating with alcohol or other substances in order to deal with emotional pain.

In this study, results are presented referring to a qualitative analysis on weekly group psychotherapy sessions with alcoholic patients. Over a period of three years, open group participation included 82 patients, who were consecutively hospitalized in a specialized detoxification unit for 4-6 weeks. Outcomes of analysis show that patients connect traumatic experiences in childhood to the need to gain relief from severe emotional pain through excessive alcohol consumption. The most frequent traumas reported by the patients can be grouped in three categories with respect to ACE: Abuse of child, trauma in child's household and neglect of child. Almost all patients reported more than one traumatic event or condition before alcohol use, and referred to being unable to cope with adult life stressors due to lack of resilience. Further, an abusive relationship with at least one of the caregivers was reported leading to repeating dysfunctional adult relationships and to the use of alcohol. Results are important both in developing tailored alcohol abuse interventions as well as implementing mental health promotion programmes.

WIV.3

ACTING OUT IN GROUP PSYCHOTHERAPY WITH ALCOHOL ABUSE PATIENTS: WHAT ACTIONS CAN REVEAL ABOUT THE THERAPEUTIC RELATIONSHIP.

Anna Trova, Maria Ginieri-Coccosis, Thomas Paparigopoulos, Ioannis A. Liappas

Acting out refers to any impulsive act which is usually aggressive and directed to either oneself or others. It is considered as substitute for verbal expression and has a symbolic sense since the person acts instead of thinking or verbalizing. The difficulty in treating acting out relates to the fact that its genetic roots are linked to preverbal experiences. This presentation illustrates qualitative data collected from group psychotherapeutic sessions with alcohol abuse/dependent patients, who were hospitalized in a specialized program in Eginition Hospital. Types of acting out include both behaviors within and outside the therapeutic setting, such as early or late coming to the sessions, repeated absences, keeping long silences or getting angry with members of the group, as well as provocative verbal behavior to regress into drinking. Acting out may be related to unrecognized tendencies within the group to get more care and attention even by attempting to split members and create subgroups. Further, acting out may involve impulsive alcohol use during the short breaks out of the hospital on weekends, minor accidents, as well as to aggressive behavior towards family members. In many ways, patients try to manipulate the setting by committing suicidal or parasuicidal attempts. Acting out phenomena can be considered in terms of the patients' projections of their self-destructive tendencies and negative self-perceptions and emotions expressed towards the therapeutic setting or the therapist. Finally, acting out may have a function of communication of hidden or unexpressed feelings and thoughts, offering very useful information that would be unavailable otherwise. The role of acting out and its therapeutic

use in group psychotherapy with alcohol abuse patients is discussed.

WIV.4

CLINICAL APPLICATIONS OF CREATIVE, PROJECTIVE AND NARRATIVE TECHNIQUES FOR QUALITY OF LIFE SUPPORT TO ALCOHOL ABUSE PATIENTS

Stella Evangelidou, Maria Ginieri-Coccosis, Thomas Paparrigopoulos, Ioannis A. Liappas

An innovative group intervention supporting Quality of Life (QoL) improvement for hospitalized alcohol abuse patients was initiated at Eginition Psychiatric Hospital in Athens, Greece. Within a group framework, creative arts, including projective drawings, clay modeling and story narratives, were used on a one-hour weekly basis. Narratives were produced in response to different stimuli such as drawings, music as well as selected pictures from TAT (Thematic Apperception Testing).

The use of creative techniques in the context of group intervention, besides being useful in providing complementary information for the patients' psychological and psychosocial functioning and psychiatric condition, it may constitute an opportunity for the patients themselves to express through creative means, deeper thoughts and unrecognized feelings. These may be identified and discussed within the group context leading to a better understanding of their behaviors regarding abuse/dependence on alcohol.

A series of themes emerged from the qualitative analysis which was performed on the patients' creative products. Themes included underlying traumatic experiences within dysfunctional families, alcohol use as a pattern of behavior through family intergenerational transmission, as well as the presence of feelings of uncertainty about future and fear of alcohol relapse.

Finally, the themes as expressed in the patients' creative productions may correspond to characteristic deficits in different domains of quality of life. Integration of creative arts, projective and narrative techniques within a group psychotherapeutic context may contribute to a multi-dimensional approach for alcohol abuse treatment.

Saturday, September 5, 2009, 10.30-11.30

Hall Thalia 3**WORKSHOP****W V****Gerontology & Mental Health****W V**Stanley Ingman¹, Daniela Simmons², Jina Lewallen³1. *Texas Institute for Research and Education on Aging*2. *National Association of Mental Health of Bulgaria, WFMH*3. *College of Medicine, Department of Geriatrics, University of Arkansas***Overall abstract**

According to the definition of the World Federation for Mental Health (WFMH), the meaning of being mentally healthy is subject to many interpretations rooted in value judgments, which may vary across cultures. Mental health should not be seen as the absence of illness, but more as a form of subjective well being, where individuals feel that they are coping, fairly in control of their lives, able to face challenges, and to take on responsibility. Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity specific to the individual's culture.

With the aging of the baby-boomer generation, the need for mental health and social services specifically for seniors is becoming increasingly significant. Elders suffering from mental health problems tend to have abnormal cognitive and behavioral patterns that are often associated with a decreased ability to function. In many cases, mental health problems in the elderly that require treatment are ignored. Improper treatment of mental illnesses in the elderly seems to be the most prominent contributor to the high suicide rate in this demographic.

The Department of Applied Gerontology in the Toulouse School of Graduate Studies at the University of North Texas brings academic knowledge to bear on public issues and problems through research, education and service activities in the public, private and not-for-profit sectors. Mental health issues among older adults in various nations is one theme of the program at the University of North Texas. This is an essential academic contribution such a program can make to the global field of mental health.

Saturday, September 5, 2009, 13.30-15.00
Hall Santorini 4+5+6

WORKSHOP

W VI

Laughing and Mental Health: Laughing Qigong from Taiwan

Chair: Chueh Chang

W VI

Jui-Hsieh Kao, Yu-Hwa Lin

Mental Health Association in Taiwan, Laughing Program

This workshop has been successfully demonstrated in Cairo of 2005 World Federation for Mental Health, 2006 P & P conference in Oslo, 2007 NAMI Convention in San Diego, and 2008 WFMH conference in Hong Kong. Here again, we will present 10 minutes for a scientific theory first, follow an actual practice 55 minutes then with 25 minutes of Q & A to all the participants.

Structure of the Laughing Qigong

There were four stages of Laughing Qigong in each session.

(1) Warm up stage:

(a) Open your body. Participants stretch their bodies and exhale the sound of "Ha", for 10 times. Through stretch and exhale, open up the suppressed body and negative feeling inside.

(b) Open you mind. Speak out the negative feeling i.e. "It is enough." Or "I am worried." Or "I am angry." Say one feeling several times by tightens one's fists and then let it go by open one's fists and stretch one's palms. And go with the sound of "Ha". This means one can face the feelings and not only let it go but also transform the negative emotions into positive energy. Repeat five times.

(c) Open your spirit. By focus on here and now, appreciate what you are now and give permission to oneself body-relaxed and mind-rest situation. By exhaling people can relax their shoulders and necks, all the way to heads. There will be a peaceful feeling and calm down situation.

(2) Practice stage. Laugh with different sounds (Yi, Wu, Ou, Ya, Ai) by Chinese five meridians (the spleen/stomach, the lung, the kidney, the liver, the heart,). All participants follow five sounds for six times with hands open and gradual stretch. Finally participants roar the sound "Ha Ha Ha," and feel the vibration of the laughter. The vibration goes to the abdominal part around the belly part.

In between each sound practice, the open your body stretch will exercise for three times. Finally, all participants can take

turn to laugh with what body gesture and laugh sounds he/she preferred. The time can last for 10 or more minutes.

(3) Close up stage. Participants used meditation and focus on breathing in and out for at least five minutes leading to relaxation and warm feelings.

(4) Group sharing stage. All participates open up one's experiences to share and discuss in the group.